Healthy Families: From ACEs to Trauma Informed Care to Resilience and Wellbeing: examples of policies and activities across IIMHL & IIDL countries

December 2016

"No one understands the challenges of the recovery journey from trauma better than the person living it"[1]

"What happened to you?" and How can we help?"[2]
(Not: "what's wrong with you"?)

At its best, trauma-informed care is resilience-informed care[3].

"If it's not racially just, it's not trauma informed"[4]

"Everyone has a right to have a future that is not dictated by the past"[5]

"The current evidence makes it clear that taking action to reduce the prevalence and inequalities in prevalence of ACEs across England is both necessary and possible"[6].

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[1] http://www.mhcc.org.au/media/32045/ticp_awg_position_paper__v_44_final___07_11_13.pdf MHCC Australia

[2] http://www.ncjfcj.org/sites/default/files/NCJFCJ_Trauma_Manual_04.03.15.pdf Preparing a Trauma Consultation in the Juvenile and Family Court, 2015

[3] SAMHSA http://humanservices.arkansas.gov/dbhs/Documents/11-0901_TIS%20TA%20Package_508%20Compliant%20(REVISED).pdf

[4] https://acestoohigh.com/2016/10/24/racing-aces-gathering-and-reflection-if-its-not-racially-just-its-not-trauma-informed/#more-6204

[5] Karen Saakvitne http://trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed_Toolkit.pdf

[6] http://www.instituteofhealthequity.org/Content/FileManager/adverse-experiences-book_final.pdf UCL Institute of Health Equity, 2015

Introduction

Past IIMHL activity in this area:

• IIMHL Leadership Exchange 2011

Dr Nadine Burke-Harris spoke at the Combined Meeting in San Francisco as part of the 2011 IIMHL Leadership Exchange. The " **Trauma Across the Lifespan: What do we know?"** session was held with Larke Huang from the Substance Abuse and Mental Health Services Administration (SAMHSA) and a panel of national experts (including Dr Burke-Harris) from the US and Canada.

SAMHSA is the key national world leader in this area as it was the first country to have national policy in this area (see the section on the US below).

• IIMHL '*Make it so*" 2012

In 2012 IIMHL '*Make it so'* [7]looked at work on trauma informed care across IIMHL countries. At that time SAMHSA in the US was still pioneering this work, while other countries were just starting to think about the issues.

In the 2012 *'Make it so'* several key points were noted:

- "*This area of work has grown in countries mainly from:*
  - *Natural and man-made disasters*
  - *Research on family violence and violence against women*
  - *Trauma in the military*
  - *Experiences of refugees*
  - *Indigenous peoples' experiences*
- *Trauma informed care appeared to be an area that is gaining momentum; for example, some have national policies in this area (e.g. the US) while others are starting to progress the area*
- *Many argue that it needs to be seen as an across-government issue (e.g. mental health and addiction, all health, social services, education and justice etc.)*
- *In the addiction/substance misuse area, experts maintain that: "To treat addiction, treat trauma"[8].*

What was also available in 2012 was an extensive body of research, assessment and treatment guidelines on PTSD; and, a large body of knowledge on child abuse and neglect and children in care as well as work on the reduction of seclusion and restraint.

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[7] http://www.iimhl.com/files/docs/Make_It_So/20120712.pdf

[8] http://www.addictionpro.com/article/treat-addiction-treat-trauma

• This current report in 2016

While the above points are still relevant in 2016, great strides have has been made in research, policy and practice across some countries; while others are beginning to explore the area more formally.

In 2016 the major differences are that there is a huge, growing body of research on the biology of ACEs, effects of brain development, toxic stress and child development; a more public health-type approach to interventions this area across sectors; and, more focus on organisational trauma informed approaches and workforce development (e.g. training and interventions for staff); more focus on public awareness (e.g. in Philadelphia), more evidence of the economic benefits of addressing ACEs and trauma; and, a focus on the desired outcome of interventions; for example, hope, resilience and wellbeing.

The following paragraph by Shonkoff from the Center for the Developing Child - Harvard University (2016)[9] highlights some of these:

> ***"New research on plasticity and critical periods in development, increasing understanding of how gene-environment interaction affects variation in stress susceptibility and resilience, and the emerging availability of measures of toxic stress effects that are sensitive to intervention provide much-needed fuel for science-informed innovation in the early childhood arena.***
> ***This growing knowledge base suggests four shifts in thinking about policy and practice:***
>
> ***"(1) early experiences affect lifelong health, not just learning;***
> ***(2) healthy brain development requires protection from toxic stress, not just enrichment;***
> ***(3) achieving breakthrough outcomes for young children facing adversity requires supporting the adults who care for them to transform their own lives; and***
> ***(4) more effective interventions are needed in the prenatal period and first 3 years after birth for the most disadvantaged children and families.***
>
> ***The time has come to leverage 21st-century science to catalyze the design, testing, and scaling of more powerful approaches for reducing lifelong disease by mitigating the effects of early adversity".***

Pediatrician Dr Nadine Burke in 2016 agrees, stating that for the education system:

> **"*Childhood adversity causes fundamental changes in development of the brain, the immune and hormonal systems, and misbehavior can be symptomatic. So teachers should work to determine the source of misbehavior then help rather than punish children. "I would echo the words of a former president of the American Academy of Pediatrics that this is the greatest unrecognized public health crisis facing our nation today," Dr. Harris said. "Now that we understand the biology behind how this happens, I see a huge opportunity for use to change outcomes in the future[10]."***

[9] Shonkoff, J (2016) Capitalizing on Advances in Science to Reduce the Health Consequences of Early Childhood Adversity. JAMA Pediatrics

[10] http://www.post-gazette.com/news/health/2016/10/11/Pittsburgh-s-Dr-Stress-plans-a-new-program-for-troubled-students/stories/201610030135

The Department of Health in England commissioned the Institute of Health Equity to build on the work of the Marmot review, to develop the evidence base around the wider social factors that shape health outcomes and contribute to health inequalities, and to support programmes and policy making at local, national and international level; in 2015 they found:

> ***"Acting to prevent ACEs could improve health, reduce inequalities and save money. Taking action on the causes, prevalence and impacts of ACEs is therefore necessary in order to improve health, reduce inequalities within generations, prevent the transmission of disadvantage and inequality across generations and improve the quality of children, young people and adult's lives[11]"***

This report

The information in this current report was obtained via two main strategies: through IIMHL contacts but mainly through a brief website search of organisations and activities. The emphasis here is on practical applications. This search assumes that all websites are up-to-date.

The focus is mainly on providing links to information related to mental health and addiction services, although as many writers suggest a public health, cross-government, response is required, some of these are noted too. The focus is also across the lifespan.

To keep it manageable, most of the information was centered on 2013 to 2016, except where a major policy document or report was found at an earlier date. While acknowledging this is a very long document, the first author has a history of high ACEs herself and is passionate about the area.

Please note it is not a definitive academic literature search, but rather a *very quick snapshot* of some recent examples of national or state policies, reports and activities across national agencies in the eight IIMHL countries. We hope this report will allow speedy access to information and activities across the eight countries.

If there is a major policy document missing we are happy to include it at any time.

We hope you find it helpful.

Janet Peters and Fran Silvestri

[11] http://www.instituteofhealthequity.org/Content/FileManager/adverse-experiences-book_final.pdf p.4

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Key points

The author notes several general concepts that have arisen from this quick 2016 scan:

- Because of the nature of ACEs and the science behind them, trauma informed care is becoming a public health social movement, as well as a clinical issue (assessment and treatment/intervention) and a systemic issue – thus it is a workforce development issue first and foremost.

- Economic cases for addressing ACEs have been made (e.g. in the US, England, Scotland and Wales).

- While ideally trauma-informed care should be explicitly envisaged as a systemic change approach that is reflected at all levels of the service system (i.e. to provide trauma-informed services, all staff of an organization, from the receptionist to the direct care worker to the board of directors, must understand how trauma impacts on the lives of the people being served so that every interaction is consistent with the recovery process and reduces the possibility of re-traumatization); in fact in practice, many agencies may start with a small focus and grow that, (e.g. educate staff on the basics or, encourage all Pediatricians to assess ACEs).

- Some staff of various agencies have expressed concern about asking about ACEs (e.g. "*it may open a can of worms", "I won't know how to respond*" or "*I may respond with emotion/ hard to hear/ reminders of own struggles"* and toolkits have addressed such concerns with practical solutions.

- Pediatricians are joining the movement (e.g. The American Academy of Pediatricians has endorsed a public-health approach and New Zealand may be starting work with Pediatricians).

- Some agencies focusing on mothers and babies health have been 'early adopters' of ACEs research and trauma informed care.

- Trauma informed care is seen as part of a suicide prevention approach by some agencies.

- There is a strong collective voice in the US looking at ACEs, trauma and people of colour.

- For countries with indigenous peoples (e.g. Canada and New Zealand) there is a need to involve such communities in work on trauma so that the result is culturally safe and effective.

- Language: England has a policy called "Troubled Families" and New Zealand has a new "Ministry for Vulnerable Children". The author suggests that more aspirational language could be used e.g. "Healthy/Strengthening Families" for the UK; Ministry for Healthy/Strong Families" for New Zealand?

- Recently, there have been attempts to provide consistency in definitions and a shared language around trauma and a trauma-informed approach to care. SAMHSA's (2014) Concept of Trauma and Guidance for a Trauma-Informed Approach puts forward definitions and a working concept of trauma and a trauma-informed approach in order to develop a shared understanding of these concepts for service systems and stakeholders. SAMHSA is a key resource for trauma-informed approaches to care and these definitions have been widely adopted.

- Several countries (e.g. England, Scotland and Wales) and States (e.g. in the US) have now measured ACES and highlight the need for a public health approach to interventions for families. There are also assessment tools for communities and practitioners.

- Australia has published guidelines for trauma services delivery across sectors (e.g. mental health, health, education and justice)

- There is a saying by Dr Gabor Mate from Canada: "*To treat addiction, treat trauma*" – some agencies are taking this approach to addiction services. The rate of past trauma in addictions clients is high: 55% to 99% of women in substance use treatment have trauma histories. Dr Mate again talking about adult addicts:

"*These are the abused children we had so much compassion for, but as adults we treat them as criminals"*.

- People who may have experienced trauma may seek help from (among other services):
    - substance use treatment or mental health services
    - hospitals, public health units, primary health care practices, community health centres, community care access centres
    - child protection agencies, parent-child services
    - violence against women/men services
    - criminal justice and correctional services
    - social services agencies, housing services, or shelters
    - services for people of diverse sexuality, race, age and/or socioeconomic backgrounds

  Thus ideally such services need to attend to each person appropriately if possible (or at least not re-traumatise people).

- Youth with experience of ACEs and trauma (i.e. peers) are starting to be involved in training (e.g. US).

- In the US particularly, many schools have adopted the principles and ACEs and work towards becoming "trauma informed schools").

- In the US there are now several states adopting 'state-wide' systemic approaches (e.g. Philadelphia)

- In Washington State there is a "public/private" partnership to move a state-wide trauma informed effort forward.

- In the US trauma informed work is occurring with veterans; in custodial settings, and, some countries are taking a trauma informed approach to working with older people.

- As has been the case for many years, PTSD remains a focus of research and practice for many organisations. Work around family violence, trauma in the military, children in care and abuse and neglect continues, with much now being informed by ACEs and trauma work.

- Work continues on the reduction of seclusion and restraint in all countries.

Recent documents looking at national perspectives

Scottish Public Health Network (ScotPHN) 'Polishing the Diamonds' Addressing Adverse Childhood Experiences in Scotland, 2016
https://www.scottishrecovery.net/wp-content/uploads/2016/06/ACE_Repor_-Final_2016.pdf

US Report: Using a Brain Science-Infused Lens in Policy Development Achieving healthier outcomes for children and families. Change in Mind initiative: Alliance for Strong Families and Communities and the Palix Foundation with strategic investment from the Robert Wood Johnson Foundation, 2016
http://alliance1.org/sites/default/files/PDF/designcim_science_infused_policy.finalsept272016.pdf

UK book: The impact of adverse experiences in the home on the health of children and young people. This report was written for the Department of Health staff of the UCL Institute of Health Equity led by Professor Sir Michael Marmot, 2015.
http://www.instituteofhealthequity.org/Content/FileManager/adverse-experiences-book_final.pdf

UK Article: Trauma-informed mental healthcare in the UK: what is it and how can we further its development? Sweeney et al. Mental Health Review Journal, 2016, Vol. 21 Iss: 3, pp.174 - 192
http://www.emeraldinsight.com/doi/full/10.1108/MHRJ-01-2015-0006

US article: Shonkoff, Capitalizing on Advances in Science to Reduce the Health Consequences of Early Childhood Adversity. JAMA Pediatrics, 2016
http://albertamentors.ca/wp-content/uploads/2016/08/Jack-Shonkoff-paper-JAMA-August-2016.pdf

NZ report: The Economics of Early Intervention. Brainwave Trust Aotearoa, April 2013.
http://www.brainwave.org.nz/wp-content/uploads/2011/11/The-Economics-of-Early-Intervention-Brainwave-Trust-Aotearoa-April-20131.pdf

Bellis et al : Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population: Alcohol Use, Drug Use, Violence, Sexual Behaviour, Incarceration, Smoking and Poor Diet, 2015
Public Health Wales & Centre for Public Health
http://www.cph.org.uk/wp-content/uploads/2016/01/ACE-Report-FINAL-E.pdf

Definitions

Context for these definitions

Where the information below is not referenced, it is from the US “The Community Resilience Cookbook” (The CCC); http://communityresiliencecookbook.org/the-language-of-aces/
or the UK, 2016 article by Sweeney et al entitled: “Trauma informed mental healthcare in the UK: what is it and how can we further it’s development?”.
http://www.emeraldinsight.com/doi/pdfplus/10.1108/MHRJ-01-2015-0006

On occasion links to other information have been inserted. The author has chosen to have full, explanatory descriptions of definitions to set a wider context for countries' policies and activities. The audience may be at different levels of awareness of this topic, thus broad information is presented here.

The CCC states:

> ***"What do we mean when we say adversity, toxic stress or resilience? To have a conversation that crosses disciplines—medicine, mental health, social service, juvenile justice, education—and includes everyone from health policy experts to grass-roots organizers, we need to be clear about our terms".***
> http://communityresiliencecookbook.org/the-language-of-aces/

Definitions

Adverse Childhood Experiences

ACEs are adverse childhood experiences that harm children's developing brains so profoundly that the effects show up decades later; they cause much of chronic disease, most mental illness, addiction and are at the root of most violence. "ACEs" comes from the CDC-Kaiser Adverse Childhood Experiences Study, a groundbreaking public health study that discovered that childhood trauma leads to the adult onset of chronic diseases, depression and other mental illness, violence and being a victim of violence. The ACE Study has published about 70 research papers since 1998. Hundreds of additional research papers based on the ACE Study have also been published in the US and ACEs have been measured in several countries (e.g. England, Wales, and Scotland).

The 10 ACEs the researchers measured:

— Physical, sexual and verbal abuse.

— Physical and emotional neglect.
— A family member who is:
- **depressed or diagnosed with other mental illness;**
- **addicted to alcohol or another substance;**
- **in prison**

— Witnessing a mother being abused.

— Losing a parent to separation, divorce or other reason.

Of course, there are many other types of childhood trauma — such as witnessing a sibling being abused, witnessing violence outside the home, loss of culture, war, natural disaster, witnessing a father being abused by a mother, being bullied by a classmate or teacher – but only 10 types were measured. They provide a useful marker for the severity of trauma experienced. Other types of trauma may have a similar impact.

Significance: The US ACE Study revealed five main discoveries:

1. ACEs are common…nearly two-thirds (64%) of adults have at least one.

2. They cause adult onset of chronic disease, such as cancer and heart disease, as well as mental illness, violence and being a victim of violence

3. ACEs don't occur alone….if you have one, there's an 87% chance that you have two or more.

4. The more ACEs you have, the greater the risk for chronic disease, mental illness, violence and being a victim of violence. People have an ACE score of 0 to 10. Each type of trauma counts as one, no matter how many times it occurs. You can think of an ACE score as a cholesterol score for childhood trauma. For example, people with an ACE score of 4 are twice as likely to be smokers and seven times more likely to be alcoholic. Having an ACE score of 4 increases the risk of emphysema or chronic bronchitis by nearly 400 percent, and suicide by 1200 percent. People with high ACE scores are more likely to be violent, to have more marriages, more broken bones, more drug prescriptions, more depression, and more autoimmune diseases. People with an ACE score of 6 or higher are at risk of their lifespan being shortened by 20 years.

5. ACEs are responsible for a big chunk of workplace absenteeism, and for costs in health care, emergency response, mental health and criminal justice. So, the fifth finding from the ACE Study is that childhood adversity contributes to most of our major chronic health, mental health, economic health and social health issues.

https://acestoohigh.com/aces-101/

Addiction/substance abuse and links with trauma

Trauma is pervasive. It can be life changing, especially for those who have faced multiple traumatic events, repeated experiences of abuse or prolonged exposure to abuse. Even the experience of one traumatic event can have devastating consequences for the individual involved. It is very common for people accessing substance use treatment and mental health services to report overwhelming experiences of trauma and violence. Often people who have experienced trauma view their use of substances as beneficial in that it helps them to cope with trauma-related stress.

Unfortunately, this seemingly adaptive coping mechanism can make people more vulnerable to substance use problems. Given that the experience of trauma is commonly associated with substance abuse, to meaningfully facilitate change and healing, substance use treatment providers must help people make the connections between their experience of trauma and their problematic substance use or mental health concerns.

How we make our services emotionally and physically safe, as well as how we create opportunities for learning, the building of coping skills and the experience of choice and control, can make a significant difference in client engagement, retention and outcomes.

http://www.ccsa.ca/Resource%20Library/CCSA-Trauma-informed-Care-Toolkit-2014-en.pdf

These traumatic experiences can also affect people with substance abuse issues confidence about accessing and continuing to get help from service providers.

"Trauma-informed care does not require that the person disclose trauma. It means that care providers must use daily practices based on safety, choice and control, which are key to empowering trauma survivors and making sure they are not retraumatized".

https://www.porticonetwork.ca/-/trauma-informed-care

Adversity

Adversity can be seen as hardship, distress or suffering. In the context of ACEs, adversity refers to circumstances in a child's life including neglect, abuse and family dysfunction. It can also refer to hardships faced by individuals and communities due to natural disaster, violence, discrimination, racism or poverty. http://communityresiliencecookbook.org/the-language-of-aces/

Anxiety

Everyone gets anxious from time to time – it's a normal response to stressful situations like having a job interview. But for some people, the feelings of anxiety can be a lot more extreme and become what's known as an anxiety disorder.

- **Generalised anxiety disorder** is where someone feels anxious about a number of things on most days over a long period of time – 6 months or more.
- **Phobias, including social phobia** are when someone feels very fearful about a particular object or situation and it interferes with life. Examples are fear of attending social events, driving over bridges, or travelling on planes.

Some other kinds of anxiety disorder are obsessive compulsive disorder, post-traumatic stress disorder and panic disorder.
http://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/anxiety

Allostasis and allostasis load

Allostasis refers to the way the brain and body respond to challenges or stresses: by reacting, adapting and then recovering. But if the stress is extreme, negative and unrelenting, the brain and body pay a price. That accumulated wear-and-tear, called allostatic load, can cause chemical imbalances, accelerate certain diseases, and even alter brain structures.

Genetics, early brain development, the social and physical environment, diet and other behaviors can all influence a person's allostatic load.
http://communityresiliencecookbook.org/the-language-of-aces/

Brain development

The basic architecture of the brain is constructed through on ongoing process that begins before birth and continues into adulthood (brain architecture).

- Brains are built from the bottom up: basic circuits lay the foundation for more complex circuits and behaviors that follow (skill begets skill).
- Interaction between genes and experience shapes the developing brain, and relationships are the active ingredient in this serve and return process (serve and return).
- Executive function skills help us plan for the future, reason, focus, solve problems, and use information in new and complex ways. These skills can be taught and should be geared up in children as early as possible (air traffic control).
- Cognitive, emotional, and social capacities are inextricably intertwined: learning and behavior are interrelated with physical and mental health over the life course (can't do one without the other).
- Toxic stress damages the developing brain and leads to problems in learning and behavior and to increased susceptibility to poor physical and mental health over time (toxic stress).
- Brain plasticity and the ability to change behavior decreases as we mature: getting it right early is easier and less costly to society and individuals than trying to fix it later.

http://alliance1.org/sites/default/files/PDF/designcim_science_infused_policy.finalsept272016.pdf

Brain development: protective factors for health development

Recent prevention resource guides from the HHS Children's Bureau (2015) encourage professionals to promote six "protective factors" that can strengthen families, help prevent abuse and neglect, and promote healthy brain development:

- Nurturing and attachment
- Knowledge of parenting and of child and youth development
- Parental resilience
- Social connections
- Concrete supports for parents
- Social and emotional competence for children

https://www.childwelfare.gov/pubPDFs/brain_development.pdf

Children in care

Six principles for supporting children in care who have been traumatised:

1. Provide safe environments and rich experiences that stimulate and enrich brain growth.
2. Support children and caregivers to understand the link between traumatic events and cognitive difficulties.
3. Develop and support positive relationships and connections in children's lives.
4. Maintain targeted interventions throughout childhood and adolescence.
5. Offer all children in care targeted and trauma-specific interventions.
6. Ensure that specific cognitive difficulties are addressed directly.

https://aifs.gov.au/cfca/publications/effect-trauma-brain-development-children

Collective impact

While the term "collective impact" is not limited to the work of building resilient communities, this approach, in which different sectors–for example, juvenile justice, education and social services–share an agenda and goals, has been key to creating successful social change.

Collective impact initiatives, unlike simple collaborations, have a "backbone organization," shared measurement systems, continuous communication and mutually reinforcing activities.

Complex trauma

When children are exposed to multiple traumatic events, such as ongoing physical or sexual abuse, witnessing family or community violence, or separation from family members, they may suffer complex trauma, with deep and long-lasting effects on their ability to think, learn and relate to others. Research has shown that the more ACEs a person has, the higher his or her risk for problems including addiction, chronic physical conditions, depression and anxiety, self-harming behaviors, and other psychiatric disorders.

Community anxiety

We live in a world where news of natural disasters, war and terrorism are streamed 24/7 around the globe. Recent events include the devastating bushfires in South West Victoria and Western Australia; floods in the Northern Territory and Far North Queensland; the Paris terror attacks, war in Syria and the threat of further terror attacks in Europe; and, more recently, the earthquakes in New Zealand.

For those who have been through traumatic events in the past, media reports can induce a re-experiencing of trauma-related distress. They can also increase general public anxiety about their own vulnerability.

https://www.psychology.org.au/inpsych/2016/psychological-trauma/

Culture (loss of)

It is well documented that indigenous peoples health has been affected by loss of culture, land and language. Examples include:

Australia: Indigenous people in Australia have experienced trauma as a result of colonisation, including the associated violence and loss of culture and land, as well as subsequent policies such as the forced removal of children. In many Indigenous families and communities, this trauma continues to be passed from generation to generation with devastating effects. Research shows that people who experience trauma are more likely to engage in self-destructive behaviours, develop life-style diseases and enter and remain in the criminal justice system. In fact, the high rates of poor physical health, mental health problems, addiction, incarceration, domestic violence, self-harm and suicide in Indigenous communities are directly linked to experiences of trauma. These issues are both results of historical trauma and causes of new instances of trauma, which together can lead to a vicious cycle in Indigenous communities.
http://www.australianstogether.org.au/stories/detail/intergenerational-trauma

Canada: First Nations people in particular have been profoundly affected by:

- intergenerational trauma
- colonization
- the residential school experience

http://www.mentalhealthcommission.ca/sites/default/files/2014-0408_mhcc_trauma-informed_care_0.pdf

New Zealand: Like most indigenous peoples, Māori were colonised and suffered from loss of land that sustained traditional lifestyles. The loss of an economic base has resulted in many Māori being forced to abandon those lifestyles and being marginalised in their own homeland. The impact of colonisation on the health of Maori has been widely discussed in literature. Māori carry a greater burden of health inequalities and die approximately eight years earlier than their Pākehā (non-Māori) cohort.
http://www.hauora.co.nz/resources/Hauora%20KeepinguptoDate3-09.pdf

DSM V Definition of trauma

The DSM V defines trauma as:

"A direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about an unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (APA 2000, p. 463).

Recommendations for **clinical** treatment include:

- Trauma-Focussed CBT and Eye Movement Desensitisation and Reprocessing Therapy (EMDR). Trauma-focused CBT includes Exposure Therapy, Cognitive Therapy, Cognitive Processing Therapy and Narrative Exposure Therapy. These therapies have at their core working through the memories of the trauma, exposure to avoided places and situations and addressing thoughts interfering in recovery.
- These recommendations apply to PTSD from both single and repeated events exposure. In the latter, where people have developed associated problems such as emotional dysregulation, interpersonal difficulties and/or dissociative symptoms, it is recommended that therapy be conducted at a slower pace with more time spent establishing a trusting therapeutic relationship and teaching emotional regulation skills.

While pharmacotherapy is considered a second line treatment, it can be important in promoting stabilisation or as an adjunct to trauma-focussed therapy. Other second line psychological treatments for PTSD include non-trauma focussed approaches. Some examples include interpersonal therapy and anxiety management".
https://www.psychology.org.au/inpsych/2016/psychological-trauma/

Early childhood development: Five numbers to remember

From the Center for the Developing Child - Harvard University:

700 New Neural Connections Per Second **-** The early years matter because, in the first few years of life, 700 new neural connections are formed every second. Neural connections are formed through the interaction of genes and a baby's environment and experiences, especially "serve and return" interaction with adults, or what developmental researchers call contingent reciprocity. These are the connections that build brain architecture – the foundation upon which all later learning, behavior, and health depend.

8 Months: Age At Which Disparities in Vocabulary Begin to Appear - Early experiences and the environments in which children develop in their earliest years can have lasting impact on later success in school and life. Barriers to children's educational achievement start early, and continue to grow without intervention. Differences in the size of children's vocabulary first appear at 18 months of age, based on whether they were born into a family with high education and income or low education and income. By age 3, children with college-educated parents or primary caregivers had vocabularies 2 to 3 times larger than those whose parents had not completed high school. By the time these children reach school, they are already behind their peers unless they are engaged in a language-rich environment early in life.

90 - 100% Chance of Developmental Delays When Children Experience 6 - 7 Risk Factors - Significant adversity impairs development in the first three years of life—and the more adversity a child faces, the greater the odds of a developmental delay. Indeed, risk factors such as poverty, caregiver mental illness, child maltreatment, single parent, and low maternal education have a cumulative impact: in this study, maltreated children exposed to as many as 6 additional risks face a 90-100% likelihood of having one or more delays in their cognitive, language, or emotional development.

3:1 Odds of Adult Heart Disease After 7 - 8 Adverse Childhood Experiences - Early experiences actually get into the body, with lifelong effects—not just on cognitive and emotional development, but on long-term physical health as well. A growing body of evidence now links significant adversity in childhood to increased risk of a range of adult health problems, including diabetes, hypertension, stroke, obesity, and some forms of cancer. This graph shows that adults who recall having 7 or 8 serious adverse experiences in childhood are 3 times more likely to have cardiovascular disease as an adult.

$4 - $9 in Returns For Every Dollar Invested in Early Childhood Programs - Providing young children with a healthy environment in which to learn and grow is not only good for their development—economists have also shown that high-quality early childhood programs bring impressive returns on investment to the public. Three of the most rigorous long-term studies found a range of returns between $4 and $9 for every dollar invested in early learning programs for low-income children. Program participants followed into adulthood benefited from increased earnings while the public saw returns in the form of reduced special education, welfare, and crime costs, and increased tax revenues from program participants later in life.

http://developingchild.harvard.edu/resources/five-numbers-to-remember-about-early-childhood-development/

What These Five Numbers Tell Us

1. **Getting things right the first time is easier and more effective than trying to fix them later.**
2. **Early childhood matters because experiences early in life can have a lasting impact on later learning, behavior, and health.**
3. **Highly specialized interventions are needed as early as possible for children experiencing toxic stress.**
4. **Early life experiences actually get under the skin and into the body, with lifelong effects on adult physical and mental health.**
5. **All of society benefits from investments in early childhood programs.**

"Nothing records the effects of a sad life as graphically as the human body"[12]

Early childhood intervention (ECI)

Research shows that what happens early in a child's life can continue to exert an effect throughout childhood. This creates a theoretical window of opportunity to improve a child's development trajectory over the longer term.

Early childhood interventions are programs that aim to do this. They are intended to address the impacts of intractable social problems such as low educational achievement and attainment, crime, welfare dependence, family conflict and instability, unemployment and poverty, early in the life course.

Table 1: Types of early childhood interventions

Primary
Programs that are openly accessible where participation is driven by users.
Programs such as Communities for Children, and many varieties of Triple P (the Positive Parenting Program) are primary-level interventions.

Secondary
Programs that are targeted towards families considered at risk or vulnerable. Programs such as HIPPY and Pathways to Prevention are secondary-level interventions.

Tertiary
Programs that are targeted towards families to prevent the further development of particular problems. Programs designed for families identified by child protection services are usually considered tertiary-level interventions.
(p.4)

[12] Dr Gabor Mate, Canada

Early Childhood Interventions are different from childcare and

Preschool

Early childhood interventions can sometimes be overshadowed by big-spending, universal, childcare and preschool programs.

Childcare refers to any non-parental care of children. In the context of public policy, it usually refers to 'formal' childcare — care outside a home environment that does not involve a relative, babysitter or other in-home

carer. The purpose of childcare is generally so that parents can undertake other activities (usually work) while having their children looked after. Formal childcare mostly consists of long day care, family day care, and — for

school-age children — out of school hours care. Childcare is funded publicly by the federal government through fee subsidies, and privately through parents.

Preschool refers to a structured early education program for all children. It is usually part-time (two or three half-day sessions a week) and most often attended by children in the year or two before they are due to begin school. The purpose of preschool is to assist in the transition to school and to equip children with the skills they need to adjust to formal schooling. Provision differs state-by-state, but most often preschool is governmentrun

(and attached to primary schools), community-run, or is part of a long day care centre. Long day care centres attract federal childcare subsidies, whereas standalone preschools are funded by state governments (in part through the federal government's 'Universal Access' program) and by parents.

Early childhood interventions largely service the same age group as childcare and preschool (often collectively referred to as 'early childhood education and care') but they are different in several ways. They are targeted, either through a 'place-based' model where programs are concentrated in particular disadvantaged communities, or through more explicit means (such as referral from child and family services). They aim to effect change through a range of means, of which centre-based early learning, home visiting, playgroups and parental counselling are just a few. Measured outcomes are similarly broad. (p.4)

https://www.cis.org.au/app/uploads/2016/09/rr19.pdf

Economics of toxic stress

"The consequences of toxic stress are among the most expensive problems society deals with. Prison is incredibly more expensive than early childhood programs. Economic dependence is much more expensive than people earning a living and paying taxes. Being healthy is much less expensive than paying for heart disease and diabetes and stroke. All of this is not only morally imperative, but it has huge financial cost implications."
http://www.heitkamp.senate.gov/public/_cache/files/2c92d623-0fd4-4237-b312-68cd17587d34/5-25-prewitt-powerpoint.pdf

Epigenetics

Even our genes respond to what happens to us, through chemical reactions that turn certain parts of the genome on or off in response to stress, diet, behavior, toxins and other factors.

Epigenetics is the study of how the social and physical environment change the expression of our genes.

Evidence-based policy

This is public policy informed by rigorously established objective evidence. There are different levels of evidence (Center for Evidence-Based Management, 2016).

There is a hierarchy of validity associated with different types of evidence.
http://alliance1.org/sites/default/files/PDF/designcim_science_infused_policy.finalsept272016.pdf

Evidence-based practice

This is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual.

It means, “integrating individual clinical expertise with the best available external clinical evidence from systematic research” (Sackett, Rosenberg, Muir Gray, Haynes, & Richardson, 1996)
http://alliance1.org/sites/default/files/PDF/designcim_science_infused_policy.finalsept272016.pdf

Health in all policies (a WHO concept: HiAP)

Health in All Policies is a **structured** approach **to working** across sectors **and with communities** on public policies. It **promotes trusting relationships and engages stakeholders to** systematically take into account the health implications of decisions.

Health in All Policies seeks synergies and avoids harmful health impacts, in order to improve **societal goals**, population health and health equity. (This definition is used by a public health services in Canterbury, New Zealand – this area has had public health issues after the 2012 earthquakes).
http://us5.campaign-archive1.com/?u=9e99e8fd26a1d68b3f1a4748b&id=57cb338096&e=312104f029

Some key HiAP messages:

- Health begins long before illness where we live, learn, work, and play.
- HiAP is an approach that acknowledges that the causes of health and wellbeing lie outside the health sector and are socially and economically formed.
- HiAP highlights the connections and interactions between health and other sectors and how together the sectors can contribute to better health outcomes.
- HiAP aims to address health inequalities.
- HiAP highlights that many of the factors that affect health and wellbeing are multiple and multi layered and lie beyond the reach of health services and health policies.
- HiAP desires to generate a “win-win” situation such as promoting the message that “taking account of health means more effective government: more effective government means improved health”

Health in all policies can be used as a framework to further ACEs and trauma work.
http://www.cph.co.nz/wp-content/uploads/chiappinfosheet3.pdf

Hope

Hope “is an optimistic attitude of mind that is based on an expectation of positive outcomes related to events and circumstances in one's life or the world at large.
As a verb, its definitions include: "expect with confidence" and "to cherish a desire with anticipation"
https://en.wikipedia.org/wiki/Hope

Interpersonal violence

This has been defined by the World Health Organisation (WHO) as the intentional use of physical force, or power, threatened or actual, against oneself, another person, or against a group or community that either results in, or has a likelihood of resulting in, injury, death, psychological harm, mal-development or deprivation). This definition includes victimisation perpetrated against intimate partners, parents, siblings, children, other relatives, friends, acquaintances, colleagues and strangers. It should be noted that interpersonal violence is often gendered, with marginalised groups being at greater risk, including but not limited to LGBTQI people and (for Australia) Aboriginal and Torres Strait Islander people.
http://www.mhcc.org.au/media/32045/ticp_awg_position_paper__v_44_final___07_11_13.pdf

Mental health as a predictor of happiness

As discussed in Fleche and Layard (2015), mental health is the biggest single predictor of life-satisfaction. This is so in the UK, USA, Germany and Australia. It explains as much of the variance of life satisfaction in the population of a country than physical health does, and much more than unemployment and income do. Income explains 1% of the variance of life-satisfaction or less. http://cep.lse.ac.uk/_new/research/wellbeing/causes_and_effects_of_wellbeing.asp

Mental distress and links with trauma

It is known that many people in contact with mental health services have experienced physical or sexual trauma (Mauritz et al., 2013), that there is a strong link between childhood trauma and adult mental distress (Bentall et al., 2014), and that experiences of marginalisation, poverty, racism and violence are correlated with poor mental health (Paradies, 2006).

This has led to a call for services to acknowledge psychological and social factors in the development of extreme mental distress (Read et al., 2009). The hope is that such models would minimise the risk that people presenting to services have their symptoms disconnected from the context of their lives.
http://www.emeraldinsight.com/doi/pdfplus/10.1108/MHRJ-01-2015-0006

Mental Illness and "eradication" of ACEs

The impact of childhood adversity on the development of adult mental illness has been studied. Using data from the World Health Organisation World Mental Health Surveys, which included 21 countries, six of which were high income countries but did not include the UK, Kessler et al estimated that eradicating childhood adversities would lead to a:

- 22.9% reduction in mood disorders;
- 31.0% in anxiety disorders;
- 41.6% in behaviour disorders;
- 27.5% in substance disorders; and
- 29.8% of all disorders studied.

The economic case for working towards eradication is strong.
https://www.scottishrecovery.net/wp-content/uploads/2016/06/ACE_Repor_-Final_2016.pdf

Neuroplasticity

Where ACEs are concerned, neuroplasticity is the good news. It refers to the brain's ability to grow, adapt, reorganize and form new connections throughout life. Exercise, sleep, music, spending time in nature, meditation, support from family and friends, and a reduction in stress can all help the brain recover from the effects of adverse experiences.
"Neuroplasticity means that ACEs are not destiny; the brain can be hurt, but it can also heal".

Post-traumatic stress disorder

It's human nature to react to fear or danger; this is often called the "fight, flight or freeze" response. But many people, after experiencing traumatic stress, feel frightened even when they're no longer at risk. PTSD can develop after experiencing a traumatic event such as war, sexual assault, a plane crash or an earthquake; it can also develop in response to the chronic stress of witnessing violence or being physically or sexually abused.

Protective factors

Think of these as the opposite of ACEs—the factors or circumstances in a child's life that buffer her/him from harm and promote stability and resilience. Research has shown that supportive family and social relationships, exercise, adequate sleep, proper nutrition, spending time in nature, listening to music, and meditation are key protective factors for individuals.

Protective community factors may include adequate housing, access to health care, support in times of need and caring adults outside the family who serve as mentors and role models.

Psychological First Aid

This training is used as prevention and early intervention

This training principles include safety, calming, connectedness, self-efficacy and hope. An example of an intervention that follows these principles is Psychological First Aid (PFA), which is widely implemented in post-disaster contexts and increasingly embedded into the critical response policy and practice of high risk industries. Philadelphia uses MHFA as one of its building blocks in community development and transformation. http://www.iimhl.com/files/docs/20160204a.pdf

Note: New Zealand has Mental Health 101 which is designed to be specifically targeted to the New Zealand environment (e.g. culturally appropriate for Maori and Pacific communities). It is taught to "frontline" agencies (e.g. Police and government social agencies staff).
http://www.blueprint.co.nz/learning/mh101

Research – future efforts

Many have suggested that more research is needed. England summarised the ideas below and they are also relevant to other countries.

Further evidence and investigation is warranted to:

- provide further information from the English context on how parental material circumstances link to child welfare interventions such as being a looked-after child or on a child protection plan. Currently children's service statistics do not collect data on parents and there has been no representative study on this relationship since 1988.
- ascertain how the fact that a large proportion (approximately half) of the English population is exposed to one or more ACEs relates to child wellbeing and development more generally, and which ACEs are more damaging for health and wellbeing. It is likely that some, such as parental separation, are not always 'adverse'.
- build on current cost estimates in order to provide up to date and good quality information on the financial costs of current ACE prevalence and the benefits of investments in prevention, as well as which individual programmes or features of programmes are cost-effective.
- ascertain how the prevalence of ACEs varies by the age of the child or young person, and to investigate whether, and how, the health impacts of ACEs vary depending on the age of the person experiencing them.
- address how risk factors change depending on the age of the child or young person, and the role of risk factors outside the home.

- evaluate the impact on genetic, epigenetic and brain function of ACEs during later childhood and adolescence.
- identify which parenting programmes are most successful to reduce ACEs (and their risk factors), whether or not findings from other contexts (particularly the US) are applicable in the English context, which features of programmes work best, and what works for older children and young people.
- investigate what makes some children and young people resilient in the face of ACEs, and in which circumstances families 'break the cycle' of the intergenerational transmission of adversity.
- provide comparative data on the impact of different child protection systems internationally in order to ascertain which approaches are most successful.

http://www.instituteofhealthequity.org/Content/FileManager/adverse-experiences-book_final.pdf

Resilience

This is the capacity to cope with stress, overcome adversity and thrive despite (and perhaps even because of) challenges in life. People who are resilient see setbacks and disappointments as opportunities to grow.

While some people may seem to be naturally more resilient, research shows that children, adults and even communities can learn skills and ways of thinking that boost resilience and help them grow.
http://communityresiliencecookbook.org/the-language-of-aces/
In the social, behavioral, and biological sciences, the term resilience is used in a variety of ways and contexts - sometimes as an individual characteristic, sometimes as a process, and sometimes as an outcome. Despite these differences, there is a set of common, defining features of resilience that illustrates how the concept has been used in research and intervention sciences. These features include the following:

- The capacity of a dynamic system to adapt successfully to disturbances that threaten its function, viability, or development.
- The ability to avoid deleterious behavioral and physiological changes in response to chronic stress.
- A process to harness resources to sustain well-being.
- The capacity to resume positive functioning following adversity.
- A measure of the degree of vulnerability to shock or disturbance.
- A person's ability to adapt successfully to acute stress, trauma, or more chronic forms of adversity.
- The process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress. Whether it is considered an outcome, a process, or a capacity, the essence of resilience is a positive, adaptive response in the face of significant adversity. It is neither an immutable trait nor a resource that can be used up. On a biological level, resilience results in healthy development because it protects the developing brain and other organs from the disruptions produced by excessive activation of stress response systems. Stated simply, resilience transforms potentially toxic stress into tolerable stress.

In the final analysis, resilience is rooted in both the physiology of adaptation and the experiences we provide for children. (National Scientific Council on the Developing Child, 2015).
http://alliance1.org/sites/default/files/PDF/designcim_science_infused_policy.finalsept272016.pdf

Video 1: The science of Resilience

http://developingchild.harvard.edu/science/key-concepts/resilience/

Resilience Questionnaire

This questionnaire (see appendix 1) was developed by the early childhood service providers, pediatricians, psychologists, and health advocates of Southern Kennebec Healthy Start, Augusta, Maine, in 2006, and updated in February 2013. Two psychologists in the group, Mark Rains and Kate McClinn, came up with the 14 statements with editing suggestions by the other members of the group. The scoring system was modelled after the ACE Study questions.

The content of the questions was based on a number of research studies from the literature over the past 40 years including that of Emmy Werner and others. Its purpose is limited to parenting education. It was not developed for research.
https://acestoohigh.com/got-your-ace-score/

Re-traumatisation

Sweeney et al state that retraumatisation essentially means to be traumatised again. It occurs when a person experiences something in the present that is reminiscent of a past traumatic event. This current event or trigger often evokes the same emotional and physiological responses associated with the original event. People are not always aware that their current distress is rooted in past events, nor do all people relive the original event in a logical, coherent manner (Durant, 2011).

The mental health system can retraumatise survivors through its fundamental operating principles of coercion and control (Bloom and Farragher, 2010). Retraumatisation includes overt acts, such as restraining and forcibly medicating a rape victim, as well as less palpable retraumatisation, such as pressure to accept medication which mimics prior experiences of powerlessness.

Staff who experience conflicts between job duties and their moral code are under chronic stress for which they must learn to cope and adapt. Those coping strategies may include “shutting off” the ability to empathise, and viewing people receiving services as “other” thereby disqualifying their humanity and basic human rights. Pessimism – rather than enthusiasm and hope – may buffer staff from their own feelings of helplessness (Chambers et al., 2014).
http://www.emeraldinsight.com/doi/pdfplus/10.1108/MHRJ-01-2015-0006

Secondary trauma/vicarious trauma

This refers to the suffering and stress that comes from witnessing, helping or trying to help a traumatized person. Nurses, teachers, hospice workers, foster parents, child welfare workers, physicians, police officers and judges may experience secondary trauma; so can emergency workers who assist following a natural disaster. Symptoms of secondary trauma can include sadness, anger, poor concentration, emotional exhaustion and shame.

Social and emotional learning

This is the understanding that people learn best in the context of supportive relationships, and that teaching children certain skills—self-awareness, self-regulation, social awareness, responsible decision-making— in a caring and trauma-sensitive environment can not only help them thrive in school but can help prevent bullying, drug and alcohol use and other risky behavior.

Social determinants of health

In some ways, a person’s health is due to the “luck of the draw.” All the circumstances in which people are born, grow up, live and work affect how they develop physically, mentally and emotionally. These circumstances—an individual’s neighborhood, family, education, race, gender, class background, diet, workplace and access to health care, for instance—are in turn shaped by a bigger set of forces: economics, social policies and politics. But the social determinants of health are not fixed: individuals and communities can work to change those circumstances so all people have equal opportunities to grow and thrive.

Sweeney et al (2016) note that research has also demonstrated that traumatic events are more frequently experienced by people in low-socioeconomic groups and from minority ethnic communities (e.g. Hatch and Dohrenwend, 2007). It has further been argued that poverty is the most powerful predictor of mental distress because it predicts so many other causes (Read, 2010). Moreover, black people are over-represented in the mental health system, are more likely to experience negative or adversarial pathways to care, to be diagnosed with psychotic disorders and to receive compulsory treatment (e.g. Mohan et al., 2006; Morgan et al., 2004).

Yet, there is little discussion of the potential role of historical and cultural trauma in this. Indeed, social trauma, including poverty, racism and urbanicity, is so prevalent it is often not recognised as integral to poor mental health by clinicians or those experiencing it.
http://www.emeraldinsight.com/doi/pdfplus/10.1108/MHRJ-01-2015-0006

The Marmot Review in 2010 set out the evidence of inequalities in health and the social determinants of health in England, and proposed six high level policy objectives in order to take action on the social determinants of health. These were:

1. **Give every child the best start in life**
2. **Enable all children, young people and adults to maximise their capabilities and have control over their lives**
3. **Create fair employment and good work for all**
4. **Ensure a healthy standard of living for all**
5. **Create and develop healthy and sustainable places and communities**
6. **Strengthen the role and impact of ill health prevention**

In 2016 it is stated that these relate to ACEs and health in three ways:

Firstly, tackling the presence and impacts of ACEs is an important component of some of these policy objectives – such as giving children the best start in life and maximising capabilities and control.

Secondly, inequalities in the SDH could be contributing to inequalities in the prevalence of ACEs. Deprived areas and families living in poverty (who do not have a healthy standard of living) are likely, on average, to have a higher prevalence of ACEs.

Thirdly, the presence of ACEs could impact on the SDH, so that children and young people who are exposed to ACEs are more likely than those who are not to grow up to live in conditions (such as in poverty, or with damaging employment) that have a negative impact on their health.
http://www.instituteofhealthequity.org/Content/FileManager/adverse-experiences-book_final.pdf (p.6)

Toxic stress

Not all stress is bad for the brain and body. The stresses that are part of everyday life—taking a test, learning to drive, preparing for a job interview—can strengthen our problem-solving abilities and boost our resilience. But continual or extreme stress, especially in the early years, can damage a child's ability to think, learn, grow and relate to others. It can have a lifelong effect on both physical and mental health.

http://communityresiliencecookbook.org/the-language-of-aces/ This Toxic Stress Response "can occur when a child experiences strong, frequent, and/or prolonged adversity – such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship – without adequate adult support. This kind of prolonged activation of the stress response systems can disrupt the development of brain architecture

and other organ systems, and increase the risk for stress-related disease and cognitive impairment well into adult years." (Center on the Developing Child at Harvard University).

http://alliance1.org/sites/default/files/PDF/designcim_science_infused_policy.finalsept272016.pdf
Research shows that nurturing, supportive relationships with adults can help reduce the damage caused by early toxic stress.

Trauma (emotional)

Trauma generally refers to an individual's emotional response—including shock, denial, anger and physical symptoms—to a dramatic threat or event: being the victim of sexual or physical abuse, gun violence, war or natural disaster. But trauma can occur even without these cataclysmic events: ongoing neglect or family dysfunction can also be traumatic, triggering changes in the brain and body that lead to physical, behavioral and mental health problems in later life.

Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea. While these feelings are normal, some people have difficulty moving on with their lives. http://www.apa.org/topics/trauma/

From SAMHSA: Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

SAMHSA then goes on to describe the three "e's" of trauma:

- Events
- Experience of events, and
- Effect

http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf

Trauma-informed care (TIC), trauma-informed approaches (TIA)

From SAMHSA: A program, organization, or system that is trauma-informed **realizes** the widespread impact of trauma and understands potential paths for recovery; **recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and r**esponds** by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist **re-traumatization.**
http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf

This is a strengths-based approach to recovery that supports the resilience trauma survivors already have through application of the principles of understanding trauma and its impacts, safety and trust, choice and control, and empowerment.

TIC is not a specific trauma intervention but a whole of service system approach whereby all aspects of a service system (e.g., practitioners through to administrative support, physical setting) need to be organised with knowledge of trauma and violence, an awareness of the pervasiveness of trauma and its impact, as well as a commitment to the multiple paths of recovery. Examples of service systems which have adopted the principles of TIC include homelessness agencies, drug and alcohol services and services caring for refugees and asylum seekers.
https://www.psychology.org.au/inpsych/2016/psychological-trauma/

Or, from Australia: Trauma-informed care is an organisational structure and treatment framework that involves understanding, recognising and responding to the effects of all types of trauma. Trauma-

informed care is based on the premise that many behaviours or responses (often classified as symptoms) expressed by people with mental illness are directly related to an experience, or experiences, of trauma. For the best recovery outcomes, the causes of a person's 'symptoms' or responses must be understood.

Understanding a person's personal experiences of trauma not only provides significant information to guide treatment, but can also guide the approach the caregiver takes to avoid further traumatisation. For example, if a person has experienced sexual or physical abuse, a support person must be particularly considerate when it comes to physical contact or exposing the person's body without consent.

There is evidence that talking to someone about the traumatic experience, being heard empathetically and without judgment and being believed, accessing information and support, and finding safety from risk of further trauma, can all assist greatly in a person's recovery. In comparison, not disclosing the traumatic event, not being believed or validated, or not having access to support can compound the trauma and restrict recovery.

In many mental health services, staff are time-poor or do not feel qualified to encourage a person to open up about their experience of trauma. However acknowledgement of the role of trauma can guide all aspects of mental health service policies and practice.
https://www2.health.vic.gov.au/about/publications/policiesandguidelines/3/C/E/5/0/trauma-and-mental-health-technical-paper-mental-health-plan

Table I The key principles of trauma-informed approaches

Recognition
Recognise the prevalence, signs and impacts of trauma. This is sometimes referred to as having a trauma lens. This should include routine enquiry about trauma, sensitively asked and appropriately timed. For individual survivors, recognition can create feelings of validation, safety and hope

Resist retraumatisation
Understand that operational practices, power differentials between staff and survivors, and many other features of psychiatric care can retraumatise survivors (and staff). Take steps to eliminate retraumatisation

Cultural, historical and gender contexts
Acknowledge community-specific trauma and its impacts. Ensure services are culturally and gender appropriate. Recognise the impact of intersectionalities, and the healing potential of communities and relationships

Trustworthiness and transparency
Services should ensure decisions taken (organisational and individual) are open and transparent, with the aim of building trust. This is essential to building relationships with trauma survivors who may have experienced secrecy and betrayal

Collaboration and mutuality
Understand the inherent power imbalance between staff and survivors, and ensure that relationships are based on mutuality, respect, trust, connection and hope. These are critical because abuse of power is typically at the heart of trauma experiences, often leading to feelings of disconnection and hopelessness, and because it is through relationships that healing can occur

Empowerment, choice and control
Adopt strengths based approaches, with survivors supported to take control of their lives and develop self-advocacy. This is vital as trauma experiences are often characterised by a lack of control with long-term feelings of disempowerment

Safety
Trauma engenders feelings of danger. Give priority to ensuring that everyone within a service feels, and is, emotionally and physically safe. This includes the feelings of safety engendered through choice and control, and cultural and gender awareness. Environments must be physically, psychologically, socially, morally and culturally safe

Survivor partnerships
Understand that peer support and the coproduction of services are integral to trauma-informed organisations. This is because the relationships involved in peer support and coproduction are based on mutuality and collaboration

Pathways to trauma-specific care
Survivors should be supported to access appropriate trauma-specific care, where this is desired. Such services should be provided by mental health services and be well resourced.
http://www.emeraldinsight.com/doi/pdfplus/10.1108/MHRJ-01-2015-0006

SAMHSA: Trauma-Informed Approach

According to SAMHSA's concept of a trauma-informed approach, "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, procedures, and practices; and
4. Seeks to actively resist *re-traumatization*."

A trauma-informed approach can be implemented in any type of service setting or organization and is distinct from trauma-specific interventions or treatments that are designed specifically to address the consequences of trauma and to facilitate healing.

SAMHSA's Six Key Principles of a Trauma-Informed Approach
A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific:

1. Safety
2. Trustworthiness and Transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice and choice
6. Cultural, Historical, and Gender Issues

http://www.samhsa.gov/nctic/trauma-interventions

The available literature suggests that there is a continuum from being *trauma aware* (seeking information out about trauma and its implications for organisations) to being *trauma-informed* (a cultural shift at the systemic level).
One useful Australian resource sets out the progression in four stages:

- ***trauma aware*:** seek information out about trauma;
- ***trauma sensitive*:** operationalise concepts of trauma within the organisation's work practice;
- ***trauma responsive*:** respond differently, making changes in behaviour**;**
- ***trauma informed*:** entire culture has shifted to reflect a trauma approach in all work practices and settings.

https://aifs.gov.au/cfca/publications/trauma-informed-care-child-family-welfare-services/export

Trauma specific interventions are those that target the specific psychological problem (e.g. therapy for PTSD).

Video 2: How does a community become trauma-informed?

https://www.facebook.com/ResilienceTrumpsAces/videos/vb.1948044472829 21/894994250597267/?type=2&theater

Trauma treatments (children)

These examples of treatments are from Australia and show examples that can also be adapted for adults.

Traumatic stress in children is treatable and there are highly effective treatments available to help children and their families. There are different types of interventions that focus on acute (immediately

following trauma), trauma-specific treatment (short-term and long-term) and intensive (in home or residential centers).

- **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (http://tfcbt.musc.edu)**

Treatments that research shows can reduce child traumatic stress are called “evidence-based treatments." One of these evidence-based treatments available in Connecticut is called, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). TF-CBT is a 16-20 session treatment model for children. TF-CBT targets children ages 4-21 and their caregivers who have experienced a significant traumatic event and are experiencing chronic symptoms related to the exposure to the trauma. TF-CBT is a time limited intervention, which usually lasts five to six months and involves outpatient sessions with both the child and caregiver. There has been strong evidence to support its ability in reducing symptoms of Post-Traumatic Stress Disorder (PTSD) and depression in both children and their caregivers. The intervention is a manualized, phased intervention that helps the child develop and enhance their ability to cope with and regulate their responses to troubling memories, sensations and experiences. Over time, through the course of treatment, the child develops a trauma narrative that helps them tell their story in a safe, supportive setting.

- **Trauma-Focused Cognitive Behavioral Therapy for Childhood Traumatic Grief (TG-CBT) (http://tfcbt.musc.edu)**

TG-CBT is an adaptation of TF-CBT for children and teens aged 6-18 who have experienced childhood traumatic grief through the loss of a loved one. TG-CBT involves the same steps as TF-CBT with additional sessions focused specifically on working through the grieving process in a healthy manner with both the child and the caregiver.

- **Alternatives for Families Cognitive Behavioral Therapy (AF-CBT) (www.afcbt.org)**

AF-CBT is an intervention that targets individual child and parent characteristics related to the abusive experience and the family context in which abuse or aggression occurs. This approach emphasizes training in interpersonal skills designed to build self-control and reduce violent behavior. During AF-CBT, school-aged children and parents (or caretakers) participate in separate but coordinated therapy sessions, often using parallel treatment materials. In addition, children and parents attend sessions together at different times throughout treatment. This approach tries to address individual and parent-child issues in an integrated way.

- **Dialectical Behavior Therapy (DBT) (http://www.dbtselfhelp.com)**

Dialectical Behavior Therapy (DBT) is a cognitive-behavioral treatment approach with two key components: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes. "Dialectical" refers to the issues involved in treating patients with multiple disorders and to the type of thought processes and behavioral styles used in the treatment strategies. DBT has five components: (1) skills training; (2) individual behavioral treatment plans; (3) access to a therapist outside a clinical setting, homework, and inclusion of family in treatment; (4) structuring of the environment (programmatic emphasis on reinforcement of adaptive behaviors); and (5) therapist team consultation group. DBT emphasizes balancing behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance of patients. Therapists follow a detailed procedural manual.

- **Eye Movement and Desensitization and Reprocessing (EMDR) (http://emdr.com)**

EMDR is a form of psychotherapy that uses a structured eight-phase approach to address the past, present, and future aspects of a traumatic or distressing memory that has been stored in the mind of the victim as a dysfunctional memory. The goal of EMDR therapy is to process these distressing memories, reducing their lingering influence and allowing clients to develop effective coping mechanisms.

- **The Child and Family Traumatic Stress Intervention (CFTSI) (http://www.crimesolutions.gov)**

CFTSI is a 4-6 session preventative model for children aged 7-18 in the days and weeks following a traumatic event or disclosure of a past traumatic event. The goals of CFTSI are to reduce traumatic stress symptoms, increase caregiver and child communication, provide skills for the child to cope with trauma reactions, reduce other external stressors on the child and assess the child's need for longer-term treatment. Currently this treatment is offered at the Yale Child Study Center in New Haven.

- **Parent Child Interaction Therapy (PCIT) (http://www.pcit.org)**

PCIT is a parent-child treatment program that helps parents of children aged 2-7 years old with behavioral problems (aggression, non-compliance, defiance, and temper tantrums). PCIT focuses on promoting positive parent-child relationships and interactions while teaching parents effective child management skills. PCIT has been adapted as an intervention for many different types of families (child welfare population, at-risk families, adoptive families, foster families, and other languages including Spanish and Chinese).

- **Child FIRST (http://www.childfirst.net)**

Child FIRST is an innovative evidence-based model that effectively decreases emotional and behavioral problems, developmental and learning problems, and abuse and neglect among very vulnerable young children (prenatal through age six years) and families. Child FIRST directly addresses these risks through 1) comprehensive, integrated services and supports to the whole family, which decreases risk and increases the capacity of the parent to nurture and support the child, and 2) home-based, parent-child intervention, which builds the nurturing relationship, protects the developing brain and optimizes child emotional development, learning, and health. The effectiveness of the Child FIRST model has been rigorously researched through a randomized clinical trial, demonstrating markedly improved outcomes in child mental health and language, parental stress and depression, protective service involvement, and access to community-based services.

- **Creative Alternatives of New York (CANY) Drama Therapy (http://www.cany.org)**

Drama therapy is the intentional use of drama and/or theater processes to achieve therapeutic goals and facilitate personal growth. CANY groups support the safe exploration of feelings and thoughts; build self-esteem increasing cooperation and peaceful conflict resolution as well as foster creative self-expression in an appropriate and empowering way. Groups focus on helping young participants give voice to their unique life experience, exploring their needs, both now and in the future, striving to help them feel both heard and seen. This approach provides clients with the chance to tell their stories, set goals, solve problems, express feelings, achieve insight and develop life skills.

Other interventions to help children who are victims of trauma:

- Provide support so that the child and family feel safe and secure
- Advocate a supportive role by caregivers and others
- Maintain healthy relationships with the child's primary caregivers and other close relatives/friends
- Reduce unnecessary secondary exposures & separations
- Help the child to return to typical routines (such as school) as soon as possible
- Facilitate open but not forced communication with the child about his/her reactions to the traumatic event
- Focus on constructive responses
- Explain to child in developmentally appropriate terms
- Encourage and support help-seeking behaviors
- Create a supportive milieu for the spectrum of reactions and different courses of recovery
- Monitor and/or refer child for a clinical trauma evaluation

http://www.ct.gov/dcf/cwp/view.asp?a=4368&Q=514042

Trauma-inducing (service processes)

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. Studies of people in the juvenile and criminal justice system reveal high rates of mental and substance use disorders and personal histories of trauma.

Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Young people bring their experiences of trauma into the school systems, often interfering with their school success. And many patients in primary care similarly have significant trauma histories which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports to individuals are often themselves trauma-inducing.

"The use of coercive practices, such as seclusion and restraints, in the behavioral health system; the abrupt removal of a child from an abusing family in the child welfare system; the use of invasive procedures in the medical system; the harsh disciplinary practices in educational/school systems; or intimidating practices in the criminal justice system can be re-traumatizing for individuals who already enter these systems with significant histories of trauma. These program or system practices and policies often interfere with achieving the desired outcomes in these systems" *(p. 2-3)*

In public services there is increasing recognition that systems may exacerbate trauma-related issues. These systems are beginning to revisit how they conduct their "business" as they realise that trauma that, left unaddressed, can get in the way of achieving good health and well-being.
http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf

Wellbeing

The Center for Disease Control & Prevention (CDC) states:
"Well-being – is the integration of physical and mental health and includes the "presence of positive emotions and moods, the absence of negative emotions, satisfaction with life, fulfilment and positive functioning".
http://alliance1.org/sites/default/files/PDF/designcim_science_infused_policy.finalsept272016.pdf

International agencies

Examples of international agencies which work in trauma include:

World Health Organisation (WHO)

ACEs are mentioned in this WHO report. International developments are requiring nations to provide safe, secure and supportive childhoods and are providing access to international evidence about the best ways to achieve this goal. With an estimated 9.6% of all children suffering sexual abuse across Europe and as many as 22.9% suffering physical abuse, the World Health Organization has launched Investing in Children: the European child maltreatment prevention action plan 2015–2020. The plan

aims to reduce the prevalence of child maltreatment by implementing preventive programmes that reduce risk and increase protective factors.
http://www.euro.who.int/__data/assets/pdf_file/0011/282863/Investing-in-children-European-child-maltreatment-prevention-action-plan-2015-2020.pdf?ua=1

There are two trauma related WHO publications (briefly described below). In addition WHO's "Health in all Policies" Training Manual is relevant as the impact of ACEs crosses sector agencies: http://who.int/social_determinants/publications/health-policies-manual/en/

An example of the Health in all Policies work in action in New Zealand is undertaken by Canterbury Public Health (which may have been fostered by the Christchurch earthquakes occurring).
http://www.cph.co.nz/your-health/health-in-all-policies/

In 2013 WHO published a new clinical protocol and guidelines to enable effective mental health care for adults and children exposed to trauma and loss. These WHO mhGAP guidelines were developed to provide recommended management strategies for conditions specifically related to stress, including symptoms of acute stress, post-traumatic stress disorder and bereavement.
The guidelines were developed by an independent Guidelines Development Group and inform a new mhGAP module on the Assessment and Management of Conditions Specifically Related to Stress.
http://www.who.int/mental_health/emergencies/stress_guidelines/en/

mhGAP module Assessment Management of Conditions Specifically Related to Stress
Also in 2013, this new mhGAP module on Conditions Specifically Related to Stress by WHO and UNHCR contains assessment and management advice related to acute stress, post-traumatic stress and grief in non-specialized health settings.
It is an annex to the mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings (WHO, 2010).
http://www.who.int/mental_health/emergencies/mhgap_module_management_stress/en/

Report 2015: Who Europe Policy Brief on Migration and health: Mental Health Care for Refugees

The very fact of being a refugee is not the most significant criterion for the potential risk of mental disorders. However, refugees can be exposed to various stress factors that could influence their mental health. These are commonly categorized as pre-migration factors (such as persecution, economic hardship), migration factors (physical danger, separation), and post-migration factors (detention, hostility, uncertainty).
http://www.euro.who.int/__data/assets/pdf_file/0006/293271/Policy-Brief-Migration-Health-Mental-Health-Care-Refugees.pdf?ua=1

United Nations

In addition the United Nations in 2015 launched the Sustainability Goals (SDGs). The SDGs include the aim of ending abuse, exploitation, trafficking and all forms of violence against and torture of children. Such ambitions are also consistent with the recent World Health Assembly resolution on violence which directs health systems globally to play a central role in addressing violence, in particular against women and children.
http://www.un.org/sustainabledevelopment/blog/2015/12/sustainable-development-goals-kick-off-with-start-of-new-year/

OECD

As policy interventions for children in OECD countries increasingly overarch traditional policy fields, demand has grown for better comparative information across a range of children's outcomes. Recently demand has grown for measures that focus on quality of life issues *beyond income poverty*, and at different points in the child's lifecycle.

The Child Well-being Module (CWBM) is a new dataset for age-specific child well-being information including data on policies, family and community contexts, and outcomes. The CWBM is part of the OECD Family Database, a portal for internationally comparable information on the situation of families in OECD countries. The CWBM holds quality-checked data on children and their family contexts to help inform cross-national and national-level analysis of policies for children, and the outcomes that they achieve. This module draws from indicators available in the OECD Family Database as well as other available internationally comparable data series and surveys.

The CWBM takes the form of a data matrix in which indicators are organised along one axis by the stages of childhood development: early (0-5 years), middle (6-11 years) and late (12-17 years). The second axis collates the indicators on the basis of:

A. Inputs (spending and structures)
B. Context (families, service provision and community)
C. Outcomes

RELATED PROJECTS:

- 3rd Child Well-being Expert Consultation (UNICEF IRC/OECD/European Commission) held in November 2015
- 2nd Child Well-being Expert Consultation (UNICEF IRC/OECD/The Learning for Well-being Consortium/European Commission) held in November 2011.
- 1st Child Well-being Expert Consultation (UNICEF IRC/OECD/European Commission) held in May 2009.
- Institutional websites of stakeholders in the field of Child Well-being research.
- Annex to OECD Social, Employment and Migration Working Paper No. 146 (supplementary information on the OECD evaluation of International Surveys of Children).

Related Documents

- OECD Family Database
- Doing Better for Children
- Doing Better for Families
- Babies and Bosses - Reconciling Work and Family Life: A Synthesis of Findings for OECD Countries
- Society at a Glance 2011 - OECD Social Indicators
- Child well-being in figures

http://www.oecd.org/els/family/oecdfamilydatabasechildwell-beingmodule.htm

UNICEF

Towards a new Global Strategy for Women's, Children's and Adolescents' Health – BMJ book

This book includes several relevant chapters, for example:

Effective interventions and strategies for improving early child development (p.23)

Effective interventions and strategies for improving early child development Investing in early child development is a smart and essential strategy for building human capital, reducing inequities, and promoting sustainable development.

Key messages:

- *Adverse exposures and experiences in early childhood increase risks for poor social, cognitive, and health outcomes*
- *Despite great strides in improving child survival over 200 million children under 5 are at risk of not reaching their full potential*
- *Interventions implemented through health, nutrition, education, and social protection sectors are effective at improving early child development*
- *Such interventions have long term health, economic, and social benefits*
- *Interventions to promote nurturing care, protect maternal mental health, and reduce poverty should be prioritised to complement and enhance services for maternal and child health and nutrition.*
  http://www.unicef.org/earlychildhood/files/WHO_EWEC_Supplement-bmj.pdf

Protecting Children from Violence: A Synthesis of Evaluation Findings

UNICEF in New York did this 389-page report in 2012.
http://www.unicef.org/evaldatabase/files/Protecting_Children_from_Violence_A_synthesis_of_Evaluation_Findings_2012.pdf

The International Society for Traumatic Stress Studies (ISTSS)

This agency is dedicated to sharing information about the effects of trauma and the discovery and dissemination of knowledge about policy; program and service initiatives that seek to reduce traumatic stressors and their immediate and long-term consequences.

The mission statement is:

"STSS is an international interdisciplinary professional organization that promotes advancement and exchange of knowledge about traumatic stress.
This knowledge includes:

- *Understanding the scope and consequences of traumatic exposure,*
- *Preventing traumatic events and ameliorating their consequences, and*
- *Advocating for the field of traumatic stress".*

ISTSS provides a forum for the sharing of research, clinical strategies, public policy concerns and theoretical formulations on trauma around the world. We are the premier society for the exchange of professional knowledge and expertise in the field.

Members of ISTSS include psychiatrists, psychologists, social workers, nurses, counselors, researchers, administrators, advocates, journalists, clergy, and others with an interest in the study and treatment of traumatic stress. ISTSS members come from a variety of clinical and non-clinical settings around the world, including public and private health facilities, private practice, universities, non-university research foundations and from many different cultural backgrounds.
http://www.istss.org/about-istss.aspx

International digital social news network: ACEsTooHigh.com and ACEsConnection.com

ACEsTooHigh.com and ACEsConnection.com comprise the ACEs Connection Network, which reaches people in 40 countries. Jane Stevens is the founder and publisher, and, the network is funded by two US foundations: The Robert Wood Johnson Foundation and The California Endowment.
https://acestoohigh.com/

"ACESTooHigh is a news site that reports on research about adverse childhood experiences, including developments in epidemiology, neurobiology, the biomedical and epigenetic consequences of toxic stress, and resilience research. We also cover how people, organizations, agencies and communities are implementing practices based on the research. This includes developments in education, juvenile justice, criminal justice, public health, medicine, mental health, social services, and cities, counties and states".

ACEsConnection.com

"Join the movement to prevent ACEs, heal trauma and build resilience"

ACEsConnection.com is a social network that accelerates the global movement toward recognizing the impact of adverse childhood experiences in shaping adult behavior and health, and reforming all communities and institutions -- from schools to prisons to hospitals and churches -- to help heal and develop resilience rather than to continue to traumatize already traumatized people.

The network achieves this by creating a safe place and a trusted source where members share information, explore resources and access tools that help them work together to create resilient families, systems and communities. http://www.acesconnection.com/

Video: ACEs primer: a great five-minute video that explains the ACE Study http://www.acesconnection.com/blog/aces-primer-great-five-minute-video-that-explains-ace-study?reply=4618020371252000 15#461802037125200015
Video: 3-minute video that explains ACEs http://www.acesconnection.com/clip/ace-study-dvd-intro-3-min

Examples of other resources

TED Talks

Three relevant TED talks include:

1 TED Talk: Dr Nadine Burke, 2014

Pediatrician Dr Burke Harris bought the results of the work on ACEs and trauma to life in a TED talk in a very clear and simple way that demands action as a community.
She explains that the repeated stress of abuse, neglect and parents struggling with mental health or substance abuse issues has real, tangible effects on the development of the brain. This unfolds across a lifetime, to the point where those who've experienced high levels of trauma are at triple the risk for heart disease and lung cancer.
She gives an impassioned plea for pediatric medicine to confront the prevention and treatment of trauma, head-on.
https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime?language=en

2 Benjamin Perks, 2015

Benjamin Perks is the UNICEF Representative to Montenegro and United Nations Resident Coordinator a.i. and also occasionally works for United Nations Staff College training on Human Rights Based Approach to Programming. He has served in numerous countries including Afghanistan, India, Georgia and Albania.
https://www.youtube.com/watch?v=qp0kV7JtWiE

3 The First 1000 Days | Johan Morreau | 2016

How important are the first 1000 days of a child's life? The most important, according to Dr Johan Morreau, a paediatrician in New Zealand of 30 years who has seen it all.

https://www.youtube.com/watch?v=K1slVo3BNtM&feature=youtu.be

Videos

The Science of Trauma - Congressional Briefing 2016

Hosted by U.S. Senator Heidi Heitkamp, leading health experts gathered to present the basic science of toxic stress, trauma and resilience, including impact on the developing brain, effects across the lifespan, and mechanisms of inter-generational transmission on May 25, 2016. There are 3 parts to this, a video and two PowerPoint presentations.

Video

https://www.youtube.com/watch?v=bZr9_1y5HhE&feature=youtu.be

PowerPoint - Elizabeth Prewitt

http://www.heitkamp.senate.gov/public/_cache/files/2c92d623-0fd4-4237-b312-68cd17587d34/5-25-prewitt-powerpoint.pdf

PowerPoint – Dr Kack Kaminsky Trauma and Epigenetics: The Physiological effects of trauma

http://www.heitkamp.senate.gov/public/_cache/files/91410a0d-11ab-44c0-832b-6b847bfe623d/5-25-historical-trauma-epigenetics-kaminsky.pdf

The Cause of Addiction, Dr Gabor Mate, Canada

What is the cause of addiction? Speaker Dr. Gabor Mate says that the main cause of addiction is childhood trauma. He also speaks about how society treats addicts, and how the "war on drugs" is actually a "war on addicts.

"The opposite of addiction is connection"

http://www.myaddiction.com/videos/drugs/gabor-mate-the-cause-of-addiction

Dr. Rob Anda at the National Summit on ACEs in Philadelphia: "ACES in Society – Where the Sciences Collide" 2013

https://www.youtube.com/watch?v=OVJ5G9pGog8&feature=youtu.be

Books

There are a huge amount of books on this subject, for example:
https://books.google.co.nz/books?id=TozFBQAAQBAJ&dq=sweden,+trauma+informed+care&source=gbs_navlinks_s

"Pinterest: The world's catalogue of images"

In the internet age this website cannot be ignored. It had some helpful images and infographics about ACEs, trauma informed care, toxic stress etc.
One example: https://nz.pinterest.com/pin/510736413966176659/
https://nz.pinterest.com/pin/378443174913128490/

Print media

Obviously the work on ACEs and trauma has been written about in the media many, many times. This three stage series is a good summary of work in the US across two decades.

New York Times

David Bornstein writing in 2016:
Tapping a Troubled Neighborhood's Inner Strength
http://www.nytimes.com/2016/08/10/opinion/tapping-a-troubled-neighborhoods-inner-strength.html

How Community Networks Stem Childhood Traumas
http://www.nytimes.com/2016/08/17/opinion/how-community-networks-stem-childhood-traumas.html

Putting the Power of Self-Knowledge to Work
http://www.nytimes.com/2016/08/23/opinion/putting-the-power-of-self-knowledge-to-work.html

AUSTRALIA

Australia has indigenous peoples (similar to those in Canada and New Zealand). This adds a different level of complexity to work on trauma. It has been said

"*If it's not racially just, it's not trauma informed*[13]"

Australia has moved a long way in this area compared to our IIMHL 2012 report. At that time the Government was including trauma in the Fourth National Mental Health Plan, states were starting to think about trauma in a mental health context and several national conferences were held on trauma informed care and practice.
http://www.iimhl.com/files/docs/Make_It_So/20120712.pdf

Mental Health Policy

The Australian Government is committed to developing a more effective and efficient mental health system that improves the lives of Australians with, or at risk of, mental illness. On 26 November 2015, the Australian Government Response to *Contributing Lives, Thriving Communities* - Review of Mental Health Programmes and Services (a report done by the National Mental Health Commission) was announced.
http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-policy

`One of the last frontiers of our society is the lack of realisation about the extent of trauma'[14].

Report 2012: The Last Frontier: Practice Guidelines for Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery

Australia's Minister for Mental Health Mark Butler announced new national guidelines for trauma-informed care and practice. **The Last Frontier: Practice Guidelines for Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery** were developed for individual practitioners and human service organizations, including hospitals, mental health clinics, prisons, schools, child welfare services, law enforcement, employment, housing, and legal services.

They were funded by Australian Government - Department of Health and Ageing.
http://www.recoveryonpurpose.com/upload/ASCA_Practice%20Guidelines%20for%20the%20Treatment%20of%20Complex%20Trauma.pdf

[13] Op cit. https://acestoohigh.com/2016/10/24/racing-aces-gathering-and-reflection-if-its-not-racially-just-its-not-trauma-informed/#more-620

[14] Warwick Middleton, cited in Helen Tobler, `Early trauma takes a long-term toll', The Weekend Australian [Health] 23-24 July 2011, p.13.

The guidelines were produced by two people from Adults Surviving Child Abuse (ASCA) -- Dr. Cathy Kezelman, (President of the Blue Knot Foundation (formally ASCA), and Dr. Pam Stavropoulos, its consultant in clinical research (both are members of ACEsConnection). The announcement was held at the country's Parliament House in Canberra on October 29, Blue Knot Day, Australia's national day of awareness about child abuse.

The national guidelines are a first step toward developing a national policy for trauma-informed practice for complex trauma, says Kezelman, a physician and president of ASCA. "They acknowledge the prevalence of unresolved complex trauma in mental health and general health and social services, and are a call for systemic change, both clinically and organizationally."

The guidelines distill the last 20 years of research related to complex trauma. Most trauma treatments focus on event-driven trauma, such as natural disasters or car crashes. But more people have complex trauma, which is two or more types of severe and chronic trauma usually experienced in childhood. Australia is the first country in the world to issue national guidelines for complex trauma and trauma-informed care and practice, combined into one document. It is now a step ahead of the United States in elevating the issue of complex trauma and its long-term health, social, and economic consequences into the national conversation.

Of note is the fact that in 2016 the Blue Knot Foundation are hosting a "match" in Sydney as part of the IIIMHL week-long Leadership Exchange.

The following is a Q-and-A Jane Stevens (US) did with Kezelman via email and Skype. It is outlined in full as it describes the key issues for Australia so well.

From ACEs Connection Network E–bulletin 2013

Why did Australia develop the guidelines?

Identifying and appropriately addressing the needs of people who have experienced trauma is a major public health challenge, not just in Australia, but globally.

- Complex trauma and its effects are often unrecognised, misdiagnosed and unaddressed. Human service systems – medical, mental health, education, social services, and criminal justice systems -- do not routinely screen for complex trauma.
- People with complex trauma usually have a decades-long "revolving door" relationship with medical, mental health and social services. Their care is fragmented with poor referral and follow-up, and the systems they engage with often, and often unintentionally, re-traumatize them.
- This situation is psychologically, financially and systemically costly. In 2007 alone, the cost of child abuse to the Australian community is conservatively estimated to be at least $10.7 billion, and is almost certainly far higher.

Up until now, changes have been isolated and sporadic. Some forward-thinking mental health organizations in Australia have instituted trauma-informed practices for responding to people with complex trauma, some organizations have developed trauma-informed training for their staff, and a few parts of the criminal justice system are instituting changes. But this does not constitute broad-based practice and systemic change.

How should Australia address these issues?

In Australia, an entire systems change must be undertaken. Mental health and other human services need to screen for complex trauma, and identify, acknowledge and appropriately address the condition and its consequences. Colleges and universities need to provide courses in complex trauma and trauma-informed practices in social work, physical or mental health, criminal justice or education. All health services and systems – not just a few -- in all sectors of human service need to adopt a trauma-

informed approach. Professor Louise Newman, a psychiatrist and director of the Centre for Developmental Psychiatry and Psychology at Monash University in Melbourne says, “Failure to acknowledge the reality of trauma and abuse in the lives of children, and the long-term impact this can have in the lives of adults, is one of the most significant clinical and moral deficits of current mental health approaches.”

Research shows that the impacts of even severe early trauma can be resolved and its negative intergenerational effects can be intercepted. People can and do recover and their children can do well. For this to occur, mental health and human service delivery systems need to reflect the current research insights.

The guidelines establish a framework that responds to the national health challenge presented by people who have experienced complex trauma and set the standards for clinical treatment and trauma-informed care and service delivery.

The Last Frontier: Practice Guidelines for Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery fills the long overdue gap between the overwhelming evidence about the effects of complex trauma on individuals and the possibilities, treatment and services that enable sustained recovery.

Why don’t treatment practices for regular PTSD work?

Trauma is often characterized as a single event, such as a car crash or natural disaster. Yet repeated extreme interpersonal trauma resulting from adverse childhood events is not only more common, but far more prevalent than currently acknowledged, even by the mental health sector.

Established guidelines for the treatment of trauma relate to post-traumatic stress disorder (PTSD). They are inadequate to address the many dimensions of complex trauma.
Research shows that most people who seek treatment for trauma-related problems have histories of complex trauma. It also shows that those who experience complex trauma may react adversely to current, standard PTSD treatments. There is thus a clear and urgent need for clinical guidelines that are directed to treatment of complex trauma.

The differences between complex trauma and `single-incident’ trauma are significant. For example, complex trauma includes repercussions of affect-dysregulation (difficulty regulating emotions and impulse control), structural dissociation (fragmentation and compartmentalisation of the personality), somatic dysregulation (challenges regulating bodily responses), and impaired self-development and disorganized attachment (challenges in formation of basic models of healthy relationships. These are not included or addressed in the diagnostic criteria for PTSD. But they are the foundation for clinicians working with survivors of complex trauma, regardless of the specific diagnosis or assessment and treatment methodologies applied.

What research are the guidelines based on?

The national guidelines are based on the research and recommendations of key clinicians and theorists of complex trauma, such as Christine Courtois and Julian Ford, authors of Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide; Bessel van der Kolk, founder and medical director of The Trauma Center at the Justice Resource Institute; Babette Rothschild, author of The Body Remembers; Vincent Felliti and Robert Anda, co-principal investigators of the ACE study, and others. These guidelines are the first to present the collective wisdom of the now substantial research knowledge that has been accumulated over the last 20 years to enable us to address complex trauma effectively using a number of core principles.

Numerous trauma-informed and trauma-specific models exist. Most were developed in the United States. The foundational principles for effective treatment of complex trauma are now solid, and best

practices continue to evolve as our understanding of complex trauma deepens.

The core principles of trauma-informed care are safety, trustworthiness, choice, collaboration, and empowerment. These principles underpin the national guidelines, and, if comprehensively implemented, would result in a major shift in the way human services currently function.

What organizations should use these trauma-informed care and service delivery guidelines?

National and international research shows that the majority of people who use mental health services have experienced complex trauma. This is also true of people who use other parts of the human service sector, including hospitals, physicians, social services, law enforcement and prisons.

The current organization of human services does not reflect this reality, is manifestly inadequate to address it, and is in urgent need of reconfiguration. It is for this reason that an ever-increasing number of people and organizations are calling for a new paradigm of trauma-informed care and practice, in physical health and mental health specifically, and across the full spectrum of human service delivery.

Current research suggests that creating a trauma-informed culture can benefit staff and clients. Staff can benefit from greater job satisfaction and reduced risk of vicarious traumatization and burnout; clients, from reducing the risk of retraumatization and enabling recovery. To the extent that the large numbers of people who experience trauma-related problems access a range of diverse services, it's critical that all aspects of human services incorporate trauma-informed practices. These include:

- Mental health and human service sectors, including drug and alcohol, sexual assault, child protection, housing, supported accommodation, and refugee services; disability, advocacy, and aged-care services; and services for indigenous, CALD (culturally and linguistically diverse), and GBLTQI (gay, bisexual, lesbian, transgender, questioning and intersex) people;
- Private-practice counselling, psychotherapy, psychology and psychiatry;
- Primary and allied health care services – general practice;
- Public and private hospitals;
- Criminal justice, child protection, emergency services, legal services, policing, education, employment and housing.

How many people in Australia have experienced some form of adverse childhood experience that can affect them later in life?

Five million Australians, out of a total population of 22.6 million, have experienced complex trauma. This number is drawn from studies that were conducted between 1992 and 2010, with the majority of the research dating from 2005-2010.

- **Child physical and sexual abuse**

In 2007 an Australian University study of more than 21,000 older Australians, the largest of its kind to date, found that over 13% reported sexual or physical abuse in childhood. These figures did not include those emotionally abused or neglected or forced to live with family violence.

In a 2005 study by the Australian Bureau of Statistics, 18% of people over 18 reported having experienced physical or sexual abuse before the age of 15. Emotional abuse, neglect and being forced to live with family violence were excluded.

- **Domestic violence**

Up to one-quarter of young people aged 12-20 years old in Australia have witnessed an incident of physical domestic violence against their mother or stepmother. Witnessing male to female parental violence ranged from 14 per cent for those living with both biological parents to 41 per cent for those living with their mother and her partner.

Children also experience domestic violence when intervening to protect their mother. A Western Australian study found that one-third of children were hit by their father while trying to defend their mother or stop the violence.

In addition to exposure to domestic violence, it is estimated that in 30% to 60% of families where domestic violence is a factor, child abuse is also occurring.

- **Living with a parent with a mental illness**

A detailed analysis in 2005 concluded that just over a million Australian children in 2005 under the age of 18 live with at least one parent who has a mental health issue.

- **Parent who abuses substances**

It has been estimated that roughly 13% of Australian children live in a home with at least one adult who misuses alcohol.

A recent analysis of the 2007 National Drug Strategy Household Survey suggested that this figure is between 17 - 34%.

- **Parent in prison**

On any given day in Australia, approximately 38,000 children have a parent in prison. About two-thirds of the women in prison are the mothers of dependent children.

- **Parental separation/divorce**

Around one in four people aged 18-34 years in 2006-07 reported experiencing the divorce or permanent separation of their parents during their childhood. In contrast, less than one in ten people aged 65 years and over had experienced parental divorce or permanent separation before they were 18 years old.

Nearly one in five people aged 75 years and older reported having experienced the death of a parent when they were children. This compares with about one in ten people aged 55-64 years and about one in twenty aged 18-24 years.

Given the results of the ACE Study, do you think that 5 million people is a low estimate?

These are conservative estimates and were left conservative due to the difficulty in accessing reliable comprehensive data. Notably while these figures incorporate statistics from a number of categories of adverse childhood experiences, they do not include statistics from all of the categories included within the ACE Study. Notably, they do not include figures for the number of adults who have experienced emotional abuse and neglect as children.

The ACE Study indicated that 64% of people have experienced one or more adverse childhood experiences and hence the figure quoted of 5 million Australian adults could well be low.

The figure of 5 million has been quoted extensively to media and also to members of Parliament and is consistently met with disbelief. It would be important for Australia to conduct its own ACE research to secure accurate prevalence figures to inform policy reform.

How will the guidelines be applied?

The national guidelines are currently being disseminated through state and federal governments and government agencies as well as federal and state-based mental health bodies, umbrella practitioner organizations, nongovernmental organizations and to consumers, workers and practitioners.

The guidelines have been well received -- they have been downloaded more than 3,500 times since their release -- but it is now time to translate the research presented in the guidelines into practice. With funding from the government and a philanthropic body, ASCA has started to develop trauma-informed training for mental health and community sectors.

ASCA has also submitted a proposal to develop education and training workshops and online learning

programs for primary care physicians and mental health practitioners from different disciplines. ASCA is also talking with the government about introducing broad-based trauma screening using Internet-based questionnaires, based on the pioneering work of the ACE Study.

What are the next steps?

We'll be watching the level of take-up or practice informed by the national guidelines, and ASCA will continue to advocate for its broad-based introduction and build its networks both nationally and internationally to enable collaboration. We hope the guidelines will lead to policy changes. ASCA and a number of other mental health organizations are driving a national agenda around trauma-informed care and practice. ASCA was involved in hosting a national forum in 2010 and a national conference around trauma-informed care and practice in 2011. The advisory working group, of which ASCA is a member, is currently developing a discussion paper to present to the National Mental Health Commission, whose role it is to advise mental health policy to government federally.

How have the national guidelines been received?

The national guidelines have been welcomed by practitioners, workers, consumers, and organizations inside and outside Australia. They are regarded as a long overdue and much needed accessible resource.

Prior to their release, 16 Australian organizations endorsed the guidelines, including the Australian Society of Psychological Medicine and the Centre for Developmental Psychiatry and Psychology; 40 individuals, including psychiatrists, psychologists, physicians, and nurses have endorsed it.

Outside institutions endorsing the guidelines include the Clinic for Dissociative Studies in London, England and the National Center on Family Homelessness in the United States. Prior to their release, 27 individuals in nine countries endorsed the guidelines, including Dr. Robert Anda, co-founder of the CDC's ACE Study, Dr. Steven Frankel, psychiatrist and associate clinical professor at University of California-San Francisco Medical School; and Dr. Catherine Classen, director of the Women's Mental Health Research Program and associate professor of the Department of Psychiatry at the University of Toronto in Canada.

Is this a significant development, i.e., do you expect a significant shift in understanding about childhood adversity and its short- and long-term consequences?

This is a highly significant development. The guidelines have been described as `ground breaking', and the level of national and international support they have received attests to the momentous point at which things currently stand. They have established the substantive research base behind the repercussions of childhood adversity.

We have been observing a gradual shift over time with progressive erosion of the stigma and taboo around child abuse and breaking of the secrecy and silence in some systems, including but not limited to religious institutions, particularly the Catholic Church, state-based institutions, organizations including the Boy Scouts and sporting organizations. The formation of the Royal Commission into institutional child sexual abuse in Australia is a crucial step toward child protection, justice, and accountability, and better meeting survivors' needs.

As a result we are now starting to see greater awareness around the reality of child abuse and neglect, although little awareness until recently about the long-term impacts of the broad diversity of complex trauma and its cost to individuals, communities and society in economic, health and welfare terms. There's little acknowledgement of the abuse that occurs in the home and family. Minimization and denial are still at play, and overcoming society's desire 'not to know' is challenging.

We believe the shift will come slowly. The recent announcement by the federal government of a Royal Commission to investigate institutional child sexual abuse will be a broad-based inquiry. ASCA is in

regular contact with Australian governmental officials as the Royal Commission takes shape and it is expected that the guidelines will inform its operation. When the evidence is irrefutable, and when the government of the day starts to shift its understanding and provides support for change, greater acknowledgement and acceptance must surely follow.

There is also a substantial economic argument for change, in terms of the burden of disease, loss of productivity and associated community impacts. In its conversations with the Federal Government, ASCA has raised the proven savings of trauma screening as evidenced by the findings of medical evaluation incorporating such screening introduced in the US, based on the ACE Study. Conversations are ongoing. Evidence of the efficacy of informed practice with improved outcomes for individuals, communities, and the next generation provides the impetus for further conversations that will generate the significant shift we need to see.
http://www.acesconnection.com/blog/australia-releases-national-guidelines-for-trauma-informed-care-complex-trauma-treatment

Child Family Community Australia information exchange, Australian Institute of Family Studies

Report 2016: Trauma-informed care in child/family welfare services, Liz Wall, Daryl Higgins and Cathryn Hunter

This paper aims to define and clarify what trauma-informed service delivery means in the context of delivering child/family welfare services in Australia. Exposure to traumatic life events such as child abuse, neglect and domestic violence is a driver of service need. Policies and service providers must respond appropriately to people who are dealing with trauma and its effects in order to ensure best outcomes for individuals and families using these services.

In addition to evidence-based programs or clinical interventions that are specific to addressing trauma symptoms, such as trauma-focused cognitive behaviour therapy, there is a need for broader organisational- or service-level systems of care that respond to the needs of clients with a lived experience of trauma that go beyond a clinical response. Some of the challenges identified in implementing and embedding trauma-informed care across services and systems are discussed.

Key messages:

- Traumatic experiences are common, with people often having multiple adverse experiences across their life. There are many serious and deleterious outcomes associated with exposure to them.
- Clients often present to child/family welfare services with a complex range of symptoms and behaviours related to prior and/or past trauma, which neither they nor those working with them have linked to this previous trauma exposure. As a result they may face an uninformed and fragmented response that is potentially re-traumatising.
- There are a small number of trauma-specific interventions that have been evaluated using a rigorous scientific standard and been shown to be effective - however, the research is often based on populations who have experienced a single traumatic event rather than complex trauma.
- Trauma-informed care is a framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives, their service needs and service usage.

- With the lack of an overarching framework in Australia, there is a danger of inconsistent or piecemeal development of trauma-informed models and practices that do not share a consistent language or framework for implementing trauma-informed systems of care in child/family services.
- As trauma affects a large proportion of the population, survivors are clients in a broad range of human services, and organisations across all settings should consider how a trauma-informed approach could benefit stakeholders, regardless of whether or not the organisation also provides evidence-based trauma-specific interventions.
- Challenges to implementing a trauma-informed approach to care include: a lack of clearly articulated definitions (e.g. of trauma-specific interventions vs the concept and principles of trauma-informed care); translating trauma-informed care to specific practice and service settings; consistency across service settings and systems; care-coordination; a lack of guidance for facilitating complex system change; and a lack of evaluation of models of trauma-informed care.
- Research is needed to explore whether different trauma-informed approaches are required for different population groups, including children, adolescents and adults, or for males and females.

https://aifs.gov.au/cfca/publications/trauma-informed-care-child-family-welfare-services

Report: 2016 Child Abuse And Neglect: A Socio-legal Study of Mandatory Reporting in Australia - Report for Australian Government Department of Social Services

This 160-page report looks at the data on reporting across Australia. A core component of this research project was to obtain and analyse official government data on the reporting of different types of child abuse and neglect, by different reporter groups (including both mandated reporters such as police, and non-mandated reporters), over the decade 2003-12 in each State and Territory.

This summary captures some of the key findings identified by our analysis, which can inform enhancements to law, policy and practice. We also identify important directions for future research.
https://www.dss.gov.au/sites/default/files/documents/03_2016/child-abuse-and-neglect-v1-aust-gov.pdf

Report: 2016 - The effect of trauma on the brain development of children: Evidence-based principles for supporting the recovery of children in care, Sara McLean. The Australian Institute of Family Studies, the Australian Government

Key messages

- Children in care experience symptoms and difficulties associated with complex trauma, however these may also be related to a number of other early life adversities such as antenatal exposure to alcohol, placement instability, poverty, neglect, and pervasive developmental issues.
- Practice and policy documents focus on trauma-informed interventions to improve cognitive functioning; however there has been very little critical research that links trauma and cognitive development, or the interventions that are effective in helping affected children.

- Interventions that target complex trauma are necessary, but may not be sufficient to meet the developmental needs of children in care.
- Some principles to keep in mind for supporting children who have been traumatised include:
    - provide safe environments;
    - support children and caregivers to understand links between traumatic experiences and cognitive difficulties;
    - develop and support positive relationships in children's lives;
    - offer all children in care targeted trauma-specific interventions;
    - maintain these interventions throughout childhood and adolescence; and
    - ensure separate cognitive difficulties are addressed directly.

https://aifs.gov.au/cfca/publications/effect-trauma-brain-development-children

Report: 2016 Trauma-informed care in child/family welfare services - The Australian Institute of Family Studies, the Australian Government

This paper aims to define and clarify what trauma-informed service delivery means in the context of delivering child/family welfare services in Australia.

- Traumatic experiences are common, with people often having multiple adverse experiences across their life. There are many serious and deleterious outcomes associated with exposure to them.
- Clients often present to child/family welfare services with a complex range of symptoms and behaviours related to prior and/or past trauma, which neither they nor those working with them have linked to this previous trauma exposure. As a result they may face an uninformed and fragmented response that is potentially re-traumatising. „
- There are a small number of trauma-specific interventions that have been evaluated using a rigorous scientific standard and been shown to be effective—however, the research is often based on populations who have experienced a single traumatic event rather than complex trauma. „
- Trauma-informed care is a framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives, their service needs and service usage.
    - With the lack of an overarching framework in Australia, there is a danger of inconsistent or piecemeal development of trauma-informed models and practices that do not share a consistent language or framework for implementing trauma-informed systems of care in child/family services. „
- As trauma affects a large proportion of the population, survivors are clients in a broad range of human services, and organisations across all settings should consider how a trauma-informed approach could benefit stakeholders, regardless of whether or not the organisation also provides evidence-based traumaspecific interventions. „
- Challenges to implementing a trauma-informed approach to care include: a lack of clearly articulated definitions (e.g. of trauma-specific interventions vs the concept and principles of trauma-informed care); translating trauma-informed care to specific practice and service settings; consistency across service settings and systems; care-coordination; a lack of guidance for facilitating complex system change; and a lack of evaluation of models of trauma-informed care. „
- Research is needed to explore whether different trauma-informed approaches are required for different population groups, including children, adolescents and adults, or for males and females.

https://aifs.gov.au/cfca/sites/default/files/publication-documents/cfca37-trauma-informed-practice.pdf

Indigenous issues

Report 2016: The state of Victoria's children: resilience, vulnerability and disadvantage

By Department of Education and Training, in collaboration with the Department of Premier and Cabinet, the Department of Health and Human Services, the Department of Justice and Regulation, and Victoria Police.

A small number of children enter school each year with a history of family risk including parental mental illness, a history of witnessing or experiencing abuse of a parent or child, gambling, and alcohol and drug problems. These risk factors are more common for Aboriginal children and for children in the most disadvantaged areas.

Although most Victorian families with children are doing well, and have community support and economic security, too many face challenges from economic insecurity, changes in circumstance and the presence of risk factors such as substance misuse, family violence and abuse.

For these families, more targeted support services are required to build resilience. While many challenges still remain for disadvantaged and vulnerable children and their families, the Education State reform will attempt to redress imbalance through:

- all Victorians having the understanding and attributes to shape their futures in a changing world regardless of their location, background and circumstance
- an education system characterised by cohesion and consistent quality, with no weak spots or cracks to fall through – from birth, children and their families will be supported to thrive through their first thousand days, through their schooling years and onto their first career and subsequent careers
- being known as a place where education is recognised by all, as an accessible and powerful force for personal, social and economic renewal.

http://www.education.vic.gov.au/Documents/about/research/sovc201314.pdf

Report 2011: Early childhood and education services for Indigenous children prior to starting school A report for the Australia Government, Institute of Family Studies

What we know

- High-quality early intervention/education improves children's lifelong outcomes across all areas—education, health (mental and physical) and wellbeing.
- Early intervention/education is more effective, particularly for vulnerable families, when it is holistic— i.e. addresses children's and families' learning needs taking into account the contexts in which they live.

- Closing the gap in outcomes between Indigenous and non-Indigenous Australians requires a focus on early intervention/education of Indigenous young children (from birth), their families and communities.

What works

- Services are more effective for Indigenous children and families when they are aware of and address cultural competence/cultural safety in their service delivery.
- A key component of cultural competence/safety often rests on employing Indigenous workers.
- It is critical that non-Indigenous staff have awareness of how to engage and support all cultures, but particularly Indigenous cultures.
- Honest engagement, building trust, working with community members is essential.
- A focus on empowerment, and working from strengths makes a difference.

What doesn't work

- We cannot assume that what works for families from the non-Indigenous culture can be used to successfully shape Indigenous programs.
- Mainstream services offering generic support without taking into account issues of cultural competence/ safety for Indigenous children and families do not help.
- Developing a one-size-fits-all approach (e.g. rolling out across the country a program that is successful in one context on the assumption that it will be successful everywhere) does not result in effective services.
- Assuming we, as outsiders to a particular community, know what will work best in that community does not result in programs that meet community needs.

What we don't know

- How to significantly increase the early childhood Indigenous workforce; to train and support Indigenous workers who will remain in their communities; and to build structures to enable Indigenous workers to develop a career path.
- How to develop unique Indigenous services for Indigenous families rather than rely on models developed for and tested with non-Indigenous groups.
- How to increase trust of Indigenous families in mainstream services and non-Indigenous staff.
- How to improve governance of Indigenous organisations to improve service delivery.
- How to best deliver programs to Indigenous families and their children in the various Australian contexts, including across geography and subcultures.
- How to support Indigenous and non-Indigenous people to move forward together in partnership in service delivery.
- How to create the funding and management structures to operate truly integrated services

http://www.aihw.gov.au/uploadedFiles/ClosingTheGap/Content/Publications/2011/ctgc-rs07.pdf

Report 2013: Stewardship Dialogues in Aboriginal and Torres Strait Islander Health: Education and early years

Two Dialogues were held in 2013 – one in July and one in October. Participants included Indigenous health leaders, people with policy and/or public administration experience and influence, and people with health system knowledge and experience. The Dialogues developed a statement of principles for effective conversations in policy and program development processes for Aboriginal and Torres Strait Islander health, and three proposals for national action.

Dialogue participants identified that education and early years interventions, implemented in collaboration with Aboriginal and Torres Strait Islander communities and properly adapted to their

settings, held the potential to produce really significant long-term effects on health and wellbeing. However, as always, poor implementation without collaboration is unlikely to realise these benefits.

It is noted that improving outcomes for Aboriginal and Torres Strait Islander children across Australia will take more than just a programmatic approach. A systemic approach is needed, with a shared focus and commitment across health, parenting and early learning services and continued work to enhance the accessibility of universal services for Aboriginal and Torres Strait Islander families.

Furthermore, an integrated approach to early childhood should be a clearly identified priority area in key policy frameworks, such as the National Aboriginal and Torres Strait Islander Health Plan, the Aboriginal and Torres Strait Islander Education Action Plan and the Belonging, Being, Becoming: The Early Years Learning Framework.

The evidence shows that early childhood provides a crucial window of opportunity for public policy interventions to shape long-term health trajectories. Once this opportunity to intervene has passed it is increasingly difficult (and typically more costly) to alter course. This synopsis summarises eight key themes that are important to the concept of 'a healthy start to life':

1. The brain: biological embedding and healthy brain development
2. The body: links between early child development and later physical health
3. Adverse childhood experiences and epigenetics
4. The impact of parenting on health child development
5. The impact of poverty on healthy child development
6. The concept of risk and protective factors to positive child development
7. The cost benefits of a health start to life 8. The importance of connection to culture for Aboriginal and Torres Strait Islander children's wellbeing

In conclusion, there is an important opportunity to make a real difference for Aboriginal children, families and communities. This would require:

- a committed and careful process of implementation of early childhood programs nationally, based on interventions that are well supported by evidence of benefit
- a respectful process of engagement and tailoring offered to each Aboriginal community
- sufficient flexibility to incorporate local priorities and build on local strengths while retaining the basic logic of the program, and
- good data collection and sound evaluation to both inform the progressive implementation of the program and to generate good knowledge of its value.

We recommend that governments and bodies with expertise in this area take up this opportunity as a priority. (p.37)
https://www.lowitja.org.au/sites/default/files/docs/FULL-PAPERS-Education-and-early-years-FINAL.pdf

Mental Health Coordinating Council

Report: 2013 Trauma-Informed Care and Practice: towards a cultural shift in policy reform in mental health and human services in Australia: A National Strategic Direction, Position Paper and Recommendations of the National Trauma-Informed Care and Practice Advisory Working Group

This paper states that it "*focuses on complex trauma – the multiple impacts of interpersonal trauma/violence including those on a person's psyche and 'sense of self.' Complex trauma is the product of overwhelming stress that is interpersonally generated*" (p.14)

Purpose

Trauma-Informed Care and Practice (TICP): a national strategic direction

This paper provides the research evidence for Trauma-Informed Care and Practice and the rationale for cultural and systemic reform in Australia and also presents recommendations for a strategic framework for implementation at both service and system levels. It additionally identifies the steps needed to embed trauma-informed principles into policy and the integration of evidence-based research into practice.

The position paper:

- encapsulates the principles of Trauma-Informed Care and Practice, and promotes the need for and benefits of their integration into mental health and human services practice and policy reform;
- delineates the contexts in which the implementation of trauma-informed care into practice would improve outcomes for consumers with trauma histories;
- establishes the breadth and depth of reform needed for the incorporation of trauma informed care and practice across and within a diversity of human service sectors, cultures, systems, professional frameworks and models of service delivery;
- explores implementation integration of Trauma-informed Care and Principles (TICP Principles) into practice at the systems and service levels; and
- identifies the range of agencies and sectors to be engaged in establishing the TICP agenda including: State and Commonwealth Governments, policy makers, Mental Health Commissions, health and human service sectors as well as the broader community.(p.2)

Position Paper Recommendations

Trauma-Informed Care & Practice (TICP) – A National Strategic Direction
Coordinated Government response

Process

- Whole of government policy reform – take-up/cross-portfolio
- Cross-government collaboration between Federal, State and Territory Governments as well as the CMO sector

Outcome

- Implementation of TICP across the broad range of human service sectors
- Incorporation of these recommendations for change to be accepted broadly across national mental health reform processes

Mental Health and Human Services

Aims

- To implement TICP principles into practice across and within mental health and human services and systems
- To embed TICP principles into the National Recovery Framework
- To integrate TICP principles into National Standards
- Inclusion of TICP in the national agenda in the next National Mental Health Commission Report Card

Process

- Engagement with State and Federal Mental Health and Human Service Ministers and senior policy makers
- Engagement with National and State Mental Health Commissions (prioritisation for policy, planning, research and sector funding)
- Integration of TICP principles into practice within the Royal Commission into Institutional Responses to Child Sexual Abuse
- Networking and collaboration with the international trauma informed community
- Education and engagement of sector (Tools, Showcase Forum, Training)
- Implementation of research into practice – policy reform and practice standards, embedding Practice Guidelines

Outcomes

- Uptake and accepted practice for community managed organisations (CMOs), public and private agencies to integrate TICP into systems and services o Workforce Development and capacity building in TICP
- Broad-based National Communications Strategy surrounding trauma (p.3)

http://www.mhcc.org.au/media/32045/ticp_awg_position_paper__v_44_final___07_11_13.pdf

Key Features of Trauma informed Care and Practice Systems

Sandra Bloom (an international leader in TIC) notes:

"Traumatised children cannot attain health within traumatising (or traumatised) organisations"
(cited in p.49)

This table from the report clearly shows the difference in systems.

Systems without Trauma Sensitivity	Trauma-Informed Care Systems
Consumers are labelled and pathologised as manipulative, needy, attention-seeking	Are inclusive of the survivor's perspective
Misuse or overuse of displays of power – keys, security, demeanour	Recognise that coercive interventions cause traumatisation/re-traumatisation – and are to be avoided
Culture of secrecy – no advocates, poor	Recognise high rates of complex posttraumatic

monitoring of staff	stress disorder (PTSD) and other psychiatric disorders related to trauma exposure in children and adults
Workers believe their key role is as a rule enforcer	Provide early and thoughtful diagnostic evaluation with focused consideration of trauma in people with complicated, treatment-resistant illness
Little use of least restrictive alternatives other than medication	Recognise that mental health treatment environments are often traumatising, both overtly and covertly
Institutions that emphasise 'compliance' rather than collaboration	Recognise that the majority of mental health staff are uninformed about trauma, do not recognise it and do not treat it
Institutions that disempower and devalue staff who then 'pass on' that disrespect to service recipients	Value consumers in all aspects of care
High rates of staff and recipient assault and injury	Respond empathically, be objective and use supportive language
Lower treatment adherence	Offer individually flexible plans or approaches
High rates of adult, child/family complaints	Avoid all shaming/humiliation
Higher rates of staff turnover and low morale	Provide awareness/training on retraumatising practices
Longer lengths of stay/increase in recidivism	Are institutions that are open to outside parties: advocacy and clinical consultants
Poor access to training and education	Provide training and supervision in assessment and treatment of people with trauma histories
Culture that focuses on symptoms and diagnoses without reference to a life journey	Focusing on what happened to the client rather than what is 'wrong with you' (i.e. a diagnosis)
Ignore disclosures and fail to address safety issues	Ask questions about current abuse
Do not take responsibility for how a person will cope once discharged from care/hospital	Address the current risk and develop a safety plan for discharge
Avoid focus on experience of trauma and minimise importance of trauma on presentation	Presume that every person in a treatment setting may have been exposed to abuse, violence, neglect or other traumatic experiences (P11-13).

Chart adapted from: Fallot, R & Harris, M 2009, 'Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol', Washington, DC. Community Connections; Jennings, A, 2004, 'Models for Developing Trauma-Informed Behavioural Health Services: Strategies Emerging from the States', Psychosocial Rehabilitation Journal, Spring, pp 1–15.
http://www.mhcc.org.au/media/32045/ticp_awg_position_paper_v_44_final_07_11_13.pdf

Report 2015: National Research Organisation for Women's Safety (ANROWS) Implementing trauma-informed systems of care in health settings: The WITH study. State of knowledge paper

The purpose of this literature review is to contextualise and inform the Women's Input to a Trauma-informed systems model of care in Health settings Study (the WITH Study).

WITH focuses on addressing the service needs of women with sexual victimisation histories that also experience mental health problems. The project, by promoting and embedding a trauma-informed systems model of care, aims to improve the experience for women by enhancing the service interface between sexual violence and the mental health sectors. This review examines the available literature on trauma-informed frameworks, models and guidelines that have been developed to guide organisations to improve service provision to survivors of sexual violence with mental health problems. The aim of the literature review is two-fold:

- to inform and refine the projects' aims and data collection; and
- to assist in the data analysis and implications
- assessment in subsequent stages.

http://media.aomx.com/anrows.org.au/s3fs-public/WITH%20Landscapes%20final%20150925.PDF

Examples of State or Territory activities

Victoria

Trauma and mental health technical paper mental health plan

The Victorian State Government published a brief document that outlines progress over the years. This document is described as: "***A technical paper linked to the discussion paper for the 10 year strategy for mental health addressing issues around trauma, trauma informed care and mental health".***

In 2014, 33 people from Department of Health and Human Services funded workforce accessed the training, ten of which were from mental health agencies.

In 2014 the Office of the Chief Psychiatrist developed and delivered Trauma-Informed Care training to mental health and emergency department staff. A total of 89 trainees received Trauma Informed Care training.

In 2015, an issue regarding trauma informed care skills of frontline staff within mental health services and emergency departments was highlighted by asylum seeker and refugee groups. To respond to this issue, the department commissioned Phoenix Australia Centre for Posttraumatic Mental Health to undertake analysis to understand the issue further and determine the best way for the department to strengthen the capability of adult mental health services front line assessment staff. This report will be complete October 2015.

Mental health first aid training has been provide by the department to the community (most recently in early 2015), and also widely used to train frontline workers such as Victoria Police and Ambulance Victoria to increase a person's knowledge of how to support a person experiencing a mental health crisis.
The Royal Commission into Institutional Responses to Child Sexual Assault, and the Victorian Royal Commission into Family Violence, which will focus further attention on the trauma experienced by victims and highlight the importance of service responses that are sensitive to this.

In 2016 the Bouverie Centre, La Trobe University, are conducting an inquiry into sector training needs for working with families who have experienced trauma.
https://www2.health.vic.gov.au/about/publications/policiesandguidelines/3/C/E/5/0/trauma-and-mental-health-technical-paper-mental-health-plan

Western Australia

The Department for Child Protection and Family Services (children in care)

These services in WA use the Sanctuary Model (by Sandra Bloom) for residential care across the state.

The Residential Care Conceptual and Operational Framework describe the major expansion and reform of residential care incorporating the overarching model and core elements informing how the Department for Child Protection residential facilities operate transforming larger hostels into smaller houses and establishing additional facilities in partnership with the community sector.

The Framework is based on the principles of the Sanctuary Model developed by Sandra Bloom and a study into residential care conducted by James Anglin in 2004. It introduces a coherent therapeutic approach to care and more importantly is a model for organisational change within the facilities. As this change is achieved it supports the gains already made.
http://www.mhcc.org.au/media/32045/ticp_awg_position_paper_v_44_final_07_11_13.pdf

RESIDENTIAL CARE PRACTICE MANUAL Residential Group Homes Department for Child Protection and Family Support Department for Child Protection and Family Support 189 Royal Street EAST PERTH Western Australia 6004

This is a 131-page manual for services. It also contains templates that may be helpful for any services working towards being trauma informed.
https://www.dcp.wa.gov.au/Organisation/Documents/ResidentialCarePracticeManual.pdf

Australian Capital Territory (ACT)

Report: 2014 Developing a Trauma-Informed Therapeutic Service in the Australian Capital Territory for Children and Young People Affected by Abuse and Neglect

This paper has been developed as part of the Trauma Recovery Centre Project funded by the ACT Government in 2013-14. The project operated from the ACT Community Services Directorate, Office for Children Youth and Family Support, Early Intervention and Prevention Services.

As a community, we need to endeavor to prevent child maltreatment before it occurs. The Child and Family Centres based in the ACT and other universal primary prevention and early intervention services focus on this goal. However, where maltreatment has already occurred, there is growing evidence that intensive intervention as early as possible in the life of the child and in the development of the problem can help to temper the detrimental effects of abuse and neglect. In essence, there is a need for 'e*arly intervention in the tertiary system'.* That is, the prevention of further traumatic and harmful situations for a child who has already come to the attention of statutory authorities.

This discussion paper will explore the policy context in which the Trauma Recovery Centre has been established as well as some of the literature regarding the impact of trauma on a child's physical, psychological and cognitive development. The key theories and/or frameworks being utilised by experts in this field will be examined as will the importance of understanding the cumulative impact of trauma on children in OoHC. An analysis of the trauma-informed services in Australia as well as the key aims of the Trauma Recovery Centre will be explored with reference to the OoHC data in the ACT, and will conclude this paper.

This paper highlights that a whole of government and cross sector approach is required to provide a trauma-informed, safe and nurturing environment for children and young people.

Significantly, there are existing services in the ACT that provide trauma-informed therapeutic support to children and young people, such as the Child at Risk Health Unit and Canberra Rape Crisis Service. A key aim of the Trauma Recovery Centre will be to compliment these existing organisations, whilst also providing a holistic, intensive and peripatetic therapeutic service.

The challenge thus lies in building a trauma-informed service system, which utilises a partnership and collaborative approach whilst also recognising the skills and expertise of individual service providers. https://www.google.co.nz/url?sa=t&rct=j&q=&esrc=s&source=web&cd=12&cad=rja&uact=8&ved=0ahUKEwjSoazmz67QAhUEUrwKHZgbC484ChAWCDAwAQ&url=http%3A%2F%2Fwww.communityservices.act.gov.au%2F__data%2Fassets%2Fword_doc%2F0005%2F642830%2FDiscussion-Paper-Trauma-Recovery-Centre-September-2014.doc&usg=AFQjCNFUI3SNLIEf0K7CaQg4Hho1el17FQ

Examples of work in other agencies

Blue Knot Foundation

As noted earlier in this report, Blue Knot Foundation, formerly known as Adults Surviving Child Abuse (ASCA), is the leading national organisation working to improve the lives of 5 million Australian adults who have experienced childhood trauma and abuse. Blue Knot Foundation helps adults who have experienced trauma in childhood recover. This includes people who have experienced child abuse in all its forms, neglect, domestic violence in childhood and other adverse childhood events. Childhood trauma affects an estimated 5 million Australian adults. Many struggle day to day with their self-esteem, relationships as well as their mental and physical health.

Research has established that people who have experienced severe early trauma can recover. And when parents have worked through their trauma their children do better too.

Blue Knot Foundation provides professional phone support, information, resources, tools and workshops to help survivors and their friends, families, partners and loved ones live better lives. We also educate and trains health professionals and others working with survivors to better support them on their healing journey.

As noted earlier, the Foundation is hosting a “match” in the IIMHL 2017 Leadership Exchange.
http://www.blueknot.org.au/ABOUT-US

Report 2015: The cost of unresolved childhood trauma and abuse in adults in Australia

In 2015 this report was published by Adults Surviving Child Abuse and Pegasus Economics, Sydney. Part of the Executive Summary states:

“Childhood trauma including abuse affects an estimated five million Australian adults. It is a substantial public health issue with significant individual and community health, welfare and economic repercussions. Unresolved childhood trauma has short-term and life-long impacts which substantially erode both national productivity and national well-being. It needs to be seen as a mainstream public health policy issue and responded to accordingly.

Pegasus Economics estimates that if the impacts of child abuse (sexual, emotional and physical) on an estimated 3.7 million adults are adequately addressed through active timely and comprehensive intervention, the combined budget position of Federal, State and Territory Governments could be improved by a minimum of $6.8 billion annually. In the population of adult survivors of childhood trauma more broadly i.e. a figure of 5 million adults, this estimate rises to $9.1 billion. These figures represent a combined effect of higher Government expenditure and foregone tax revenue.

If adult survivors of childhood trauma and abuse experienced the same life outcomes as nontraumatised adults, the collective budget deficits of Australian governments would be improved, at a minimum, by an amount roughly equivalent to the entire Government outlay on tertiary education. These estimates, based on a conservative set of assumptions, indicate extraordinary cost savings. On different, but still plausible assumptions, the annual budgetary cost of unresolved childhood trauma could be as high as $24 billion”.

http://www.asca.org.au/Portals/2/Economic%20Report/The%20cost%20of%20unresolved%20trauma_budget%20report%20fnl.pdf

The Blue Knot Foundation has a huge amount of resources: fact sheets, videos, practice guidelines etc.
http://www.blueknot.org.au/Resources/General-Information

Mental Health Australia

> **"We need to embed trauma informed practice within all health and human service *systems to provide appropriate trauma-informed services to those needing them. The provision of trauma informed services must also be supported by trauma specific services, which provide specific interventions to address the consequences of trauma."***

The website notes:
Trauma can arise from single or repeated adverse events that threaten to overwhelm a person's ability to cope. When it is repeated and extreme, occurs over a long time, or is perpetrated in childhood by care-givers it is called complex trauma.

Two thirds of people presenting to mental health services, inpatient and outpatient, have a lived experience of child physical or sexual abuse. Other causes of complex trauma include emotional abuse, neglect, family violence, living with a parent with a mental illness or who abuses substances, war and refugee trauma, separation and loss. In Australia 5 million adults have been affected by childhood trauma.

Many trauma survivors show remarkable resilience. However many are left struggling day to day with their health, wellbeing, emotions, relationships, and sense of self and identity. Complex trauma affects not only its victims but those with whom they are in contact as well as the children they go on to have. Research has established that trauma is a major public health problem. Yet within current systems it is frequently unrecognised, unacknowledged, and unaddressed. Many of those affected have been inadvertently re-traumatised in systems of care lacking the requisite knowledge and training around the particular sensitivities, vulnerabilities and triggers of trauma survivors.

Trauma Informed Practice is a strengths-based framework which is founded on five core principles – safety, trustworthiness, choice, collaboration and empowerment as well as respect for diversity. Trauma informed services do no harm i.e. they do not re-traumatise or blame victims for their efforts to manage their traumatic reactions, and they embrace a message of hope and optimism that recovery is possible. In trauma informed services trauma survivors are seen as unique individuals who have experienced extremely abnormal situations and have managed as best they could.

Becoming trauma informed necessitates a cultural and philosophical shift across every part of a service and is applicable to all human and health service systems. Trauma informed systems understand the dynamics of traumatic stress, survivors in the context of their lives and the role of coping strategies. They feature safety from harm and re-traumatisation, emphasise strength building and skill acquisition rather than symptom management, and foster true collaboration and power sharing between workers and those seeking help at all service levels.

Studies have shown that programs that utilise a trauma-informed practice model report a decrease in symptoms, an improvement in consumers' daily functioning, and decreases in the use of hospitalisation and crisis intervention.

Trauma-informed services do not cost more than standard services and report more successful collaboration with all stakeholders, enhanced skills, and a greater sense of self-efficacy among consumers, improved staff morale, fewer negative events, and more effective services and positive outcomes. https://mhaustralia.org/general/trauma-informed-practice

Phoenix Australia – Centre for Posttraumatic Mental Health

This Centre promotes recovery for the 15 million Australians affected by trauma. We do this by working with individuals, organisations and the community to understand, prevent, and recover from the potential adverse effects of trauma.

Phoenix Australia is an independent, not-for-profit organisation with an affiliation with the University of Melbourne. In summary it offers research, education and training for individuals and agencies.
http://phoenixaustralia.org/expertise/

It has a good video to describe trauma simply:
http://phoenixaustralia.org/recovery/

"We have a strong track record of knowledge translation initiatives with government departments, agencies and services that assist veterans, Defence personnel, emergency services, sexual assault counsellors, homeless support agencies, and child and family sector services".
http://phoenixaustralia.org/resources/trauma-research/

Conference paper 2013: Improving the identification of Adverse Childhood Experiences in developmental clinics: Does it make a difference?

Paper presented at the 13th Australasian Conference on Child Abuse and Neglect: Protecting children - new solutions to old problems, Canberra, ACT.

Research by University of NSW and Department of Community Paediatrics, Sydney & South Western Sydney Local Health Districts looked at children in the south west of Sydney – the most populous, ethnically diverse health region.

Their results found:

- Half the children attending developmental clinics in metropolitan Sydney have ACE identified, 10% have significant burden of early life adversities.
- Children with high ACE sores are more likely to be exposed to abuse and neglect, have child protection service involvement and be in foster care.
- Utilisation of the personal health record is generally poor, and needs to be promoted particularly for children with high ACE scores
- The ACE checklist may be a valuable adjunct to paediatric clinics, to improve identification and support for socially at-risk children.

http://www.aic.gov.au/media_library/conferences/2013-accan/presentations/Raman.pdf

Australian Childhood Foundation

The issue
Child abuse and neglect is one of Australia's darkest social stories. The most recent figures from the Australian Institute of Health and Welfare tell us that in 2013 - 2014 there were 304,097 new reports of abuse and neglect across Australia, which equates to one report every two minutes.

Abuse and neglect have a devastating impact on the lives of children, and the trauma that results from their experiences can continue to shatter their lives long after the abuse itself has stopped. Trauma impacts on the brains of children and young people, shaping their behaviour and reactions to the world around them. It robs children of their childhoods. It steals their self-confidence, their sense of safety, their carefree innocence, their ability to trust others, even their ability to learn.

Without specialist help and protection, the experience of abuse can become the starting point for a lifetime of struggle, confusion, conflict and breakdown. It can lead to depression, drug and alcohol addiction, violence, crime, mental illness and youth and adult suicide.

What is child abuse?
In Australia, child abuse is usually defined by the laws developed by a state government. The laws reflect attitudes in society about the standards of care and protection that children need from their parents or other family members. The laws are also a sign of the commitment made by a community - that ensures that violence towards children is not tolerated. Children and young people under the age of seventeen can be victims of child abuse. There are five main types of child abuse. Many children experience more than one form of abuse:

- Physical abuse
- Psychological abuse
- Neglect
- Sexual abuse and exploitation
- Bullying
- Being forced to live with family violence

http://www.childhood.org.au/learn/the-issue

Our trauma informed principles

The Australian Childhood Foundation has developed its own models of trauma informed therapeutic services and out of home care programs. Fundamentally, the approach of the Foundation has been based on integrating a commitment to overarching principles of effective practice with vulnerable children and their carers/families with an interpretation of the evidence base emanating from the neuroscience of child development, trauma, attachment and interpersonal neurobiology.

These principles are set out in summary form below.

WHAT ARE THE OVERARCHING PRINCIPLES UNDERPINNING OUR PRACTICE WITH CHILDREN AND FAMILIES?

- We believe that a respect for children's rights is critical to transformative practice.
- We believe that an appreciation of child development should underpin all our intervention.
- We believe that growth for children is embedded in their relational context.

- We believe that the nature of children's experience of violence sets the parameters for how they make sense of it.
- We believe that children's experience of their culture is a connection to resources of belonging and support.
- We believe that an understanding of the neurobiology of trauma is the platform for assessment and intervention with children and families.

WHAT ARE THE PRINCIPLES OF TRAUMA INFORMED PRACTICE THAT GUIDE THE THERAPEUTIC SERVICES OF THE AUSTRALIAN CHILDHOOD FOUNDATION?

Trauma significantly alters baseline physiological arousal levels in children.
Children are likely to benefit from environments of care which pay attention to their mood, focus on adjusting their sensory stimulation to help them stay physically present feel safe to connect with others, and engage predictable strategies from carers that reduce reactivity and minimise volatile responses.

Trauma reduces cortical capacity to regulate subcortical activation in children.
Carers may benefit from understanding that traumatised children are likely to find it difficult to utilise reasoning and logic to modify their behaviour or reactions. These children are also unlikely to learn from consequences, particularly when they are in heightened arousal states. It is possible to support carers to avoid the frustration associated with the failure of traditional parenting approaches by increasing their knowledge of trauma. If they understand that trauma acts to scramble cortical functioning and reduce children's capacity to be guided by rule-based frames of behaviour, they will be less likely to rely on such parenting methods. In addition, children's recovery from trauma will be enhanced through interactions with carers which promote physical activity that stimulates lower order parts of the brain responsible for movement, play and balance.

Trauma disrupts memory functioning in children.
Children are likely to benefit from strategies which support stressed memory systems, including the introduction of visual and mnemonic cues to prompt short term memory rehearsal and recall, repetition of episodic and narrative structures and the establishment of routines to structure behavioural rehearsal. In addition, children's ability to generalise learning from one setting to another is also hampered by memory difficulties. As such, care contexts should be resourced to implement coordinated plans of responses that support the translation of children's learning from one environment to the other.

Trauma disconnects children from relational resources that can mitigate its effects.
Traumatised children will require opportunities to experience attachment relationships which offer consistency, nurture and predictability. Carers can be resourced to understand the significance of daily exchanges, knowing that each exchange with their carer can help children to develop ways of experiencing the world and relationships that counteract previous attachment patterns. Increasing carer sensitivity to attuned communication with children is a core competency for caring for children with trauma backgrounds.

Trauma restricts the attentional capacity of children.
Children may benefit from care environments which enable them to engage in experiences which redirect their attention away from past trauma oriented activation to the here and now. Carers can be supported to offer children chances to act and react in playful ways which are likely to lead to intensely positive experiences. These opportunities relieve the burden on traumatised children shifting their attention from the past. They also powerfully connect children and carers in shared activities that promote trust and belonging.

Trauma based behaviour is functional at the time in which it develops as a response to threat.
Carers can be supported to understand the purpose and meaning of trauma based behaviour in children, helping to shift their interpretations away from blame to greater acknowledgement of the ongoing impact of children's abuse experiences. This functional analysis approach enables carers to develop the confidence to plan to respond to children. This analysis can also be translated into other settings such as school, where similar behaviours can intrude on children's every day experiences.

Trauma limits children's response flexibility and adaptability to change.
Traumatised children may get 'stuck' due to constant trauma triggers, and so enact patterns of defensive behaviour that make sense in the light of their initial trauma(s) but may not seem obvious to those around them. It is important for carers to understand, that while in these triggered states, children have little capacity to reshape their responses without the intentional resourcing of adults in their immediate care environment. Carers and other significant individuals will need to be resourced to focus on introducing change in small increments, preparing and supporting children to become accustomed to one change before initiating another. In this context, carers and others can be supported to understand the benefits of predictability and routine for children as well as the need for practicing flexible responses in acts of daily living.

Trauma undermines identity formation in children.
Children are likely to benefit from reinforcement by carers and others for examples of qualities that denote positive sense of self and resource personal agency. Carers will need to be resourced to understand the significance of their role in nurturing an emerging self-identity specifically at various developmental transition points for children.

Trauma diminishes social skills and isolates children from peers.
Children with trauma backgrounds need support to engage positively with peers in social situations. Carers and other individuals will need to appreciate the importance of their role in modeling social skills and respectful interactions. This will resource traumatised children to build a network of relationships which promote connection and afford further opportunities to reconstruct their attachment styles.
(This framework of evidence was first published by Joe Tucci and Janise Mitchell as ***Nine Plain English Principles of Trauma Informed Care*** *on Prosody on 28 April 2015. Click here to read the full article.* http://www.childhood.org.au/blog/home/2015/april/trauma-informed-care*)*
http://www.childhood.org.au/for-professionals/our-trauma-informed-principles

Research reports (examples)
The utility of a reflective parenting program for parents with complex needs: An evaluation of Bringing Up Great Kids
file:///Users/janetpeters/Downloads/2014%20BUGK%20EVALUATION.pdf

They count for nothing: Poor child protection statistics are a barrier to a child - centred national framework.
file:///Users/janetpeters/Downloads/They%20Count%20for%20Nothing%20Report%20Feb%202014.pdf

http://www.childhood.org.au/for-professionals/research-and-advocacy/research

Conference 2016: Childhood Trauma: Tracing new developments in relational, body oriented and brain-based approaches to recovery and change

An International Conference on Innovation in Therapeutic Approaches with Children, Young People and Families. http://childtraumaconf.org/

CANADA

In 2012 the IIMHL 'Make it so' noted there was emerging work being done in Canada. *Changing Direction, Changing Lives: The Mental Health Strategy for Canada* talked about trauma informed alternatives to the use of seclusion and restraint, with a view to making these practices virtually unnecessary.

In addition *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada* outlined a continuum of care in support of strengthened community, regional and national responses to substance use challenges.
The framework was developed through extensive consultation and collaborative work between government and First Nations. It includes a focus on mental health and trauma[15].

Mental Health Commission of Canada

Webinar 2014: Trauma-informed systems and organizations

Presented By: **The Mental Health Commission of Canada & Tim Wall, Director of Counselling Services, Klinic Community Health Center, Winnipeg.**
Klinic is the home of the Manitoba Trauma Information and Education Centre which is dedicated to enhancing the capacity of service providers and organizations to effectively meet the needs of people affected by psychological trauma.

Excerpts from the presentation:

"Who we are today is not who we need to be tomorrow"
(Davidson, 2004)

Trauma is often at the root of:

- Poverty, homelessness, violence
- Addictions, mental illness, suicide
- Poor health outcomes/physical and chronic illnesses
- Poor academic performance
- Lower efficiency, productivity

Effects of trauma include:

- Changes to the brain
- Increased physical and mental stress
- Compromise immune system
- Decreased trust
- Attachment difficulties; conflictual relationships
- Hyper arousal and hyper vigilance
- Rigid or chaotic behaviour Effects of trauma are felt across the life span

[15] Make it so 2012 http://www.iimhl.com/files/docs/Make_It_So/20120712.pdf (p.5)

Nine Functions of an Integrated Prefontal Cortex/Upstairs Brain

1. Body Awareness
2. Ability to Attune to Others
3. Balanced Emotions
4. Ability to Calm Fears
5. Ability to Pause before Acting
6. Capable of Insight and Reflection
7. Ability to Feel Empathy
8. Capable of having a Sense of Morality, Fairness and the Common Good
9. Ability of Being Intuitive

Organizations and systems that are trauma- informed are:

- More accessible
- More effective
- More efficient
- More compassionate
- Healthier – for clients and service providers

http://www.mentalhealthcommission.ca/sites/default/files/2014-0408_mhcc_trauma-informed_care_0.pdf

Correctional Service Canada

Response of the Correctional Service of Canada to the 42nd Annual Report of the Correctional Investigator 2014 - 2015

The purpose of the federal correctional system, as defined in law, is to contribute to the maintenance of a just, peaceful and safe society by carrying out sentences imposed by courts through the safe and humane custody and supervision of offenders; and by assisting the rehabilitation of offenders and their reintegration into the community as law-abiding citizens through the provision of programs in penitentiaries and in the community (*Corrections and Conditional Release Act*, s.3)

Over the last decade, CSC has faced numerous challenges stemming from a more complex and diverse offender population profile, resulting in new pressures on the Service and its operations. In response to the requirements of managing a changing offender profile and in achieving quality public safety results for Canadians, CSC will continue to focus on six key priorities as outlined in its Report on Plans and Priorities:

1. Safe management of eligible offenders during their transition from the institution to the community, and while on supervision
2. Safety and security of members of the public, victims, staff and offenders in our institutions and in the community
3. Effective, culturally appropriate interventions for First Nations, Métis and Inuit offenders
4. Mental health needs of offenders addressed through timely assessment, effective management and appropriate intervention, relevant staff training and rigorous oversight
5. Efficient and effective management practices that reflect values-based leadership in a changing environment
6. Productive relationships with diverse partners, stakeholders, victims' groups, and others involved in public safety.

Health Care in Federal Corrections

One of 18 recommendations was:

> **"Recommendation 7:**
> ***"I recommend that CSC examine international research and best practices to identify appropriate and effective trauma-informed treatment and services for offenders engaged in chronic self-injurious behaviour, and that a comprehensive intervention strategy be developed based on this review.***
>
> CSC will conduct a literature review of international research and best practices in the provision of trauma-informed treatment for chronic self-injury. Moreover, CSC has engaged an external expert with experience in the provision of trauma-informed care to First Nations populations, to liaise with CSC's Regional and National Complex Mental Health Committees and to provide trauma-informed case consultations for identified offenders with complex mental health needs. The literature review will be complete by September 2016".

http://www.csc-scc.gc.ca/publications/005007-2805-eng.shtml

The Centre for Addiction and Mental Health (CAMH)

CAMH is Canada's largest mental health and addiction teaching hospital, as well as one of the world's leading research centres in the area of addiction and mental health.

CAMH combines clinical care, research, education, policy development and health promotion to help transform the lives of people affected by mental health and addiction issues.
http://www.camh.ca/en/hospital/about_camh/who_we_are/Pages/who_we_are.aspx

It is part of the "Portico" network which provides a wide range of trauma related resources for mental health and addiction services: websites, reports and assessment tools.
https://www.porticonetwork.ca/-/trauma-treatment-tools-and-resources

The Canadian Centre on Substance Abuse

"This organisation changes lives by bringing people and knowledge together to reduce the harm of alcohol and other drugs on society. We partner with public, private and non-governmental organizations to improve the health and safety of Canadians".

Extracts from **The trauma-informed Toolkit**:

Implications for substance abuse services

Services that work with people with trauma, substance use and mental health problems face pressures in keeping treatment environments healthy and safe, and in not becoming reactive and hierarchical. Trauma-informed services involve clients, clinicians, managers and all personnel—from the receptionist to the funder—working in ways that demonstrate understanding of the needs of trauma survivors.

Together with individual interactions, service practices and policies, they create a democratic and supportive organizational culture. A key aspect of trauma-informed practice is understanding how

trauma can be experienced differently by refugees, people with developmental disabilities, women, men, children and youth, Aboriginal peoples, and other populations.

An increasing amount of material is being published on tailoring substance use treatment approaches to take trauma—and these differing experiences of it—into account. Of particular note is the increasing understanding of the impact of historical and intergenerational trauma for Aboriginal peoples in Canada, and the implications for trauma-informed substance treatment for Aboriginal peoples as part of a broad approach to policy, treatment and community interventions.

Trauma-informed practice can be implemented at multiple levels. The Jean Tweed Centre in Toronto, for example, has braided trauma-informed practice into its treatment programs for women and children. The Centre for Addiction and Mental Health in Toronto, a larger institution, is an example where organization-wide change processes have been undertaken to minimize the use of restraints in their services, and to involve consumers in consultation on services (including implementing a client bill of rights).

Evidence-based practices in the substance use field (such as motivational interviewing) are consistent with trauma-informed practice in their valuing of collaborative, empowering stances. Trauma-informed services demonstrate awareness of vicarious trauma and staff burnout. Many providers have experienced trauma themselves and 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.
http://www.ccsa.ca/Resource%20Library/CCSA-Trauma-informed-Care-Toolkit-2014-en.pdf

Brief report 2015: by IMPART (Intersections of Mental Health Perspectives in Addictions Research Training)

Gender, Trauma & Substance Use

Many people with substance use problems or addictions have experienced trauma.

Some key facts and issues

- Traumatic experiences are prevalent for women with substance use concerns: 90% of women in treatment for alcohol problems in Canada report abuse related trauma as a child or adult.
- Historical trauma experienced by Indigenous men has been found to be linked to substance use problems and mental health concerns; and trauma-informed and culturally grounded approaches have been found helpful to support recovery.
- 44.6% of participants in the North American Opiate Medication Initiative (NAOMI) in Vancouver reported a history of physical or sexual abuse.
- Trans*female youth report high prevalence of PTSD, gender-related discrimination, psychological distress, and substance use. Substances may be used to cope with symptoms of trauma and discrimination

http://addictionsresearchtraining.ca/wp-content/uploads/2015/06/infosheet-MH-SU-trauma-fact03.pdf

Examples of activities in Provinces

Manitoba

Report 2013: Trauma-informed: The Trauma Toolkit, Second Edition

This Toolkit was made possible in part due to the support from the Government of Manitoba, Department of Health Living and Health Canada's First Nations and Inuit Health Branch.

"This toolkit aims to provide knowledge to service providers working with adults who have experienced or been affected by trauma. It will also help service providers and organizations to work from a trauma-informed perspective and develop trauma-informed relationships that cultivate safety, trust and compassion.

Traumatic events happen to all people at all ages and across all socio-economic strata in our society. These events can cause terror, intense fear, horror, helplessness and physical stress reactions. Sometimes the impact of these events does not simply go away when they are over. Instead, some traumatic events are profound experiences that can change the way children, adolescents and adults see themselves and the world. Sometimes the impact of the trauma is not felt until weeks, months or even years after the traumatic event. Psychological trauma is a major public health issue affecting the health of people, families and communities across Canada.

Trauma places an enormous burden on every health care and human service system. Trauma is not only a mental health issue, but it also belongs to every health sector, including primary/ physical, mental and spiritual health. Given the enormous influence that trauma has on health outcomes, it is important that every health care and human services provider has a basic understanding of trauma, can recognize the symptoms of trauma, and appreciates the role they play in supporting recovery. Health care, human services and, most importantly, the people who receive these services benefit from trauma informed approaches.

Trauma is so prevalent that service providers should naturally assume that many of the people to whom they provide services have, in some way or another, been affected by trauma. Although trauma is often the root cause behind many of the public health and social issues that challenge our society, service providers all too often fail to make the link between the Introduction The Trauma-informed Toolkit, second Edition 6 trauma and the challenges and problems their clients, patients and residents, and even co-workers, present" (p.5-6).

This is a 147-page document that includes indigenous issues; here are some chapter titles:

- What is Trauma? 9
- Who Can Be Traumatized? 12
- Trauma-informed Practices 15
- What is Trauma-informed Practice? 15
- Organizational Checklist 22
- Policies and Procedures 24
- Monitoring and Evaluation 29 Post-Traumatic Stress Disorder (PTSD) 30
- Three Elements of PTSD 31

- Trauma Continuum 33 Types of Trauma 36
- Interpersonal and External Trauma 36
- Developmental Trauma: Child Abuse 38
- The Experience of Immigrants and Refugees 40 Historic Trauma: The Legacy of Residential School 45
- Residential Schools 45
- Impacts 47
- Hope and Resilience 51 Cultural Teachings/Healing Practices 52
- The Seven Sacred Teachings 54
- Role of the Elder 56
- The Far Reaching Effects of Trauma: Prevalence 59
- The Effects of Trauma 65 The Neurobiology of Trauma 70

http://trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed_Toolkit.pdf

Ontario

Presentation, 2015:Trauma-informed care at the Centre for Addiction and Mental Health, Methadone Prescribers Conference

2015 Sheryl Spithoff MD CCFP Leslie Molnar MSW RSW Women's College Hospital, University of Toronto

Extracts:

Canadian Community Health Survey (Afifi 2014)

- Self-reported prevalence of child abuse- 32%
- Physical (26%), sexual (10.1%), exposed to intimate partner violence (7.9%)
- Strong association with adult mental health problems including suicide attempts and drug abuse/dependence
- Canadian stats- adulthood – 6% report current or most recent past partner physically or sexually victimized them (Stats Canada 2011)
- 1/4 women are sexually assaulted in lifetime (Sexual assault Canada 2012)

ACEs & Trauma

- Researchers estimated that ACEs were responsible for at least ½ to 2/3 of drug addictions
- ACEs affect neuro-development
- Dysfunction in hypothalamic-pituitary-adrenal (HPA axis), in dopamine, serotonin, endorphin pathways, in development of pre-frontal cortex
- Problems with affect-regulation, attachment, identity, relationships, sense of meaning
- High levels of anxiety, depression, suicidality
- Rarely feel at ease and relaxed

Substance use affects many of these neural pathways:

- Endorphins, serotonin, dopamine
- Dopamine release from many psychoactive substances prone to misuse is often 5-10x greater than physiological (food, sex, companionship)
- For the first time ever enough for those with trauma to feel happy, at ease
    - "Two drinks short of normal"
    - coping mechanism

- However, over time brain responds by decreasing dopamine release and dopamine receptors (also changes in other pathways)
- Leads to tolerance and withdrawal

Video shown:
Dr Gabor Mate (Vancouver) Video 2013:
https://www.youtube.com/watch?v=yCzXbsGAXiI

Asking about ACEs

Health care providers express the following worries:

- I won't know how to respond
- I won't have the time to hear the whole story
- I don't have the skill set and will make things worse
- I may respond with emotion/ hard to hear/ reminders of own struggles

Give an explanation of why you are inquiring about trauma:

"We know that childhood histories of abuse/trauma are much more common than once thought. As well, studies show that childhood and adulthood trauma can have an impact on physical and mental health."

Example of a screening question: – "*Have you experienced any difficult life events (abuse, violence, trauma) that think might be related to some of the things you are struggling with now?"*

http://www.cpso.on.ca/CPSO/media/documents/Methadone/Presentations/15Nov6_Spithoff-Sheryl_Molnar-Leslie.pdf

British Columbia (BC)

Report 2013: The Trauma-Informed Practice (TIP) Guide

This is a 102-page report.

"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 and 2012 in each of the BC Health Regions.

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

This report also has helpful information guides for practitioners:

Appendix 1 Info Sheet on Self-Care for Practitioners 42
Appendix 2 Trauma-Informed Practice Organizational Checklist 45
Appendix 3 Info Sheet on Trauma-Informed Engagement Skills 58
Appendix 4 Info Sheet on Asking About Trauma and Responding to Disclosure . . 66
Appendix 5 Info Sheet on Strategies for Sharing Information About Trauma 73
Appendix 6 Info Sheet on Grounding Skills and Self-Care Strategies 76
Appendix 7 Trauma-Informed Practice Related Resources ……..86
http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

AMSSA (Affiliation of Multicultural Societies and Service Agencies of BC)

AMSSA is a unique province-wide association that strengthens over 70 member agencies as well as hundreds of community stakeholder agencies who serve immigrants and newcomers, and build culturally inclusive communities, with the knowledge, resources and support they need to fulfill their mandates.

They have a section of the website that lists Canadian and International resources that have a trauma informed practice focus.
http://www.amssa.org/resources/quicklinks-resources/trauma-informed-practice/

Issues specifically for immigrant and refugee populations are:

- Discrimination
- Economic pressures
- Stigma (mental health issues)
- Distrust
- Language and low literacy
- Fear of deportation

http://www.amssa.org/resources/videos/webinars/trauma-informed-practice-supporting-clients-who-have-experienced-complex-trauma/

Nova Scotia

Nova Scotia Trauma Informed Network

"Decolonizing violence and trauma informed research, knowledge translation, policy and practice".

At NSTIN we have been thrilled by Community, Provincial and Federal responses since forming the Nova Scotia Trauma Informed Network in 2013. Our Trauma Informed workshops have been organized and funded by Nova Scotia, PEI, and Newfoundland Government funded agencies, community-based non-profits, as well as the Public Health Agency of Canada.
Violence and Trauma Informed practice plays a critical role in community, enhancing our capacity to:

- meet people where they are
- work together from a people- and place-centered perspective
- link Interventions together with Health Promotion, Prevention and Early Intervention, and
- provide the supports people themselves identify are needed
- NSTIN is committed to:
    - plain language practice, research and knowledge translation
    - addressing violence at personal, interpersonal and structural levels, and
    - increasing our community capacity to help all people access the services they identify are needed, at the sites that are safe for them.

Due to the success of the regional workshops, we were asked by PHAC Ottawa to create and deliver a national Webinar for the Public Health Agency of Canada on February 26, 2015: *Family Violence Prevention – Building Trauma Informed Communities.*

Many resources are available online. http://www.novascotiatraumainformednetwork.org/

Examples of other agencies and activities

Canadian Mental Health Association (CMHA)

The Canadian Mental Health Association (CMHA), founded in 1918, is one of the oldest voluntary organizations in Canada. Each year, we provide direct service to more than 100,000 Canadians through the combined efforts of more than 10,000 volunteers and staff across Canada in over 120 communities.

As a nation-wide, voluntary organization, the Canadian Mental Health Association promotes the mental health of all and supports the resilience and recovery of people experiencing mental illness. The CMHA accomplishes this mission through advocacy, education, research and service.
http://www.cmha.ca/about-cmha/#.WCDlauF975Y

The CMHA has good information for consumers and families e.g.:
http://www.cmha.ca/mental_health/post-traumatic-stress-disorder/#.WCDl0eF975Y

The CMHA also ran the following workshops:

Trauma-Informed Care Workshops, 2015

Looking Through a Trauma Lens: An Introduction to Working with Children, Youth and Their Families in the Context of Traumatic Experiences

This project offered four, two-day, in-person workshops focused on trauma-informed frameworks and strategies for working with children and youth with complex mental health issues delivered in Thunder Bay, Ottawa, Toronto and London.

These two-day workshops provided a background on current understandings of how trauma impacts children, youth and their families. Facilitators described promising research and best practices for working with children and youth who have experienced trauma. The workshops also addressed how best to identify the myriad of traumatic responses using a culturally sensitive framework, and how to encourage healing in individuals and communities. On the second day, participants explored themes related to vicarious trauma and the implications of being a helping professional in this field.

The face-to-face workshops were designed to support the systems transformation outlined in MCYS' *Moving on Mental Health*. There was particular emphasis on the third of the eight core services, "Counselling and Therapy Services." The goal was to provide current information and research about trauma-informed treatment services for children and youth with complex mental health needs that can reduce the severity of, and/or remedy the mental, social and behavioral challenges of children and youth with complex mental health needs.
http://www.complexneeds.ca/trauma-informed-care-workshops/

Project Trauma Support

This is a new Canadian program that addresses Post Traumatic Stress and Operational Stress Injury in military personnel, veterans and first responders.

Our team consists of mental health professionals and police and military officers who have extensive lived experience. Our goal is to provide timely access and deliver effective help to those suffering from service related trauma.

We aim to support our colleagues to minimize their distress and help them to remain active and healthy in their lives. We recognize the great contribution made by those who protect us and our mission is to empower them to continue to serve.
http://projecttraumasupport.com/

YWCA Canada

This document is a 10-page handout for women explaining key concepts about trauma.

Excerpts:

"First, do no more harm. Recognize that harm has been done".

From an Early Childhood Development Project participant

"I will not give up … I will be one of the first in my family to put these things behind me".

“Learn from women who have ‘lived experience’. Trauma-informed practices recognize the knowledge and wisdom of women who have experienced trauma and engage their expertise. Examples:

- Inclusion of women with lived experience in organizational planning;
- Seeking and acting on their feedback;
- Involving them in delivering staff training” (p.6).

“Go beyond a singular focus on problematic substance use, or even a dual focus on trauma and substance use. Those issues must be understood as part of a bigger picture that includes gender, culture, and other factors” (p.6)

“Collaborate across sectors. Given the array of impacts that trauma can have, a woman may also need access to other services such as income security, housing, parenting and children’s services, primary health care, mental health services, and culture-specific services. Collaborative team-based approaches across multiple service sectors can facilitate seamless connections, reduce the need for a woman to retell her story repeatedly, and build systemic responses to complex issues and needs” (p.6)
http://ywcacanada.ca/data/research_docs/00000333.pdf

Centre for Suicide Prevention

Report 2015: TRAUMA, TRAUMA-INFORMED CARE (TIC), and SUICIDE PREVENTION: A suicide prevention toolkit

Excerpts include:

“There is a considerable prevalence of trauma among people in Canada.

The vast majority of mental health care clients have had some form of traumatic exposure (Rosenberg, 2005). These negative experiences place them at a higher risk for co-occurring mental health issues such as mood- and substance use-disorders. Additionally, these individuals are also at a greater risk for suicide.

This increased realization of the pervasiveness of traumatic experiences by health care professionals has prompted a determined effort to implement a better approach to treating patients. This improved approach will take into account the impact that previous traumatic experiences have had on an individual’s overall mental health.

Trauma- Informed Care (TIC) is the response.

Trauma-Informed Care (TIC) is a systemic approach that ensures all people who come into contact with the behavioural health system receive services that are sensitive to the impact of previously incurred trauma. People need to receive these services regardless of the access point they enter the system—emergency room, psychiatrist office, rehabilitation centre, community care, to name but a few.

TIC is a strengths-based framework, approach, and philosophy based on a grounded understanding of and responsiveness to the prevalence of trauma. It is defined as, “care that is organized around a

contemporary, comprehensive understanding of the impact of trauma that emphasizes strengths and safety, and focuses on skill development for individuals to rebuild a sense of personal control over their life" (Yeager, et al. 2013, p.595). The physical, psychological, and emotional safety of both clients who are trauma survivors and their health care providers is crucial. A concerted effort is also made to avoid the re-traumatization of the survivor, which has often been an unintentional consequence of trauma treatment (SAMHSA, 2014; Harris and Fallot, 2001). TIC was designed to be both preventative and rehabilitative. TIC is now the expected norm in most behavioural health treatment systems, and it represents a significant paradigm shift from what has been called a "deficit perspective" to one that is strengths-based (British Columbia Ministry of Health, 2013).

(an excerpt from iE13:Trauma Informed Care: Trauma, Substance abuse and Suicide Prevention)

A TIC approach to suicide prevention should first involve an awareness campaign designed to inform and educate the general public and, more specifically, everyone who is in contact with potential trauma victims. The underlying assumption is that everybody has experienced trauma and should, therefore, be assessed for it. TIC raises the bar by implementing and formalizing a "universal" screening policy where everyone is first screened and then assessed for both trauma and suicidality. Also, everyone is assessed for past traumatic experiences, as opposed to receiving an assessment based solely on their current presenting symptoms. This "universal" approach results in people being treated in the most humane, holistic, and comprehensive manner possible, regardless of their unique personal histories.

The causes of a suicide are multidimensional and complex, and there is rarely one single reason that causes someone to die by suicide. The prevention of suicide is similar. There is no one-size-fits-all prevention strategy that keeps people from taking their own lives. TIC, however, provides a much more comprehensive avenue by which we can identify those at risk (Olson, 2013)"
https://www.suicideinfo.ca/wp-content/uploads/2015/05/Trauma-Informed-Care-Toolkit.pdf

ENGLAND

In 2012 no information could be found on ACEs or trauma informed care.[16]

In 2016 some Government agencies in England (and Wales) use the language of ACEs and trauma informed care. There is a growing interest and work has begun mainly it seems in the care of "looked after children" (i.e. children in state care), mental health and maternal health.

However all work has the same aims and objectives (i.e. healthy children, adults and families; and safe, culturally appropriate services).

Mental Health

Mental health policy under the 2010-15 Coalition Government

The Mental Health Strategy for England

The Government's mental health strategy, No Health without Mental Health: A cross-government mental health outcomes strategy for people of all ages (February 2011) set out the Coalition's plan to improve people's mental health and wellbeing and improve services for those with mental health problems.

The strategy set six key objectives:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support • Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination.
- The strategy also made explicit the Government's objective to give equal priority to mental and physical health.

file:///Users/janetpeters/Downloads/CBP-7547.pdf

The Five Year Forward View for Mental Health, Feb 2016

A report from the independent Mental Health Taskforce to the NHS in England February 2016

This report does not include ACEs or trauma informed care concepts.

[16] Make it so, 2012 http://www.iimhl.com/files/docs/Make_It_So/20120712.pdf

First, we have made a set of recommendations for the six NHS arm's length bodies to achieve the ambition of parity of esteem between mental and physical health for children, young people, adults and older people.

Second, we set out recommendations where wider action is needed. Many people told us that, as well as access to good quality mental health care wherever they are seen in the NHS, their main ambition was to have a decent place to live, a job or good quality relationships in their local communities. Making this happen will require a crossgovernment approach.

Finally, we have placed a particular focus on tackling inequalities. Mental health problems disproportionately affect people living in poverty, those who are unemployed and who already face discrimination. For too many, especially black, Asian and minority ethnic people, their first experience of mental health care comes when they are detained under the Mental Health Act, often with police involvement, followed by a long stay in hospital. To truly address this, we have to tackle inequalities at local and national level.

> *"In addition, some children are particularly vulnerable to developing mental health problems - including those who are looked after or adopted, care leavers, victims of abuse or exploitation, those with disabilities or long term conditions, or who are within the justice system. The Departments of Health and Education should establish an expert group to examine their complex needs and how they should best be met, including through the provision of personalised budgets". (p.16)*

https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

Examples of recent policies are:

Children and young people's mental health – policy, CAMHS services, funding and education, 2016

The Department of Health's press release outlines its commitments to the report's recommendations: An extra £1 billion will be invested in mental health care by 2021 and a million more people will get mental health support. The announcement follows the publication of a report by the Mental Health Taskforce, chaired by Paul Farmer, Chief Executive of Mind.

The taskforce has reviewed mental health care and has set out its vision for preventative, holistic mental health care and making sure that care is always available for people experiencing a crisis. The recommendations to be delivered by 2021 include:

- an end to the practice of sending people out of their local area for acute inpatient care
- providing mental health care to 70,000 more children and young people
- supporting 30,000 more new and expectant mothers through maternal mental health services
- new funding to ensure all acute hospitals have mental health services in emergency departments for people of all ages

increasing access to talking therapies to reach 25% of those who need this support

- a commitment to reducing suicides by 10%

http://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7196

Norman Lamb, Minister of State for Care and Support set up the Children and Young People's Mental Health and Wellbeing Taskforce

"I wanted to identify what the problems were, what was stopping us from providing excellent mental health care for young people. The Taskforce brought together professionals from across the education, health and care system to figure this out. They also worked with charities and community organisations and, importantly, they brought in young people and their families, too. We needed a comprehensive view to understand the wide-ranging issues affecting our mental health service.

This is the 2015 Government report of the work of the Taskforce and it sets out what we need to do to overcome the status quo. We need a whole child and whole family approach, where we are promoting good mental health from the earliest ages. We need to improve access to interventions and support when and where it is needed, whether that's in schools, GP practices, hospitals or in crisis care. We mustn't think about mental health in a purely clinical fashion.

"The economic case for investment is strong. 75% of mental health problems in adult life (excluding dementia) start by the age of 18. Failure to support children and young people with mental health needs costs lives and money. Early intervention avoids young people falling into crisis and avoids expensive and longer term interventions in adulthood. There is a compelling moral, social and economic case for change" (p.13)

"There is a strong link between parental (particularly maternal) mental health and children's mental health. For this reason, it is as important to look after maternal mental health during and following pregnancy as it is maternal physical health.

According to a recent study, maternal perinatal depression, anxiety and psychosis together carry a longterm cost to society of about £8.1 billion for each one-year cohort of births in the UK, equivalent to a long-term cost of just under £10,000 for every single birth in the country. Nearly three-quarters of this cost (72%) relates to adverse impacts on the child rather than the mother. Some £1.2 billion of the long-term cost is borne by the NHS" (p.33).

Trauma is mentioned briefly:

> ***Improving access for parents to evidence-based programmes of interventions, and support to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour. With additional funding, this would be delivered by:***
>
> ***• enhancing existing maternal, perinatal and early years health services and parenting programm***es. (P.17)

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

Parliament

Report 2015: Mental health and well-being of looked-after children

Some extracts:

13. Current methods of assessing children and young people's mental health and well-being as they enter care are inconsistent and too often fail to identify those in need of specialist care and support. Initial assessments are rarely completed by qualified mental health professionals with an appreciation of the varied and complex issues with which looked-after children may present.

14.*We recommend that the Government amends the statutory guidance to make clear that an SDQ should be completed for every child entering care as a starting point. In addition all looked-after children should have a full mental health assessment by a qualified mental health professional. Where required this should be followed by regular assessment of mental health and well-being as part of existing looked-after children reviews.*

Looked-after children who need access to mental health services often have numerous and complex issues that require specialist input across multiple agencies. We have heard evidence that CAMHS is often unable to provide this care due to high thresholds and a refusal to see children or young people without a stable placement. The inflexibility of CAMHS is failing looked-after children in too many areas and leaving vulnerable young people without support.

22.*CAMHS should not refuse to see children or young people without a stable placement or delay access to their services until a placement becomes permanent.*

23.*We recognise that CAMHS is not the only, or in many cases the most suitable, source of support for looked-after children. We recommend that where possible CAMHS should form a part of a multi-agency team in which education, health and social carework in partnership. Looked-after children and young people are best supported when professionals collaborate and services are tailored to the needs of the individual.*
http://www.publications.parliament.uk/pa/cm201516/cmselect/cmeduc/481/48102.htm

National Childrens Bureau

In a response to the above report:

"The 10,000 children and young people a year who go into care in the UK should have their mental health assessed so they can be helped to recover from childhood trauma and abuse, ministers are being urged".

https://www.ncb.org.uk/news-opinion/news-highlights/time-mental-health-looked-after-children-be-priority

The Department for Education

This agency is responsible for child protection in England. It sets out policy, legislation and statutory guidance on how the child protection system should work.

At the local level Local safeguarding children boards (LSCBs) co-ordinate, and ensure the effectiveness of, work to protect and promote the welfare of children. Each local board includes: local authorities, health bodies, the police and others, including the voluntary and independent sectors. The LSCBs are responsible for local child protection policy, procedure and guidance. There are 13 laws that relate to this area.

Mental health and behaviour in schools: Departmental advice for school staff, 2016

This advice is for: Primary and secondary school teachers, pastoral leaders, Special Educational Needs Coordinators, designated teachers for looked after children and others working to support children who suffer from, or are at risk of developing, mental health problems.

> *"Schools can use the Strengths and Difficulties Questionnaire (SDQ) to help them judge whether individual pupils might be suffering from a diagnosable mental health problem and involve their parents/carers and the pupil in considering why they behave in certain ways".*

This document is extensive in its information but doesn't mention ACEs or trauma informed care.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/508847/Mental_Health_and_Behaviour_-_advice_for_Schools_160316.pdf

Policy and guidance

Working together to safeguard children (2015): A guide to inter-agency working to safe guard and promote the welfare of children

The Department for Education published an updated version of the key statutory guidance for anyone working with children in England in March 2015. It sets out how organisations and individuals should work together and how practitioners should conduct the assessment of children. This latest guidance updates the previous version published in 2013 This is not a major review, but does include changes around:

- referral of allegations against those who work with children
- clarification of requirements on local authorities to notify serious incidents
- a definition of serious harm for the purposes of serious case reviews.

It also incorporates legislation and statutory guidance published over the last two years.https://www.nspcc.org.uk/preventing-abuse/child-protection-system/england/legislation-policy-guidance/

The UK's 4 nations – England, Northern Ireland, Scotland and Wales – have their own child protection system and laws to help protect children from abuse and neglect. Each nation has a framework of legislation, guidance and practice to identify children who are at risk of harm, and take action to protect those children and prevent further abuse occurring.
https://www.nspcc.org.uk/preventing-abuse/child-protection-system/

The NSPCC commissioned the University of Edinburgh to carry out a mapping review of UK research on the subject of child protection published from January 2010 until December 2014. This project provides an evidence base to inform further academic research, child protection policy development, and the priorities of research funders.
https://www.nspcc.org.uk/services-and-resources/research-and-resources/2015/landscape-child-protection-research-united-kingdom/

Public Health England

Guidance 2016 - Health matters: giving every child the best start in life

This resource for health professionals and local authorities focuses on investing in early years services from pregnancy through to 2 years old.

Contents:

- Summary
- Why the early years are so crucial
- Foundations for promoting child health
- Fit for pregnancy: pre-conception
- Fit during pregnancy: staying healthy in pregnancy
- Risk factors in pregnancy
- Protecting health in infancy
- Supporting the transition to parenthood
- The first 2 years in life
- We all have a role to play

https://www.gov.uk/government/publications/health-matters-giving-every-child-the-best-start-in-life/health-matters-giving-every-child-the-best-start-in-life

Examples of activities from other agencies

Report 2016: Trauma-informed mental healthcare in the UK: what is it and how can we further its development?

Angela Sweeney Sarah Clement Beth Filson Angela Kennedy , (2016), Mental Health Review Journal, Vol. 21 Iss 3 pp. 174 - 192

This seminal paper describes what applying trauma-informed principles to a mental health service would look like:

“Trauma-informed mental health services are strengths based: they reframe complex behaviour in terms of its function in helping survival and as a response to situational or relational triggers.

Reframing refers to looking at, presenting, and thinking about a phenomenon in a new and different way, and replaces traditional individual/medical model approaches to madness and distress with a social perspective, somewhat akin to the Social Model of Disability (Wilson and Beresford, 2002). Reframing behaviour as meaningful allows providers to address underlying needs and utilise less intrusive strategies.

In a trauma-informed mental health service, all staff – clinical and non-clinical – understand the impact of trauma on a person's ability to survive in the present moment. Crucially, this entails a shift from thinking "what is wrong with you" to "what happened to you" (Harris and Fallot, 2001). The critical roles of racism, sexism, homophobia, ageism, poverty and their intersectionalities are recognised. Survivors in crisis are not viewed as manipulative, attention-seeking or destructive, but as trying to cope in the present moment using any available resource.

Providers do not fear asking about trauma, yet do so in ways that are respectful of potential retraumatisation; the power of telling one's story but also the impotency of telling it where nothing changes (Filson, 2011); the need to move at the survivor's pace; the need to truly listen; and the need for post-disclosure support. Survivors are forewarned about trauma questions, and can choose not to answer. Trauma information is integrated into treatment plans so that people can be referred to trauma-specific services (if wanted) (see Read et al., 2007 for a full account of why, when and how to ask about abuse).

The basic safety of environments is prioritised – physical, psychological, social and moral – with organisations making a commitment to non-violence (Bloom, 2006). Staff receive support to help them focus on trauma, and steps are taken to build a sense of community and shared responsibility between staff and survivors (Bloom, 2006). This means that services prioritise building trusting, mutual relationships between staff and survivors. When relationships are prioritised, policies and procedures (such as time limited sessions with a therapist) can be re-evaluated in light of whether or not they support TIAs.

TIAs in mental health aim to reduce or eradicate coercion and control, including medication as restraint, verbal coercion, threats of enforced detention, withholding information, restrictive risk-aversive practices, disrespectful and infantilising interactions and Community Treatment Orders (see, for instance O'Hagan, 2003). Clinicians understand the revictimisation that "power over" relationships reinforce. Training and supervision provide staff with the tools to attend to potential relational and situational triggers and to use trust-based, collaborative relationships to support people.

Survivors often encounter numerous human services across their lives. To be trauma-informed, each service within and beyond the local mental health system should operate according to TIA principles. This includes primary care, A&E, talking therapies, mental health teams, crisis care, the police, social services and voluntary sector services (such as trauma-specific service providers) (p.179-180).
http://www.emeraldinsight.com/doi/pdfplus/10.1108/MHRJ-01-2015-0006

Report 2015: The impact of adverse experiences in the home on the health of children and young people, and inequalities in prevalence and effects

This UK report is quoted:
There are clear inequalities in the prevalence of ACEs, which leads to inequalities in impacts There is a clear inequalities dimension to ACEs. While all ACEs are present across society, inequalities in wealth, disadvantage and the existence of poverty impact on the chances of experiencing ACE.

Children growing up in disadvantaged areas, in poverty, and those of a lower socioeconomic status are more likely to be exposed to ACEs compared to their more advantaged peers – and more likely to experience 'clustering' (co-occurring) of ACEs.

Aside from these socioeconomic factors, there is a range of other risk factors for ACE, including poor and harmful parenting approaches and the relative stress under which families live. These risk factors are also universal but are again more likely to occur lower down the social gradient . Due to inequalities in the prevalence of ACEs, and the observed negative health impacts of ACEs, it is likely that ACEs are currently contributing to health inequalities. There is also evidence that ACEs are 'transmitted' across generations – so that the children of parents who experienced ACEs in their own childhood are also more likely to experience ACEs (14-16). This perpetuates inequalities in health across generations.

Acting to prevent ACEs could improve health, reduce inequalities and save money

Taking action on the causes, prevalence and impacts of ACEs is therefore necessary in order to improve health, reduce inequalities within generations, prevent the transmission of disadvantage and inequality across generations and improve the quality of children, young people and adult's lives. One study suggested that 12% of binge drinking, 14% of poor diet, 23% of smoking, 52% of violence perpetration, 59% of heroin and crack cocaine use and 38% of unintended teenage pregnancy prevalence nationally could be attributed to ACE experience below the age of 18.

Reducing these rates would improve health and also save money. The cost of child maltreatment alone has been estimated to total £735m a year and reducing the health impacts of ACE could decrease pressure on the NHS and other local support services. In 2009 the costs of domestic violence in the UK were estimated at £1.9bn in terms of lost economic output, £10bn in human and emotional costs and approximately £3.1bn to government funded services. The cost of children in care is £2.9bn, of which an estimated half is spent on abused children.

There are risk factors which increase the chances of being exposed to ACEs

In order to take effective action to reduce ACE prevalence, it is necessary to understand the risk factors for adverse experiences. While anyone can be exposed to ACEs, there is an increased risk associated with the following circumstances.

The context in which families live: Families that are socially isolated, live in poverty or deprived areas, or are of a low socioeconomic status are all at higher risk of exposure to ACEs than those that are not. For example, children who live in the most deprived 10% of neighbourhoods have a 10 times greater chance of being on a child protection plan than children in the least deprived 10% of neighbourhoods.

Parental and family factors: Poor parenting, low parental age and family structure have all been shown to correlate with ACE prevalence (15, 22, 23).

Household adversity: The presence of adversity in the home is an ACE in itself – and can have direct impacts on children's health and wellbeing (24). However it also increases the risk of other ACEs. For example, parental abuse of drugs or alcohol has been detected in over half of parents who neglect their children (25).

Suggested actions to tackle the risk factors for ACEs

Taking preventive action to reduce the prevalence of ACEs, and thereby improve population health, therefore requires acting on the risk factors identified. Some current policies,

for example the Troubled Families Programme, aim to do this. However this and many other interventions are only available for those with the very highest levels of need. It may be the case that many children who are exposed to ACEs but are not identified by local safeguarding systems would benefit from a 'proportionate universalism' approach, universal in scope but recognising the increased burden faced by those lower down the social gradient. This could act on the three risk factors as follows:

Improving the context in which families live

a. Community level
Local programmes that tackle social isolation, increase community coordination and mitigate the negative impact of poverty, the recession and austerity measures on families may help to reduce stress, increase resilience, and therefore reduce ACE prevalence.

b. National level
National efforts are needed to ensure that spending and policy decisions do not lower the living standards of families below a level needed to afford a healthy life, or increase inequalities. Given that 34% of families are currently receiving less than the minimum income standard (27), a reversal of the economic fortune of families will be needed. Addressing low wages and insufficient benefits for families would help to reduce health inequalities and reduce inequalities in childhood wellbeing.

Tackling parental and family risk factors Parenting programmes have a range of benefits, and some have been found to reduce child maltreatment. Making these available to a wider range of parents, and implementing them with the involvement of a range of sectors, could reduce ACE prevalence.

Reducing household adversity
Local organisations and practitioners can work in multiagency teams to provide integrated responses that recognise multiple needs and adversities, and act holistically and flexibly to better detect and respond to those facing adversity at home. National government departments (including Health and Education) can support these efforts by providing combined budgets and measurement tools, training staff to respond to adversities, and acting as an advocate for positive policies across government. In addition, all policies could usefully incorporate the principles of early intervention and prevention, integrated working and proportionate universalism. Integrated working, for example, can help both to detect and respond to the risk factors for ACEs. This should include a range of partners including criminal justice, health, education and other services and staff who work with families.

More evidence is needed on policy implementation and the relative benefits of programme options. However, from the evidence available it is clear that ACEs affect a large proportion of the population, and that they are impacting on physical and mental health, potentially reducing life expectancy and contributing to inequalities in health. The evidence that shows a greater prevalence for those living in poverty or lower down the social gradient creates a clear equity case for action. There is also a clear economic case for taking action. Acting on known risk factors can help prevention efforts to reduce adversity, improve health and tackle health inequalities and a range of other desirable social and economic outcomes.
http://www.instituteofhealthequity.org/Content/FileManager/adverse-experiences-book_final.pdf

Justice: Criminal Justice System Training By Prof Stephanie Covington (Center for Gender and Justice La Jolla, California) "Becoming Trauma Informed" (2015)

(This training and - 109-page accompanying booklet - for criminal justice professionals in the United Kingdom is an adaptation of the original version created for Correctional Service Canada)

"Criminal justice professionals have become more aware of the effects of interpersonal violence on the lives of many women and of the impact this has in custodial settings.

Jurisdictions need to become "trauma informed" in order to understand and deal with effects of toxic stress, neglect, and abuse on the physical health, mental health, and management issues of women involved in the criminal justice system. When staff members become trauma informed, they develop greater understanding of the typical behaviours that are these women's reactions to authority and confinement, and they gain new skills in responding to these behaviours.

Using trauma-informed practices also enhances safety and security in women's facilities. This training provides information about the lives of typical women involved in the criminal justice system, the process of trauma, and the effects of toxic stress, abuse, and trauma. It also provides information on appropriate responses and self-care for criminal justice staff members such as yourself.

Objectives of the Program

- To learn about the pervasiveness of violence in the world and in the lives of women in the criminal justice system
- To know the definitions of violence, trauma, and being "trauma informed"
- To understand how knowledge about trauma can make your job easier as well as enhancing safety
- To learn about self-care"

('One Small Thing' works with staff in women's prisons and in the community, developing approaches grounded in understanding, fostering positive outcomes for all. We call this trauma-informed practice. Lady Edwina Grosvenor established 'One Small Thing' to champion trauma-informed practice with criminalised women. It is run by the Centre for Crime and Justice Studies).
http://www.onesmallthing.org.uk/about/

http://www.onesmallthing.org.uk/wp-content/uploads/2015/09/Becoming-trauma-informed-participant-booklet.pdf

Lancashire Care NHS Foundation Trust

Routine Enquiry about Adversity in Childhood (REACh)

The REACh project is led by Dr Warren Larkin, Consultant Clinical Psychologist and Clinical Director at Lancashire Care, and aims to train professionals to ask about childhood adversity as part of any standard assessment. https://www.lancashirecare.nhs.uk/REACh

Mission Statement

To raise awareness amongst professionals and the public about long term outcomes of adverse childhood experiences. Lancashire Care will do this by supporting practice change to embed routine enquiry about adversity in childhood within every appropriate assessment.

What is REACh?
REACh is a process introduced by Lancashire Care to routinely ask people during an assessment about traumatic/adverse experiences in their childhood. It encourages disclosure, helps practitioners to respond appropriately to what is heard and then plan interventions which improve their health and wellbeing in the longer term.

Dr Larkin notes:
"We also know that routinely enquiry about adversity in childhood is rare in routine practice (Fellitti, 2014; Read et al 2006; Larkin & Read 2013) and that if we don't ask directly, we will not be told about it, potentially carrying out multiple interventions over long periods of time without improving outcomes. This transformational work was designed to increase awareness amongst professionals of the impact of childhood adversity and to embed routine enquiry in organisational systems and processes. The long term aim was to identify best practice and respond earlier to adults and children who have suffered childhood trauma or adversity. Embedding routine enquiry across organisational systems would develop a response which focuses support on addressing the long term causes of poor outcomes rather than the presenting symptoms or risk taking behaviours. Screening for ACE's would enable practitioners to identify adults who have high A.C.E. scores which may lead to not only poor health and social outcomes but also increasing the risk of exposing their children to adverse experiences. The goal is then to support these individuals and families through targeted parenting programmes and interventions such as Think Family to enable them to provide safe and supported childhoods for their own family[17]".

Contact Dr Larkin to obtain the questionnaire they used.

Work undertaken
In 2013 Lancashire Care NHS Foundation Trust piloted routine REACh (Routine Enquiry About Adversity in Childhood) training for 100 staff who were part of the early intervention service. This initial work was based on the research he and colleagues were undertaking into the relationships between psychological trauma and psychosis (Larkin & Morrison 2006; Read et al 2005). This experience provided valuable insight into the essential ingredients required to implement and embed routine enquiry. Funding in 2013/14 enabled a further project which was designed to explore what was required to implement and embed routine enquiry about adversity in childhood within a range of settings and to identify further learning. The project was exploratory in nature and took a wide and flexible approach and led to some key themes and further recommendations for good practice across settings.

Until that point routine enquiry had only been trialled within the mental health field and the project leads felt it important to widen this approach in order to benefit other sectors. Partnerships were established with both Local Authority, Public Health and Charitable and Voluntary sector organisations in order to implement REACh across the various sectors. Alongside the obvious training and education for staff about why, when and how to enquire safely and sensitively (on average 1 day), there was also an element of organisational support to help teams navigate the potential risks and challenges of using this approach. A common concern was the possible impact on service demand, the potential for gaps in service provision to be revealed and implications for staff training and supervision. In the majority of cases these concerns were not realised and with the follow-up support offered by the small but dedicated REACh team, all of the teams who have embraced REACh have successfully made routine enquiry a foundation for their everyday practice.

[17] Warren Larkin, Email communication November 2016

A recurring theme was that before the REACh training, professionals were not aware of the impact of childhood adversity on later life outcomes. On follow-up none of the teams were reporting any difficulty in enquiring and there had been no obvious increase in service demand following the change in practice. Without exception participants reported that using the REACh approach led to individuals disclosing experiences which they had not previously disclosed despite numerous previous contacts with a range of services. The number of individuals disclosing 4 or more A.C.E.'s varied between 23% and 45% between the organisations. The highest percentage was from an organisation working with young people in the substance misuse field. In 2014/15 a further collaboration between Public Health in Blackburn with Darwen and LCFT saw this work expanded to include multiple organisations, primarily working within substance misuse.

There has been a positive response from professionals who have found the systematic and planned discussion about adversity to be a powerful tool in the therapeutic process, enabling individuals to talk about and disclose very difficult experiences that may have taken place many years before. Partners recognised that without a deeper understanding of the individual's early experiences there is the risk of repeating inappropriate interventions or even potentially risky interventions, that don't address root causes and have little or no chance of improving outcomes for service users in the longer term.
Two qualitative studies have been carried out.

Common themes from individuals who were asked ACE questions:

- *Individuals normalised some of their adverse childhood experiences such as physical abuse, emotional abuse, substance misuse and divorce/separation*

- *Routine enquiry questions were seen by individuals as brief and not too intrusive as they do not ask for specific details*

- *Positive relationships with professionals contributed to a successful routine enquiry. This was not based on longevity but on quality. Feeling comfortable and trusting a professional made disclosure easier for individuals*

- *A question that has emerged from professionals is 'when do you ask routine enquiry questions?' Providing individuals feel comfortable then routine enquiry questions could be asked immediately to new clients. The training is therefore crucial in raising awareness of individuals routine enquiry needs*

Next Steps
Further work will consider how to raise greater awareness about the impact of ACEs on our communities and to assist other organisations to adopt the REACh approach or to develop ways to adopt these principles in a way that facilitates better outcomes for their service users. Specifically:

- Determining who to screen as a priority – potentially targeting the teams working with those service users at increased risk of 4+ ACEs: For Example, Youth Offending; Probation; Troubled Families; Health Visitors; Paediatricians
- Development of the use of a resilience score to be used alongside the ACE screening
- Adapting the approach used successfully with adult groups, to be used with children and young people
- Creating a website to act as a resource for service providers and the public which would offer free materials and help share best practice

- Development of a network of REACh trained organisations and professionals to ensure sustainability of the REACh approach and disseminate good practice

Longitudinal research will look to investigate how the long term practice of professionals has changed following training and to ascertain if there is evidence to support the view that individuals benefit from improved physical, emotional and life outcomes following enquiry /appropriate early intervention and any associated cost avoidance/savings.
For more information please contact Dr Warren Larkin or Glyn Jones via the contact us page on the website.[18]
www.lancashirecare.nhs.uk/reach

YoungMinds

The organisation above is cited as best practice in this report.

Report Beyond Adversity: Addressing the mental health needs of young people who face complexity and adversity in their lives

This report is a call for action, as Sarah Brennan Chief Executive of YoungMinds states:

"It is the experiences we find hardest to talk about in our society which have a lasting impact on the mental health and wellbeing of children and young people. Be it family breakdown, bereavement, domestic violence or sexual abuse, we must ensure that all services are better able to identify childhood adversity and help to resolve the trauma related to it"(p.2)

"This new report by YoungMinds calls for urgent action by Government, the NHS and local areas to ensure that all of children's mental health needs and wellbeing are addressed in the local transformation of services".

"Government now has a welcome focus on meeting the mental health and emotional needs of these children, however this is not translating into change and practice on the ground. Government and local agencies do not share a common understanding of adversity, complexity, vulnerability and trauma in childhood. This means that there is significant variance between local areas and service responses to identifying and meeting their needs. For example, a recent review of Local Transformation Plans suggests that 1 in 5 local areas are not sufficiently covering the needs of children and young people who face adversity and complexity in their lives" (p.5)

http://www.youngminds.org.uk/assets/0003/0188/Report_-_Beyond_Adversity.pdf

While Wales is not part of IIMHL they have done research on the population and ACEs.

[18] Warren Larkin, email communication, November 2016.

Public Health Wales NHS Trust

Report 2015: Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population: Alcohol Use, Drug Use, Violence, Sexual Behaviour, Incarceration, Smoking and Poor Diet

This is one in a series of reports examining the prevalence of Adverse Childhood Experiences (ACEs) in the Welsh adult population and their impact on health and well-being across the life course. The series will include reports on:

- The prevalence of Adverse Childhood Experiences and their association with health-harming behaviours in the Welsh adult population.
- The impact of Adverse Childhood Experiences on chronic ill health, use of health and social care services and premature mortality in Welsh adults.
- The impact of Adverse Childhood Experiences on mental well-being in Welsh adults.

Preface

Over 2,000 adults aged 18-69 years participated in the ACE Study for Wales, providing anonymous information on their exposure to ACEs before the age of 18 years and their health and lifestyles as adults. The study achieved a compliance rate of 49.1% and the sample was designed to be representative of the general population in Wales.

Data were collected in participants' places of residence using an established questionnaire incorporating the short ACE tool developed by the US Centers for Disease Control and Prevention and based on work by Felitti et al (1998).

Similarly in the UK (as reported by Bellis), experiencing ACEs has been linked to a whole variety of health harming behaviours and illnesses. The US ACE study findings demonstrated that as the total count of ACEs increases so does the risk of experiencing the following conditions:

- Alcoholism and alcohol abuse
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Foetal death
- Health-related quality of life
- Illicit drug use
- Ischemic heart disease (IHD)
- Liver disease
- Risk for intimate partner violence
- Multiple sexual partners
- Sexually transmitted diseases
- Smoking
- Suicide attempts
- Unintended pregnancies
- Early initiation of smoking
- Early initiation of sexual activity
- Adolescent pregnancy

Bellis et al in the Welsh population showed people who have experienced four or more ACEs when compared to another person who has no experience of ACEs were:

- almost 4 times more likely to smoke;
- almost 4 times more likely to drink heavily;
- almost 9 times more likely to experience incarceration; and
- some 3 times more likely to be morbidly obese.

Those with higher ACE scores were also at greater risk of:

- poor educational and employment outcomes;
- low mental wellbeing and life satisfaction;
- recent violent involvement;
- recent inpatient hospital care;
- chronic health conditions;
- having caused/been unintentionally pregnant aged <18 years; and
- having been born to a mother aged <20 years.

Suggested actions:

Firstly, improved awareness is needed of the importance of early life experiences on the long-term health, social and economic prospects of children. Information should be available to a wide range of professionals (health, education, social, criminal justice and others) on ACEs, their consequences and how they can be prevented. Information should also be disseminated to the public and especially those planning or having children.

All parents and their children in Wales should already have access to support services – especially in early years. However, a better understanding is needed of specifically what support every individual should and ultimately does receive. Support must conform to established and emerging evidence of what works in the prevention of ACEs and the successful development of resilience in children.

Finally, some families (often but not exclusively in deprived communities) require enhanced support in parenting and child development. Again, such services are already in place across some parts of Wales. However, what is actually delivered, how well needs are met and how well interventions match the evidence for ACE prevention is sometimes unclear.

ACEs may be prevented through enhanced public and professional awareness, evidence-informed universal service specifications, effective pathways into additional support, monitoring of intervention coverage and content and, routine audit of fidelity to intervention specifications. While Public Health may have a leadership role in these developments they
require partnerships and investment from healthcare services, local authorities and more widely across the whole public sector.

Policies including the Well-being of Future Generations (Wales) Act 2015 provide the legitimacy for such activity, and structures such as United in Improving Health provide the opportunity for the essential co-ordination of assets, investments and activity in order to make it happen.
http://www.cph.org.uk/wp-content/uploads/2016/01/ACE-Report-FINAL-E.pdf

Police

College of Policing report: authorised professional practice (APP) for England & Wales

This report includes (among a raft of areas):

Recognising mental vulnerability in children and young people

While it doesn't use the language of trauma-informed care it is moving that way. Training is done by the Early Intervention Foundation http://www.eif.org.uk/

Further information
Mental health problems affect young people as well as the adult population. In children and adolescents, however, mental health conditions often emerge in ways that are less easily defined. For example, this can be through:

- behavioural problems
- emotional difficulties
- substance misuse
- self-harm.

(Youth Justice Board 2016)
Mental health professionals may also be reluctant or unable to provide a clear diagnosis, as the adolescent brain is still evolving. For further information, see The Early Intervention Foundation.
Police officers must be able to identify when mental illness may be an underlying cause of a young person's behaviour. This ensures that young people can access effective referral pathways for assessment, treatment and support.

If children and young people's mental health needs are addressed at the earliest opportunity it may help reduce the likelihood of these problems escalating, improve life chances and prevent crime.
http://www.app.college.police.uk/app-content/mental-health/mental-vulnerability-and-illness/#recognising-mental-vulnerability-in-children-and-young-people

Report 2013: The cost of troubled families Department for Communities and Local Government

Again this work does not use the language of trauma and ACES but there are similarities in objectives. This report considers the financial case for local authorities and other local agencies to invest in effective services for troubled families, in order to make savings.

The Troubled Families team within the Department for Communities and Local Government has been working with a group of local authorities across England to examine their work in this regard and plans for the future. This report looks at the pre-intervention cost of troubled families, the case for investment in family intervention services and the links between areas' service improvement plans and the financial case for change.

Framework for the Troubled Families Programme
In most of these cases, this is because these are looking to reduce demand on acute services (e.g. child protection, A&E services, mental health services) in the long term: They want to both tackle the

needs of their most complex families and re-model their service provision so that they can identify symptoms earlier, target preventative approaches accordingly and prevent a new generation of troubled families from emerging.
https://www.gov.uk/government/publications/the-cost-of-troubled-families

Mental Health Foundation

Report 2016: The impact of traumatic events on mental health

This user-friendly report provides an introduction to the impact on your mental wellbeing when you experience a traumatic event and ways to look after yourself and seek support.

https://gallery.mailchimp.com/c4f6b2fca0e12e49c424dea9f/files/the_impact_of_traumatic_events_on_mental_health_MHF_UK_2016.pdf

Report 2015: Fundamental Facts about Mental Health

This is a very comprehensive 94-page document from the MHF. Some key points:

- *"Mental health problems are one of the main causes of the burden of disease worldwide.1 In the UK, they are responsible for the largest burden of disease– 28% of the total burden, compared to 16% each for cancer and heart disease.*
- *Around 50% of women with perinatal mental health problems are not identified or treated. The costs to the UK economy for untreated perinatal mental health problems is estimated to be around £8.1 billion for each one-year cohort of births; this is the equivalent to around £10,000 per year for every single birth in the UK. These costs are generally the result of not identifying mothers' mental health needs or treating them effectively.6 However, when mothers are referred, there are known treatments that work well for most cases*
- *Ten per cent of children and young people (aged 5-16 years) have a clinically diagnosable mental problem9 yet 70% of children and adolescents who experience mental health problems have not had appropriate interventions at a sufficiently early age*
- *Common mental health problems such as depression and anxiety are distributed according to a gradient of economic disadvantage across society16 with the poorer and more disadvantaged disproportionately affected from common mental health problems and their adverse consequences.*
- *Mental health problems constitute the largest single source of world economic burden, with an estimated global cost of £1.6 trillion (or US$2.5 trillion) – greater than cardiovascular disease, chronic respiratory disease, cancer, and diabetes on their own.20 In the UK, the estimated costs of mental health problems are between £70-£100 billion each year and account for 4.5% of GDP.*
- *In the UK, 70 million days are lost from work each year due to mental ill health (i.e. anxiety, depression and stress related conditions), making it the leading cause of sickness absence".* (p 7-9)

Social determinants in association with lifecourse

The effect of adverse conditions in early life on mental health and how this can influence outcomes through to adult and later life are described in this section.

- *Adverse conditions in early life are associated with higher risk of mental health problems.*
- *Environmental conditions and lifestyle factors are associated with negative physiological and psychological development in children, which can endure throughout later life.*
- *There is evidence that the costs of mental health problems impact across generations, in relation to both the mental health of offspring and their socioeconomic status. A significant correlation has been found between maternal mental health and children's income, where one standard deviation reduction in mental health leads to a 2% reduction in income.*
- *In childhood, poor attachment, neglect, lack of quality stimulation, and conflict all negatively affect future social behaviour, educational outcomes, employment status and mental and physical health. Family breakdown, including parental separation and single parent homes, is strongly associated with poor mental health in adults and children.*
- *Protective parenting activities may offset social gradients in social and emotional difficulties among children as young as three years" (p.63)*

https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-15.pdf

Centre for Mental Health

Report 2016: Missed opportunities: A review of recent evidence into children and young people's mental health, Lorraine Khan

Again this report, while not focusing on ACEs or trauma informed care, does look at what works for children and parents.

On average, children and young people with mental health difficulties **go ten years between first becoming unwell and getting any help**.

Missed Opportunities finds that mental health problems are common among young people (affecting one in ten, or an average three in every classroom), but that awareness is poor and most attempts by parents to get help are unsuccessful.

Providing a comprehensive overview of mental health from ages 0-25, the report highlights that there is an average delay of a decade in children receiving help. This decade of delay sees their problems multiply and get progressively worse, eventually escalating into a crisis. Moreover, whilst three-quarters of parents whose children are experiencing mental ill-health seek help, only one-quarter of children receive any support.

The review finds that some groups of children and young people face especially high risks for poor mental health. They include children who have been subjected to neglect and abuse, children who are bullied or who bully, and children whose parents have mental health problems. Groups with higher rates of poor mental health also include lesbian, gay, bisexual and transgender young people, those in the youth justice system and those who have been looked after by local authorities.

Missed opportunities highlights that childhood mental health problems can cast a long shadow, well into adult life. However, it also finds that most common childhood mental health problems can be treated effectively, if early and effective help is provided.
https://www.centreformentalhealth.org.uk/missed-opportunities

National Institute for Health and Care Excellence – NICE

Interestingly the NICE Guidelines on domestic violence have some information on ACEs (see below) those Guidelines relating to self-harm do not.

Domestic violence and abuse: how services can respond effectively
Local government briefing [LGB20] Published date: June 2014

".....Domestic violence and abuse is a significant public health problem. People of all ages, from all sectors of society, may experience it. The effects can last a long time after the final incident. For example, childhood exposure can disrupt social, emotional and cognitive development. This can lead to the adoption of risky behaviours such as alcohol misuse or illicit drug use which, in turn, can cause poor health, disease, disability and early death (Adverse childhood experiences study Centers for Disease Control and Prevention)".
https://www.nice.org.uk/advice/lgb20/chapter/Introduction

A search on the NICE website shows one result for "trauma informed care" (see below)

Report 2013: The integration of a Trauma and Self Injury (TASI) systemic Programme for Women who use forensic services: developed, delivered and evaluated in collaboration with those who use it

Trauma informed care for women in a forensic service.

The Trauma and Self Injury (TASI) programme is systemic and multi modal in its delivery. It has been co-developed with the women who use forensic services. This population has experienced trauma, has complex post traumatic stress disorder (PTSD) related symptoms, uses self injury as a way of coping and is at risk of hurting others. Whilst it was developed within the National High Secure Service for Women (NHSHSW) it has been integrated across a pathway of women's medium and low secure forensic services.

The programme is delivered at 3 levels; Level 1 includes proactive health and wellbeing initiatives along with co-developed and delivered education; Level 2 focuses on the enhancement of a trauma informed therapeutic milieu, which promotes a safe collaborative environment enhancing the women's capacity to deal differently with their distress; Level 3 provides NICE recommended individual and group therapies. A variety of measures were used, with all having two formal assessment measures used in all cases: Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998) & Trauma Symptom Inventory (TSI; Briere, 1995).

Evaluation has shown great success in this work:

"The learning has been transferred and has impacted on the delivery and engagement of women and male patients in other forensic services. It has been particularly embraced in low and medium secure services within our trust. The learning has been widely disseminated and progress shared with members of the organisation and wider stakeholders as all progress reports via the Forensic NICE

Annual Report (attached as supporting evidence.) Its impact has been shared at international, national and local conferences".
https://www.nice.org.uk/sharedlearning/the-integration-of-a-trauma-and-self-injury-tasi-systemic-programme-for-women-who-use-forensic-services-developed-delivered-and-evaluated-in-collaboration-with-those-who-use-it

Blackpool: Better Start

"Happy, healthy and ready to learn"

Early child health and development begins in communities where children are conceived, grow-up, learn and play in a positive way. The Better Start partnership is responsible for implementing services which families need for their children to be healthy, happy and ready to learn. We are determined to make a decisive change to transform their life chances.

We want to achieve a generational shift, ensuring that today's babies enjoy the early care and nurture they need for healthy development and to be ready for school, and that in turn, as they grow up and become parents themselves, they will pass on the Better Start legacy to the next generation.
https://www.blackpoolbetterstart.org.uk/better-start/

Training 2016: The Centre for Early Child Development

"Better Start is holding a free Trauma Informed Care workshop designed for all staff who come into contact with pregnant women; from those on the ***front desk*** *to* ***clinicians, front line workers*** *to* ***administrators.*** *The workshop will be held on Friday 18th November 2016 at Bickerstaffe House, Blackpool.*

National statistics show that approximately one in five women has a history of childhood maltreatment, and issues relating to sexual abuse are particularly pertinent in pregnancy. This means that pregnancy and birth can sometimes be extremely challenging and often health and social care services are provided with little knowledge of their traumatic experiences.

We are excited to be working alongside Julia Seng PhD Professor of Nursing, Obstetrics, and Women's Studies at the University of Michigan and Dr Elsa Montgomery, Head of Department of Midwifery at Kings College, London, who are experts in this field.
Our workshop will support you to think about what may have happened to these women and provide services in a way that is sensitive to their experiences, enabling them to feel safer".
https://www.blackpoolbetterstart.org.uk/get-involved/events/free-workshop-trauma-informed-care/

IRELAND

In 2012 there was little if any work on ACEs and trauma informed care, however a guidance document on psychosocial responses to major emergencies was underway[19].

Ireland has clinical and community resources for suicide, PTSD, and ED care (see below) which do not focus on trauma. It does have a strong focus on reduction of seclusion and restraint (see below).

The Department of Health

Our role is to provide strategic leadership for the health service and to ensure that Government policies are translated into actions and implemented effectively. We support the Minister and Ministers of State in their implementation of Government policy and in discharging their governmental, parliamentary and Departmental duties.

This includes:

- advising on the strategic development of the health system including policy and legislation;
- evaluating the performance of the health and social services; and
- working with other sectors to enhance people's health and well-being.

The health service seeks to improve the health and wellbeing of people by:

- Keeping people healthy;
- Providing the healthcare people need;
- Delivering high quality services;
- Getting best value from health system resources.

http://health.gov.ie/about-us/

National Taskforce on Youth Mental Health, 2016-17

"This is a significant milestone in our work to empower and support young people to strengthen their resilience, mental health and wellbeing".

The Taskforce will maintain an exclusive youth focus, defined as children and young people aged 0 to 25. The Taskforce will involve and include young people in its work, as well as engaging widely with key stakeholders. The Taskforce will meet monthly and will operate as an action-oriented, decision making group focussed on making improvements and getting things done. It will work in collaboration with different sectors and communities to improve:

1. Emotional literacy around talking about mental health and reduce stigma
2. Awareness of services and supports
3. Accessibility to services and supports at different times and in different areas

[19] Make it so, 2012 http://www.iimhl.com/files/docs/Make_It_So/20120712.pdf

4. Alignment of services and supports across different providers (public, private, community, and voluntary)

The Taskforce will be asked to take an innovative and creative approach to these issues by leveraging technology, online platforms, social media, the education system and existing services to achieve its aims.
http://health.gov.ie/national-taskforce-on-youth-mental-health/

Heath Services Executive

The HSE is a large organisation of over 100,000 people, whose job is to run all of the public health services in Ireland. The HSE manages services through a structure designed to put patients and clients at the centre of the organisation.
http://www.hse.ie/eng/about/Who/

The Mental Health Division has responsibility for all Mental Health Services including:

- Area based Mental Health Services including approved in-patient residential centres and all community based teams
- Child and Adolescent Mental Health, General Adult, Psychiatry of Old Age
- National Forensic Mental Health Service
- National Counselling Service
- National Office for Suicide Prevention

http://www.hse.ie/eng/about/Who/mentalhealth/

Relevant Information on the HSE website

National Clinical Programme For the Assessment and Management of Patients Presenting to Emergency Departments following Self-Harm,
Health Service Executive & College of Psychiatrists of Ireland, March 2016

Suicide is well recognised as a serious public health issue with 11,126 self-harm presentations to Emergency Departments (ED) in Ireland and 459 deaths in 2014. It requires a diversity of responses: social, educational, occupational and health related. This 66-page Clinical Programme is a part of an overall strategy and specifically addresses the care and treatment required by people who present to the Emergency Departments (ED) of acute hospitals following an episode of self-harm or with prominent suicidal ideation.
http://www.hse.ie/eng/about/Who/clinical/natclinprog/mentalhealthprogramme/selfharm/nationalclinicalprogselfharm.pdf

PTSD: Post-traumatic stress disorder (PTSD) is a psychological and physical condition that is caused by very frightening or distressing events. It occurs in up to 30% of people who experience traumatic events.
http://www.hse.ie/eng/health/az/P/Post-traumatic-stress-disorder/

Treatment is outlined. http://www.hse.ie/eng/health/az/P/Post-traumatic-stress-disorder/Treating-post-traumatic-stress-disorder.html

Books on overcoming childhood trauma are available but do not appear to focus on the “trauma-informed care” model, rather psychological therapies.

http://www.hse.ie/eng/services/list/4/Mental_Health_Services/powerofwords/childhoodsexualabusehelpbooks.html

You are not alone: This booklet provides practical help and advice for those coping with a death by suicide. Others, who have lost loved ones in sudden or tragic circumstances such as road traffic accidents, may also experience some of the same feelings of loss and grief that suicide survivors can experience and may benefit from the advice provided.
http://www.hse.ie/eng/services/publications/Mentalhealth/You_Are_Not_Alone_booklet_.pdf

The Mental Health Commission

The main vehicle for the implementation of the provisions of the Mental Health Act, 2001 is the Mental Health Commission, which was established in April 2002. It is an independent statutory body, whose primary function is to promote and foster high standards and good practices in the delivery of mental health services and to ensure that the interests of detained persons are protected.
http://www.mhcirl.ie/

Mental Health Commission Seclusion and Physical Restraint Reduction Strategy – Consultation Report

This information includes comprehensive information on seclusion and restraint.
Mental Health Commission Seclusion and Physical Restraint Reduction Strategy - Consultation Report

- Seclusion and Physical Restraint Reduction - Consultation Document
- Seclusion and Physical Restraint Reduction - Knowledge Review and Draft Strategy

http://www.mhcirl.ie/for_H_Prof/Consultations/prevconsult2013/

Examples of other agencies and activities

A search for “ACEs” and “trauma informed care” of Jigsaw, Samaritans and Mental Health Ireland did not produce results.

The National Service User network’s newsletter mentioned “ACEs Connection” a US e-bulletin:
http://www.aimmentalhealth.org.uk/national-survivor-user-network-nsun-bulletin-30-august-2016/

A 2016 training for Social Care Workers is described below and the following report on youth has a clear focus on ACEs and trauma informed care.

Social Care Ireland

SCI provides Members with advocacy, representation, support in the practice of Social Care Work, as well as an opportunity to improve the Standards and Quality of Social Care Work in Ireland.

Training August 2016: "Adverse Childhood Experiences (ACEs) and the Resilient Brain: An understanding of and response to some child & youth mental health difficulties"

Some background to the event: A key concept underlying ACE studies is, how stressful or traumatic childhood experiences can result in social, emotional and cognitive impairment, which in turn may lead to mental health difficulties and diagnosed mental health illness. *This is often manifested through challenging behaviour, violence orientation and depression.*
Recent developments in neurobiology demonstrate that 'fear-based' childhood experiences can disrupt brain development, brain structure and brain function. Fear during infancy and early childhood has a cumulative impact, resulting in the exploding rates of physical, mental and social pathologies.

Children and families experience a host of problems when encountering adversity – however, they can thrive when their basic 'biosocial needs' are met. This Master-Class is designed to highlight contemporary findings and shine a focus on the requirement to build relationships and create environments which can foster safety, belonging, achievement, personal power, a sense of purpose and adventure.

T*his Master-Class will focus on:*

1. ACEs and Developmental Trauma: How to use the ACEs framework as a quick measure of the level of childhood trauma and (a)The 10 ACEs Categories & (b) The Core Problem of Dysregulation.
2. Helping Kids who Hurt: Pillars of Transforming Care: Highlighting examples of interventions which foster safety, connections, and coping (Relational Safety, Connecting in Crisis, Types of Coping).
3. Trauma and Resilience Science: Describing how the diverse fields of Trauma and Resilience are connected. (a) Multiple Forms of Trauma & (b) Evolving Science of Resilience.

https://www.socialcareireland.ie/event/adverse-childhood-experiences-aces-resilient-brain/

While Northern Ireland is not part of IIMHL they are undertaking some trauma informed-related work in social care agencies.

Northern Ireland

Video 2012

Therapeutic approaches to residential child care in Northern Ireland (12 minutes)

Children and young people looked after in residential settings have some of the highest levels of need. It is therefore crucial that staff have the right skills and support available to them. This film shows how children's homes in Northern Ireland have introduced training in 'therapeutic approaches' for their residential child care staff. The approaches help staff to have a better understanding of how children's experiences affect them, to consider their emotional needs and foster resilience. It focuses on the experience of staff and young people at the Lakewood Secure Unit.

Messages for practice

- 'Therapeutic approaches' can help residential childcare staff to use a therapeutic perspective in their day-to-day social work with children and young people
- Staff in Northern Ireland reported that it had enhanced their practice, particularly their relationships with young people and the consistency of approach taken by staff.
- Young people also reported improved relationships and a better atmosphere in the homes. In the case study shown in the film, the young people felt that the therapeutic approaches had helped them to talk about their feelings, and for their behaviour to be understood.
- Implementation is helped by providing training and supporting materials, and wider systems working in a supportive manner, for example careful planning when a young person is first admitted to a home

http://www.scie.org.uk/socialcaretv/video-player.asp?v=therapeuticapproachestoresidentialchildcareinnorthernireland&dm_i=4O5,SSMO,6EJX41,2CHKG,1

Children's charity NCB Northern Ireland

"Our work includes practice development, direct participation work with children and young people, research and evaluation projects, as well as sharing knowledge through publications, resources and events all aimed at supporting children and young people and those who work with or for them". https://www.ncb.org.uk/northern-ireland

We provide technical support to the Early Intervention Transformation Programme (EITP), which is part of the Delivering Social Change/the Atlantic Philanthropies Signature Programme.

The aim of the EITP is to improve outcomes for children and young people across Northern Ireland through embedding early intervention approaches. Collectively funded over a four-year period by the Departments for/of Education, Health, Employment and Learning, Communities and Justice, Northern Ireland Executive Office and the Atlantic Philanthropies, the EITP transforms mainstream services for children and families to deliver long-term improvement.

We are supporting the EITP to:

- Transform mainstream 0–4 services to better equip parents to give their children the best start in life.
- Help families with emerging needs access help quickly before problems become embedded.
- Positively address the impact of adversity on children by intervening both earlier & more effectively to reduce the risk of poor outcomes later in life.

https://www.ncb.org.uk/northern-ireland/projects-and-programmes/early-intervention-transformation-programme

Rethinking Children's Services: Fit for the Future?

This is a collection of essays that explore new perspectives and practical ideas for how we can do better for vulnerable children across the country, at a time when children's services are struggling against a backdrop of tightened budgets, increasing demand and mixed outcomes. The essays are written by some of the children's sector's most influential figures – from government advisers, local authorities and academia to leading voluntary sector organisations.

Authors include:

- Lord Warner, Sir Martin Narey
- Louise Casey (DCLG)
- Professor Donald Forrester, Martin Pratt (Camden)
- Donna Hall (Wigan)
- Michael Little (Dartington Social Research Unit)
- Kathy Evans (Children England)

Key recommendations

The authors challenge traditional approaches, critique current practice and put forward a range of ideas for the transformation of children's social care for the next decade and beyond.

Their suggestions include:

- Rethinking the commissioning, statutory and regulatory frameworks to allow differently qualified case workers to support social workers
- A new, strategic focus on building long-term relationships, rather than bureaucratic systems
- A reimagining of how we respond to children at risk
- A commissioning system that enables co-production from both state and community-led organisations, empowering young people and families to be agents in their own solutions
- The creation of a collaborative system that allows local authorities and third sector organisations to share best practice and evidence in a coordinated way

https://www.ncb.org.uk/what-we-do/how-we-work/policy-information/reports-big-issues/rethinking-childrens-services

A range of resources for youth and people working with youth are available: https://www.ncb.org.uk/resources-publications

In 2013 This organisation hosted a series of events in 2013 to increase understanding about when to invest in a child's life for maximum impact.

Speakers included Steve Aos (Washington State Institute for Public Policy), an expert in cost-benefit methodology and its potential application in the local policy arena, and Dr Ian Manion, Executive Director for the Ontario Centre of Excellence for Child and Youth Mental Health. Manion is an expert in the life-stage approach to mental health strategy development.

They were joined by Mark Friedman (Fiscal Policy Studies Institute, Santa Fe) who has developed the 'outcomes based accountability' approach to policy, and Vincent Felitti, an expert in cases where children face multiple adversities. Felitti is the co-principal investigator of the Adverse Childhood Experiences Study, a collaboration between the US Centers for Disease Control and Prevention and the Kaiser Permanente care consortium.

NCB Northern Ireland Director Celine McStravick remarked: "Finance Minister Simon Hamilton has confirmed budgets up to and beyond 2018 will be even tighter and coupled with the ever increasing expectations of an understandably demanding public, it is clear that tough times lie ahead. "Hence it is critical that we combine all of our knowledge of the evidence, not just the costs of a programme but what difference it can actually make in a child's life." http://www.agendani.com/ncb-events-focus-on-child-investment/

NEW ZEALAND

In 2012 it was noted that psychological trauma had been a focus for New Zealand after the earthquakes in 2011 which had many fatalities. (Unfortunately in November 2016 New Zealand has had further earthquakes). In 2012 there was little focus on ACEs or trauma informed care. One example was the work by Te Pou around the reduction of seclusion and restraint[20] across mental health, disability and education services.

In 2016 several agencies are starting to look at trauma (e.g. Ministry of Health, Ministry of Social Development (work on "Vulnerable Children"), Ministry of Education, Te Pou and the Werry Workforce Whāraurau). Family violence is a key focus for New Zealand as well.

In the information below is the seminal work by Debra Wells in 2004 who led the way in New Zealand with her paper: "Disturbing the Sound of Silence: Mental health services' responsiveness to people with trauma histories". Debra came to the conclusion that:

"New Zealand must acknowledge that the current models of service delivery are generally unresponsive to people with abuse histories".

http://www.hdc.org.nz/publications/other-publications-from-hdc/mental-health-resources/disturbing-the-sounds-of-silence-mental-health-services'-responsiveness-to-people-with-trauma-histories

Ministry of Health

There has also been a huge amount of activity occurring in the area of vulnerable children and earlier intervention with children. The Ministry is also starting work looking ACEs and trauma informed care in late 2016/early 2017.

New Zealand Health Strategy: Future direction, April 2016

"All New Zealanders live well, stay well and get well"

This updated strategy shares the common view of where we want to go in New Zealand health. The five themes – people-powered, closer to home, value and high performance, one team and smart system – are cornerstones in establishing a health sector that understands people's needs and provides services that are integrated across sectors, emphasising investment early in life, maintaining wellness, preventing illness, and providing support for the final stages of life.

At the launch of the New Zealand Health Strategy, the first author (Janet Peters) gave a presentation on early trauma issue based on her personal story.
http://www.health.govt.nz/about-ministry/what-we-do/powering-our-future

http://www.health.govt.nz/system/files/documents/publications/new-zealand-health-strategy-futuredirection-2016-apr16.pdf

[20] Robyn Shearer, Te Pou, email communication 2016.

Whānau Ora programme

Whānau Ora is a key cross-government work programme jointly implemented by the Ministry of Health, Te Puni Kōkiri and the Ministry of Social Development.

It is an approach that places families/whānau at the centre of service delivery, requiring the integration of health, education and social services and is improving outcomes and results for New Zealand families/whānau.

Further information is below under Te Puni Kokiri.

Whanau Ora is important as it focuses on better health outcomes for Maori. Any future work on ACEs would need to dovetail with this programme.
http://www.health.govt.nz/our-work/populations/maori-health/whanau-ora-programme

Report: 2012: Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017

This Plan provides a strong vision to guide the mental health and addiction sector, as well as clear direction to planners, funders and providers of mental health and addiction services on Government priority areas for service development over the next five years.

The Plan focuses on four key areas:

- making better use of resources
- improving integration between primary and secondary services
- cementing and building on gains for people with high needs
- delivering increased access for all age groups (with a focus on infants, children and youth, older people and adults with common mental health and addiction disorders such as anxiety and depression.

In Rising to the Challenge trauma is mentioned but not focused on, that is:

- Table 4: **People with low-prevalence conditions and/or high needs: priority actions**

Ensure services are sensitive to past experiences of trauma	**DHB providers p.25**

Rising to the Challenge will be refreshed in 2016-7.
http://www.health.govt.nz/publication/rising-challenge-mental-health-and-addiction-service-development-plan-2012-2017

Report 2016: Commissioning Framework for Mental Health and Addiction: A New Zealand guide

The Commissioning Framework is part of an outcome-focused approach. This framework, along with the Mental Health and Wellbeing Outcome Framework, provides national guidance to enable us to measure outcomes that make a real difference for people. ACEs and trauma informed care are not mentioned in this document.
http://www.health.govt.nz/publication/commissioning-framework-mental-health-and-addiction-new-zealand-guide

New Legislation in New Zealand

Report 2012: The White Paper for Vulnerable Children

The White Paper for Vulnerable Children 2012 Children 2012 introduced new legislation the Vulnerable Children Act 2014 to better protect vulnerable children and changes to other legislation - the Children, Young Persons, and Their Families Act 1989 and the KiwiSaver Act 2006.

The Vulnerable Children Act 2014 introduces the following changes:

- Chief Executives of the New Zealand Police, Ministries of Education, Justice, Social Development and the Director-General of Health are accountable to Ministers for developing and implementing a cross-agency plan on vulnerable children, which is to be reported on.
- The development of child protection policies for staff employed by agencies who work with children.
- Standardised safety checking for the entire Government-funded children's workforce to help identify the people who pose a risk to children. Includes confirmation of identification and a Police Check involving thorough criminal history checks and a risk assessment with periodic reassessment.
- Workforce restrictions for those who have committed serious offences as specified in the Act who may pose a risk to children.

Children's Action Plan

The Children's Action Plan is a cross-sector programme established to protect vulnerable children by proactively reducing child abuse and neglect.

The Children's Action Plan sits behind the White Paper for Vulnerable Children released in 2012 and provides the framework outlining the solutions and actions to be taken to resolve the issues with vulnerable children. It is a living document that will continue to evolve and be updated in line with the changes outlined in the White Paper.

The White Paper contained a range of solutions including legislative changes, information sharing, tracking vulnerable children, tougher penalties and monitoring of child abusers, screening those who work with children, local children's teams and shared responsibilities for all New Zealanders.
http://www.health.govt.nz/our-work/life-stages/child-health/childrens-action-plan-programme

State Services Commission

It has been 100 years since the Public Service Act 1912 came into force, and the set up of New Zealand's Public Service Commission (PSC) - now referred to as the State Services Commission (SSC). The SSC leads and provides oversight on Public Services funded by the Government.
http://www.ssc.govt.nz/sscer

Better Public Services: Supporting vulnerable children

We know there is a link between early childhood experiences and adult mental health, drug and alcohol abuse, poor educational outcomes and unemployment. Too many children are at risk of poor outcomes because they do not get the early support they need.

The human and financial costs of not facing up to these challenges are too high. We know that remedial spending is often less effective, and more costly, than getting it right the first time. For example, treating rheumatic fever alone costs an estimated $40 million a year in New Zealand. Early intervention brings benefits in terms of reduced imprisonment and arrest rates, higher employment and higher earnings later in life. By doing better for vulnerable children, we could set them on a pathway to a positive future, and help build a more productive and competitive economy for all New Zealanders.

The result areas include the 3 below:

RESULT 2: INCREASE PARTICIPATION IN EARLY CHILDHOOD EDUCATION

In 2016, 98% of children starting school will have participated in quality early childhood education. The percentage of children who have attended ECE before starting school has steadily increased each year since 2000, and was 96.4% as at December 2015. This was an increase of 0.3 percentage points since December 2014.

The Ministry of Education is intensifying engagement with priority communities in order to reach the 98% target in 2016.
http://www.ssc.govt.nz/bps-supporting-vulnerable-children

The Treasury

Report 2016: Characteristics of Children at Greater Risk of Poor Outcomes as Adults

Prepared by the Analytics and Insights team at the Treasury
Analytical Paper 16/01

This paper uses integrated administrative data to identify and describe the characteristics of children who are at higher risk of poor long-term outcomes, including low school attainment, long-term benefit receipt and contact with the justice system.

This work is part of a broader work programme which seeks to improve the lives of New Zealanders by applying evidence-based investment practices to social services. The “social investment” approach aims to use information and technology to better understand the people who need public services and what works, and to adjust services accordingly.

The analysis updates and extends an earlier study that also identified groups of children at higher risk of poor long-term outcomes. It makes use of new information available in Statistics New Zealand's Integrated Data Infrastructure (IDI), including information on selected health service use, births, border movements, and educational participation.

The report provides separate analyses of data for children aged 0-5 and 6-14 years, reflecting the initial focus of social sector agencies on the younger age group. Results for all children aged 0-14 years are also included.

Research objectives

The earlier study found that a small number of characteristics observed in the integrated administrative data were correlated with poorer outcomes as young adults, including low school attainment, long-term benefit receipt and contact with the justice system. The current analysis focuses on the children who had two or more of the following characteristics (or indicators):

- having a substantiated finding of abuse or neglect by Child, Youth and Family (CYF) or having spent time in their care
- having spent more than three-quarters of their lifetime supported by benefits
- having a parent who has received a community or custodial sentence
- having a mother who has no formal qualifications (p.2)

http://www.treasury.govt.nz/publications/research-policy/ap/2016/16-01/ap16-01.pdf

Report 2016: Research Using Administrative Data to Support the Work of the Expert Panel on Modernising Child, Youth and Family (2016)

"Until recently, there has only been limited statistical information available about the subsequent life outcomes of children and young people who have contact with child protection services. This paper provides some important insights into the nature and extent of contact with Child, Youth and Family as well as subsequent adult outcomes depending on the level of contact.

The paper uses a new dataset that links records from a range of government agencies. This new data allows an analysis of government service utilisation for a cohort of children born between 1 July 1990 and 30 June 1991. The analysis looks at the extent to which children in the birth cohort had contact with Child, Youth and Family as a result of either care and protection or youth justice concerns. Prior to 18 years of age, around 15% of the cohort had some form of care and protection contact with Child, Youth and Family. Approximately 4.4% were referred to Child, Youth and Family for youth justice reasons.

The paper also reports on the subsequent education, benefit receipt and criminal justice outcomes. The data shows that, compared to other children in the cohort, those who had contact with Child, Youth and Family were less likely to attain basic school qualifications, were more likely to be early entrants to the benefit system (sometimes with their own children) and were more likely to have later contact with the adult corrections system." (p.3)

"The high rate of mortality among young people who have had contact with Child, Youth and Family has important implications for child protection and other services.

A key issue is that the child protection response should not just focus on physical safety of children, but it should also provide services to help children and young people recover from the trauma of abuse and neglect". (p.32)
http://www.treasury.govt.nz/publications/research-policy/ap/2016/16-03/ap16-03.pdf

Ministry of Social Development

Prime Minister's Youth Mental Health Projects

In 2012 the Government announced new investment - more than $12.2 million over the next four years from the Social Development Vote in the Prime Minister's Youth Mental Health package of initiatives.

Youth Workers in low decile secondary schools

Youth workers trained in mental health issues will be employed in selected low decile secondary schools.

This initiative builds on the current Multi-Agency Support Services in Secondary Schools (MASSiSS) service currently provided in 17 schools in South Auckland, Porirua and Flaxmere, with the additional requirement that the workforce has training in working with young people with mental health issues.

The youth workers will be contracted by existing community NGO providers through funding from Child, Youth and Family. The service will be available to students and their families and whānau, at no cost to them. The youth workers will work closely with existing school-based services and will link to community-based services.

By year three, an estimated 20,000 students in 27 schools will have access to a school-based youth worker or social worker. The youth workers and social workers will also be trained in using the Ministry of Education's evidence-based Check and Connect programme, which targets young people who have, or are at risk of, disengaging from school.
This new initiative will cost more than $8.6 million over four years.

Social Media Innovations Fund

The Government is going to launch a public-private partnership (PPP) Social Media Innovations Fund. This PPP fund will help youth service providers keep their services technologically up to date and use social media to help young people access information on mental health.

Contributions from corporates and philanthropists will be sought, alongside Government funding of $2 million over four years, to fund good ideas which could bring breakthroughs in youth mental health services.

The Fund will foster innovation and the fast tracking of ideas, and help existing helplines and websites to improve their use of social media technology to engage with young people.

Information for Parents, Families and Friends

Parents, families and friends play a key role in identifying and encouraging young people with mental health issues to seek help and they need good access to authoritative information.

A contestable fund will be established that will allow non-government organisations to bid for funding to provide information to parents, families and friends. There will be an annual funding round for interested NGOs.

This initiative will cost $1 million over four years.

Social Support in Youth One Stop Shops (YOSS)

Youth One Stop Shops (YOSS) provide free, youth-friendly health and social services to young people. Community-based, they share a philosophy of positive youth development. YOSS have developed in response to young people's preferences.

The Ministries of Social Development and Health will provide separate time limited support for existing effective YOSS. MSD's contribution will be focused on social support services and may include building youth worker capacity or capability.

This initiative will cost $600,000 and is available for the 2012/2013 financial year only.
http://www.msd.govt.nz/about-msd-and-our-work/newsroom/factsheets/budget/2012/pms-mental-health-services.html

Related Documents

- **Youth_Mental_Health_project-Family_and_Community.pdf** (pdf 93.4 KB)
- **Youth_Mental_Health_project-School_Based_Initiatives.pdf** (pdf 111.77 KB)
- **Youth_Mental_Health_project-Online_initiatives.pdf** (pdf 93.41 KB)
- **Youth_Mental_Health_project-Health_Sector.pdf** (pdf 91.06 KB)
- **Youth_Mental_Health_project-FAQs.pdf** (pdf 92.1 KB)

https://www.beehive.govt.nz/release/pm-unveils-youth-mental-health-package

Investing in Children Programme

This work has occurred over 2015- 2016.

Background

An Expert Advisory Panel was established in April 2015, to review the current care and protection system. This meant not simply focusing on Child, Youth and Family, as many reviews had done in the past, but looking at all of the system players, including other agencies, private sector, NGOs, and community groups.

The Panel proposed an ambitious and substantial reform programme that will significantly extend the range of services provided to vulnerable children and young people, and take a proactive and life outcomes-focused approach to meeting their needs.

Investing in Children Programme: Transformational change

In response to the recommendations of the Expert Panel's Final Report, the Government agreed that a bold and urgent overhaul of the care and protection and youth justice systems was required.
The Investing in Children Programme, formed in April 2016, is tasked with leading the fundamental shift required to achieve better outcomes for vulnerable children. This includes developing a system which prioritises the earliest opportunity for a stable and loving family, and enables all children to feel a sense of identity, belonging and connection.

The reform programme takes a cross-sector, social investment approach, and draws on the experience and expertise of professionals, communities, caregivers, young people and families. This is a long-term transformation programme over four to five years. An aspirational roadmap has been developed that sets out the key changes for children and young people, families and whānau, caregiving families, staff, partners and providers over the next four years.

The roadmap below includes trauma informed approaches:
See the Investing in Children aspirational roadmap (PowerPoint 141.12KB)

The future - a child-centred system

The operating model for our new system for vulnerable children will be underpinned by six foundation building blocks:

- A child-centred system
- High aspirations for Māori children
- An investment approach
- Strategic partnerships
- A professional practice framework
- Engaging all New Zealanders

https://www.msd.govt.nz/about-msd-and-our-work/work-programmes/investing-in-children/

New "Ministry for Vulnerable Children, Oranga Tamariki"

The Investing in Children Programme is developing the strategies, framework, mechanics, policies, and procedures required for the operating model of the new Ministry for Vulnerable Children, Oranga Tamariki, which comes into effect on 1 April 2017.
The new Ministry:

- signals a whole of sector approach
- provides a single point of accountability
- has a broader remit, including prevention as a core area of focus.

Find out more about the establishment of the new Ministry for Vulnerable Children, Oranga Tamariki.

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Five core services of the new Ministry

At the heart of our new system are vulnerable children or young people. We will take a broader view to include children who are at significant risk of harm now or into the future. This may be as a consequence of their family environment, and/or their own complex needs, and include young people who have offended or may offend in the future. The new Ministry will focus on five core services:

- Prevention services
- Intensive Intervention services
- Care Support services
- Youth Justice services
- Transition Support services.

These will not operate as silos, but will be integrated horizontally and vertically.
http://www.msd.govt.nz/about-msd-and-our-work/work-programmes/investing-in-children/index.html

Trauma-informed care would sit at the prevention end of services, but would also cut across all service provision.
http://www.msd.govt.nz/about-msd-and-our-work/work-programmes/investing-in-children/service-and-practice-model.html

Te Puni Kokiri

Whānau Ora at a glance

Whānau Ora is an innovative whanau-centred approach to empowering whānau to achieve better health, education, housing, skills development and economic outcomes.

The whānau experience

Whānau Ora puts whānau at the centre of decision-making about the services and opportunities they need and how they access them. Community, government and iwi agencies that provide services to whānau are expected to work in a co-ordinated way that is responsive to whānau needs.
Whānau may use the services of a navigator, a practitioner who helps them to identify their needs and aspirations, plan for the future, and access co-ordinated services in areas such as education, primary health and employment, to carry out the plan.

The Whānau Ora Partnership Group

The Whānau Ora Partnership Group is the Crown/Iwi body that provides strategic leadership to Whānau Ora. The Partnership Group, which is chaired by the Minister for Whānau Ora, is comprised of six Iwi Chairs representatives and the Ministers of Finance, Education, Health, Social Development and Economic Development. Read more

Whānau Ora outcomes

The Whanau Ora Partnership Group has developed a shared Whānau Ora outcomes framework. The framework guides the direction of Whānau Ora in the short, medium and long term, and assists the monitoring of its progress.

Seven key outcomes to empower whānau into the future lead the framework. Read more
https://www.tpk.govt.nz/en/whakamahia/whanau-ora/

Ministry of Education

“The Ministry of Education is the Government’s lead advisor on the education system, shaping direction for education agencies and providers and contributing to the Government’s goals for education.”
http://www.education.govt.nz/ministry-of-education/our-role-and-our-people/what-we-do/

Traumatic Incident Teams

Preparing for and dealing with emergencies and traumatic incidents
Your school or ECE may face a natural disaster or pandemic. Other traumatic incidents could include criminal acts or student suicide. It's important to be prepared for these events and know how to respond if they happen.

On this page:

- What can we help with
- How can we help
- Useful resources
- Further information

You can contact our specially trained staff at any stage to support your early childhood education (ECE) service or school as you prepare for or deal with an emergency or traumatic event.

Such emergencies or events could relate to natural disasters, for example, an earthquake, a flood or an outbreak of a serious infectious disease, or they could be human-induced, for example, accidental or non-accidental death or serious injury of a child, young person or staff member, allegations of abuse involving a staff member, loss of property through fire or vandalism.
http://www.education.govt.nz/school/student-support/emergencies/

There were 205 requests for support in 2015 in New Zealand more than one a day for the school year. The teams are seen as excellent by schools.[21]

Health & Disability Commission

Report 2004: Disturbing the Sound of Silence: Mental health services' responsiveness to people with trauma histories

As noted above, in the information below is the seminal work by Debra Wells in 2004 who wrote a report for the (now defunct) Mental Health Commission. In the first formal examination of this area in New Zealand, Debra spoke with people who had used services and had a history of abuse.

She noted that the purpose of this paper is to answer the question, 'are mental health services in New Zealand responsive to people with trauma histories'? In essence she found the answer was mainly "No".

Barriers to implementation of trauma informed services (as cited by Young et. al 2001) were seen as:

"While these can be seen as systemic issues, research indicates that there are also a number of factors which are barriers that individual clinicians face. These are:

- Fear of vicarious traumatisation
- Discomfort with discussing personal topics
- Concern about client embarrassment
- Time constraints
- Lack of training and confidence
- Severity of disturbance and fear of exacerbating disturbance

[21] NZ Herald, October 2016.

- Clinicians' beliefs regarding the reliability of clients' accounts
- Concern about 'false memory syndrome'
- Clinicians' and clients' gender
- Having a bio-medical based theory of etiology".

She noted that people had largely felt silenced and people said:

"We want:

- mental health services that look beyond diagnosis to the whole person, and practitioners who are willing to form therapeutic relationships with us
- training for ALL mental health staff in all aspects of trauma treatment and recovery, some of which would be provided by abuse survivors
- the creation of alternative services designed to diminish or eliminate the need for hospitalisation for those with abuse histories
- a stop to pathologising and medicating our distress
- mental health staff who ask about our histories and what we believe about what has created our distress, and who then work accordingly
- mental health services that do not perpetuate the abuse through its practices
- access to professionals who work effectively with people with trauma histories
- movement beyond a bio-medical approach to mental illness
- national recognition in mental health policy, planning and funding of the ongoing effects of abuse in peoples' lives
- national leadership in this area"(p.6).

"New Zealand must acknowledge that the current models of service delivery are generally unresponsive to people with abuse histories".

(To note: this appears to only be available in a word document format – it is not in a link).

Human Rights Commission

The Human Rights Commission with our NPM partners are leading a project to review seclusion and restraint policies and practices in New Zealand.

The Human Rights Commission and the other National Preventive Mechanisms (NPM) under the Optional Protocol to the Convention Against Torture (OPCAT) have repeatedly raised concerns about the way Government agencies detain some New Zealanders, including the use of seclusion and restraint.

International monitoring bodies have also raised some discrepancies in the way seclusion and restraint policies and practices are implemented in New Zealand.

The project will identify best practice and policy, both in New Zealand and internationally, and will result in a report that will help guide New Zealand's seclusion and restraint policies practices in future. https://www.hrc.co.nz/news/seclusion-and-restraint-do-you-want-share-your-experience/

Examples from other agencies and activities

Te Pou o te Whakaaro Nui

CEO Robyn Shearer noted that the aim for Te Pou's work is to have trauma informed thinking threaded throughout all activities[22].

TheMHS Conference 2016

Te Pou hosted a conference in 2016 in which two presentations were relevant to this report:

Arthur C Evans from Philadelphia gave a great presentation on his work:
http://www.themhs.org/resources/1393/keynote-powerpoint-beyond-the-black-box-the-transformation-to-a-population-health-approach

And he also appeared on NZ TV with CEO Robyn Shearer:
http://www.tepou.co.nz/resources/te-pou-chief-executive-robyn-shearer-and-dr-arthur-c-evans-speak-on-breakfast-television-/751

The reduction of seclusion and restraint practices

In 2016 Te Pou are actively involved in the NZ Human Rights Commission review on seclusion and restraint. The review has a broad scope across mental health, disability, police and corrections. *"The Commission are impressed keen to promote solutions so we are hopeful we can influence a broader approach to this – especially in disability and education*[23]".

Te Pou has done a great deal of work, and offers a wide range of strategies and techniques, for the reduction of seclusion and restraint practices in mental health impatient units. Seclusion and restraint are traumatising experiences for people receiving services and staff delivering services. Evidence based tools are available to support in-patient services to reduce seclusion and restraint, developed by Te Pou with support from the Ministry of Health. There are also resources in the area of sensory modulation.

Reducing and working to eliminate seclusion and restraint is highlighted as a priority action in *Rising to the Challenge*. Currently New Zealand has made good progress towards reducing seclusion and restraint and Te Pou will support DHBs to continue that work.
http://www.tepou.co.nz/initiatives/reducing-seclusion-and-restraint/102

Films and videos regarding trauma informed care:

http://www.tepou.co.nz/resources/trauma-informed-care-workshop-resources/226#downloads

[22] Robyn Shearer, email communication 2016
[23] Ibid.

Report 2015: Towards restraint-free mental health practice Supporting the reduction and prevention of personal restraint in mental health inpatient settings

This 2015 document is a good example of the work being undertaken. It is a practice based guidance which supports the reduction and prevention of personal restraint in mental health inpatient settings. http://www.tepou.co.nz/uploads/files/resource-assets/towards-restraint-free-mental-health-practice-may-15-web.pdf

Equally Well

There is great overlap with this work and what ACEs research and trauma informed care are trying to achieve.

Equally Well is a group of people and organisations with the common goal of reducing physical health disparities between people who experience mental health and addiction problems, and people who don't. Mental health and addiction service users are important partners in this work.

Everyone should have the same opportunities to be physically well. However that's not always the case.

In New Zealand and overseas, people with mental health and addiction problems tend to have worse physical health than their counterparts in the general population, and a shorter life expectancy. Diabetes, cardiovascular disease, metabolic syndrome, cancer and oral health issues are more common for this population group.

Equally Well is about taking initiative and working together for change. Equally Well supporters span the health, mental health and social sectors, and include community organisations, mental health and addiction NGOs, primary care, district health boards, medical colleges and education providers.

http://www.tepou.co.nz/initiatives/equally-well-physical-health/37

Trauma informed care workshop resources

In 2011 Te Pou hosted workshops on trauma informed care – the first such training in New Zealand.

On their webpage are eight resources a mix of videos, presentations and documents. These resources are from two trauma workshops co-hosted by Te Pou. The workshops were held in response to concerns from people around addressing trauma needs and preventing re-traumatising.

The workshops were facilitated via IIMHL and run by US-based experts, Dr Bob Glover from the National Association of State Mental Health Programme Directors (NASMHPD) and Dr Brian Sims, senior director of behavioural and mental health for Conmed Healthcare Management.
http://www.tepou.co.nz/resources/trauma-informed-care-workshop-resources/226

The Werry Workforce Whāraurau

The Werry Workforce Whāraurau is funded by the Ministry of Health to deliver a number of workforce development initiatives for the Infant, Child & Adolescent Mental Health and/or Alcohol and Other Drugs (ICAMH/AOD) sector.

Workforce Whāraurau provides workforce development including the implementation of best-practice evidence-informed intervention implementation, training, evaluative-research and project work for individuals, families and practitioners. http://www.werrycentre.org.nz/

In 2016 the Programme is focusing on training in trauma informed care and is coordinating a "Sector Leader's Day" on 2nd December 2016 focusing on 'Trauma Informed Service Delivery'.

"We are currently looking at a scoping of across-sector training needs in the area, which will inform what we offer in the future. Additionally, all of our project scopings include a consideration of where trauma 'fits', a good example being the 'Supporting Parents Healthy Children' Project and our Parenting programme implementation".

An example of 2016 training is:

Our focus on Childhood Trauma continues and clinical psychologists Dr Sarah Bendall and Shona Francey from Orygen in Australia bring us a skills-focused workshop in Wellington on November 17th entitled **Safe approaches to addressing trauma with adolescents and young people.**

This half-day workshop will present a framework for safely assessing for trauma (particularly childhood interpersonal trauma) and trauma-related symptoms in adolescents and young adults. It is applicable to professionals working in case management and support roles as well as those in more therapeutic roles. Participants will learn best practice skills in how to safely and appropriately ask about trauma experiences. The workshop will use interactive formats, and will include didactic elements and skills-based work.

At the end of the workshop, participants will have a greater understanding of:

Ways to manage trauma disclosures in order to reduce any potential distress of a young person.

How to assess for the effects of trauma.

How to furnish vulnerable young people with skills to manage high emotion and distress in preparation for assessing for trauma and its consequences.

How to integrate into their practice a method for young people to communicate in-session distress to their clinician.

Knowledge of how young people experience talking about trauma with mental health professionals.

Considerations of self-care and vicarious post-traumatic stress in working.http://www.werrycentre.org.nz/news/workforce-update-sept

Examples of key Werry Workforce Whāraurau initiatives are:

Supporting Parents Healthy Children (formerly COPMIA)

Whilst many children of parents who have mental health and/or addiction problems fare well, a proportion are vulnerable to a range of poor outcomes, including increased risk of developing mental health issues. This project aims to increase the capability of health professionals to identify and attend to the needs of these children and their family/whānau.

Choice & Partnership Approach (CAPA)

The Choice and Partnership Approach is a service redesign model offering choices to young people and their families in their dealings with mental health and addiction services, and partnership with clinicians during treatment. Integrated into the Choice & Partnership Approach are the 7 Helpful Habits (7HH) to enhance service delivery and efficiency. This project focuses on training, implementation support, and helping services to monitor the impact of the Choice & Partnership Approach through data collection.

HEEADSSS training in primary health

The HEEADSSS assessment tool is a key instrument for primary health care workers to identify mental health and AOD concerns early. Expanded use of the HEEADSSS assessment is one of 22 initiatives recommended by a cross-agency project, led by the Department of Prime Minister and Cabinet, on improving services for young people with, or at risk of, mild to moderate mental health disorders.

Incredible Years® Parent Management Training and Primary Care Triple P

The Werry Workforce Whāraurau has built a sustainable workforce development model in Incredible Years® Parent Management Training for the CAMHS sector over the past eight years. We provide training, follow-up supervision and support for accreditation, as well as training and supporting Peer Coaches who coach new group leaders in developing their delivery skills.

A suite of Incredible Years® resources (Ngā Tau Miharo) has been developed for Māori group leaders and we are currently developing resources for Pacific group leaders.
http://www.werrycentre.org.nz/professionals/current-workforce-projects

Research 2016 and ongoing: The Dunedin Multidisciplinary Health and Development Study

http://dunedinstudy.otago.ac.nz/

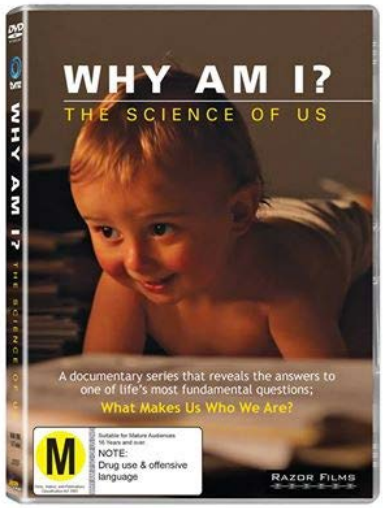
This internationally renowned study the “Dunedin Multidisciplinary Health & Development Study” (“Dunedin Study” for short) has now been ongoing since 1972-73, over 40 years.

“Thanks to the continued outstanding support and commitment of our Study members, we achieved 95% retention at the most recent age 38 assessment (2010-2012)”

The first assessment (or "Phase") following the Study members' birth in 1972-73 was undertaken when they were aged 3 years. Since then, there have been assessments at ages 5, 7, 9, 11, 13, 15, 18, 21, 26, 32 and, most recently, at 38 years (Phases 3 to 38 respectively). For the earlier phases,

assessments normally occurred within six weeks of the Study member's birthday. For the more recent phases, however, assessments normally occurred within 9 months of the Study member's birthday. During an "assessment phase", our Study Members come back to the Dunedin Research Unit for a one-day assessment from wherever in the world they are living - an impressive exercise considering more than 40 of them now live in the UK/Europe and a further 25 in Asia, Middle East, US and Canada! Once in Dunedin, almost all aspects of their physical and mental health are examined - this includes cardiovascular, dental, respiratory, sexual and mental health, psychosocial well-being, and detailed interviews about relationships, behaviour and family.
http://dunedinstudy.otago.ac.nz/studies/assessment-phases/the-assessments

It has led to a video series:



Seven research themes have evolved over the last 40 years focusing on: mental and neuro-cognition, cardiovascular risk, respiratory health, oral health, sexual and reproductive health and psychosocial functioning. A seventh, more applied theme, seeks to maximise the value of the Study findings for New Zealand's indigenous people Mâori (or tangata whenua translation "people of the land").

The Study has published over 1200 papers and reports to date, with almost 2/3 of these being in peer reviewed journals.
http://dunedinstudy.otago.ac.nz/publications

Two examples of papers:

Lest we forget: comparing retrospective and prospective assessments of adverse childhood experiences in the prediction of adult health, Reuben et al, in The Journal of Child Psychology and Psychiatry, September 2016.

http://onlinelibrary.wiley.com/doi/10.1111/jcpp.12621/full

Childhood maltreatment, juvenile disorders and adult post-traumatic stress disorder: a prospective investigation, Breslau et al, October 2013

https://www.cambridge.org/core/journals/psychological-medicine/article/childhood-maltreatment-juvenile-disorders-and-adult-post-traumatic-stress-disorder-a-prospective-investigation/1CEFA43577CD6C796E338D65CDBA6722

Overall, this research has shown that adverse experiences during childhood, including socioeconomic disadvantage, maltreatment and social isolation, are associated with a cluster of mental and physical effects, including a higher risk of depression and immune and metabolic abnormalities associated with poor health later in life.

Thus promotion of healthy psychosocial experiences for children is a necessary and potentially cost-effective target for the prevention of age-related disease.

https://www.mentalhealth.org.nz/assets/Uploads/MHF-Quick-facts-and-stats-FINAL.pdf

Adverse childhood experiences (ACEs; e.g. abuse, neglect, and parental loss) have been associated with increased risk for later-life disease and dysfunction using adults' retrospective self-reports of ACEs. A research study of Dunedin and US populations tested whether associations between ACEs and health outcomes are the same for prospective and retrospective ACE measures.

Prospective ACE records confirm associations between childhood adversity and negative life outcomes found previously using retrospective ACE reports. However, more agreeable and neurotic dispositions may, respectively, bias retrospective ACE measures toward underestimating the impact of adversity on objectively measured life outcomes and overestimating the impact of adversity on self-reported outcomes. Associations between personality factors and the propensity to recall adversity were extremely modest and warrant further investigation. Risk predictions based on retrospective ACE reports should utilize objective outcome measures. Where objective outcome measurements are difficult to obtain, correction factors may be warranted.
https://www.ncbi.nlm.nih.gov/pubmed/27647050

Brainwave Trust

Report 2013: The economics of early intervention

Brainwave Trust Aotearoa made a submission to the Health Select Committee: Inquiry into preventing child abuse and improving children's health outcomes in May 2012 in response to the first term of reference for the enquiry "to update knowledge of what factors influence best childhood outcomes from before conception to 3 years, and what are significant barriers regarding the impact of early experience on a child's brain development". They were asked us to provide further information on the economic argument for early intervention.

This 2103 paper demonstrated that intervening in the early years is not only effective but also economically efficient.

"Intervening in the zero-to-three period, when children are at their most receptive stage of development, has the potential to permanently alter their development trajectories and protect them against risk factors present in their early environment. Both biological and environmental conditions play a role. Children from low socioeconomic backgrounds typically have poorer health in terms of the prevalence of illness, the severity of illness, the likelihood of mortality, and the incidence of disease (Chen et al, 2002 in Doyle et al, 2009). Possible explanations for this include genetic influences, environmental exposures to toxins, quality of medical care, and behavioural factors (Anderson & Armstead, 1995 in Doyle et al, 2009)".(p.12)

Some of the answer in improving productivity as a nation will, maybe surprisingly, be in how we treat our young children. In Heckman's (2000) words:

"The real question is how to use the available funds wisely. The best evidence supports the policy prescription: invest in the very young and improve basic learning and socialisation skills" (p.1)

"As a country we spend billions of dollars addressing the results of early childhood adversity. The research now provides compelling evidence regarding the long term ramifications of the construction of brain architecture in infants and children in the first few years. The early plasticity of the brain becomes its vulnerability. It also demonstrates the far reaching outcomes when those early years have been less than adequate in terms of the individual and society.

We know that the programmes that are in place to ameliorate those problems (prisoner rehabilitation, drug and alcohol programmes, remedial support in school etc) are an expensive impost on the taxpayer yet we still provide them.

A dollar invested in the early years however provides a very much higher return than a dollar invested later. Interventions which reduce ongoing expenses to the health system will also have benefits in education, corrections, etc which accrue both to society and the individual. Of course, intervention in the early years is not the only possible point of intervention, but it does provide the best return". (p.16)

http://www.brainwave.org.nz/wp-content/uploads/2011/11/The-Economics-of-Early-Intervention-Brainwave-Trust-Aotearoa-April-20131.pdf

University of Otago

Report 2015: Pathways to child health: development and wellbeing: Optimal environments for orchids and dandelions – an overview of the evidence

The Ministry of Health commissioned a report in 2015 which was written by Kvalsvig and colleagues. It is surprising that ACEs and trauma were not mentioned. The Ministry notes:

"This review discusses the findings of a rapid review of some of the latest evidence on the pathways to optimal health and wellbeing for children from birth to age 14 years, through the developmental periods of infancy, early and middle childhood and early adolescence.

Influences on health and development are considered under three headings: the environment of relationships in which a child develops; the physical, chemical and built environments in which the child and family live; and nutrition for health".

http://www.health.govt.nz/publication/pathways-child-health-development-and-wellbeing-optimal-environments-orchids-and-dandelions-overview

Auckland University of Technology (UNITEC)

National Institute for Public and Mental Health Research

The Pacific Study

The Pacific Islands Families (PIF) Study is following a cohort of 1398 Pacific children within their family environment over the first 13 years of the child's life. Extensive consultation within Pacific communities has contributed to the development of this multidisciplinary project and the inclusion of psychosocial and health concepts that are relevant to these communities. It is anticipated that this prospective, longitudinal study will generate important practical information on Pacific child and family health and psychosocial functioning over critical developmental stages.
https://niphmhr.aut.ac.nz/research-centres/centre-for-pacific-health-and-development-research/pacific-islands-families-study

What is the Pacific Islands Families Study?

The Pacific Islands Families (PIF) Study is an ongoing longitudinal birth cohort study that has been tracking the health and development of 1,398 Pacific children and their parents since the children were born at Middlemore Hospital in South Auckland in the year 2000. It is the only prospective study specifically of Pacific peoples in the world.

What are the aims of the PIF Study?

The PIF Study's broad aims are to determine optimum pathways for Pacific children and families during critical developmental periods by identifying risk and resilience factors that influence positive and negative outcomes; and to provide Pacific-specific evidence and make empirically-based strategic recommendations to improve the health and well-being of Pacific children and families and address the social disparities they face in New Zealand.https://niphmhr.aut.ac.nz/research-centres/centre-for-pacific-health-and-development-research/pacific-islands-families-study/about-the-study
Fathers subjected to higher levels of paternal physical abuse in childhood were significantly more likely to physically discipline their child with smacking than those with lower levels of paternal physical abuse, after adjusting for confounding factors; as were fathers subjected to higher levels of maternal physical abuse[24].

Pathways

Pathways is a mental health NGO which saw the need for different models of care in the mental health sector.

Based on a strong belief that people could recover from mental illness, Pathways first introduced community-based, residential living support in quality accommodation then rapidly expanded into the mobile support services delivered into people's homes, acute alternatives to hospital admission and

[24] Email from Prof. Janis Paterson, Experience of physical abuse in childhood and perpetration of physical punishment and violence in adulthood amongst fathers: findings from the Pacific Islands Families Study Pacific Health dialogue September 2011, vol. 17, No. 2

wellbeing programmes that now form the majority of their services to people.
http://www.pathways.co.nz/services/overview

Over the years Pathways has continually developed its services based on examples of best practice from around the world. And just as importantly, based on feedback from the people that matter most – those who use the services, their whānau and the passionate Pathways team.

Pathways' spirit of doing 'Whatever it takes' has remained as a constant.

"When people come to us, their poor mental health has often made their world become very small. At Pathways we want to help people feel as if the world is an exciting place that holds opportunity, growth and positive life experiences".

"We recognise the impact of trauma"

"*We realise trauma may have played a part in people becoming unwell, so we try to recognise the impacts that trauma may have had on them. We're committed to doing everything we can to ensure people don't experience any further trauma from being involved with our services*".
http://www.pathways.co.nz/about/whats-important

Mental Health Foundation

"The Mental Health Foundation of New Zealand is a charity that works towards creating a society free from discrimination, where all people enjoy positive mental health & wellbeing. We work to influence individuals, whanau, organisations and communities to improve and sustain their mental health and reach their full potential".

While a few resources mention trauma informed care, it is not a strong focus of this organisation.
https://www.mentalhealth.org.nz/

SCOTLAND

In 2012 Scotland signaled its intention to promote a more joined up method to policy and in 2016 it has achieved that. It also includes trauma informed work in its approach.

Scotland's Mental Health Strategy 2012-2015

This Strategy includes psychological trauma as a key priority (Scottish Government, 2012).

The strategy states that "General Services should be Trauma Aware", and aims to improve recognition and awareness of trauma in Primary Care and Mental Health Services, encourage staff to make appropriate referrals for trauma survivors, and roll out trauma training. Although TIAs are not named, this is nevertheless a welcome development.
http://www.emeraldinsight.com/doi/pdfplus/10.1108/MHRJ-01-2015-0006

Scotland's focus on the first 3 years and children

In addition a new focus on birth to 3 years, and then on children has been undertaken with several actions underpinning this:

> *"The period between pregnancy and 3 years is increasingly seen as a critical period in shaping children's life chances, based on evidence of brain formation, communication and language development, and the impact of relationships formed during this period on mental health. It is therefore also a critical opportunity to intervene to break cycles of poor outcomes." (p.19)*

http://www.gov.scot/resource/0039/00398762.pdf

Mental Health in Scotland – a 10-year vision

The new Mental Health Strategy will be published in late 2016. It follows a four-year strategy that ran from 2012 to 2015. The new Strategy will cover a 10 year period. A period of consultation is now underway.

Similar to New Zealand's Health Strategy, it is organised around life stages:

- Start Well – ensuring that children and young people have good mental health, and that we act early when problems emerge;
- Live Well – supporting people to look after themselves to stay mentally and physically healthy, to get help quickly when they need it, and to reduce inequalities for people living with mental health problems
- Age Well – ensuring that older people are able to access support for mental health problems to support them to live well for as long as possible at home.

Three of the eight priorities involve mothers, infants and children:

Priorities	Early action	result
1. Focus on prevention and early intervention for pregnant women and new mothers. Health services are alert to, identify, and address mental health issues of pregnant women and new mothers.	• Perinatal mental health – improve the recognition and treatment of mental health problems in the perinatal period. This will initially be done through the introduction of a network of specialist staff working together, which is formally known as a Managed Clinical Network. • Perinatal mental health – focus interventions on the most vulnerable mothers who are at the highest risk.	Health services are alert to, identify, and address mental health issues of pregnant women and new mothers. Better long-term outcomes for children
2. Focus on prevention and early intervention for: • **infants,** • **children and** • **young people.**	In 2016-17, develop a range of evidence-based programmes targeted to promote good mental health, support key vulnerable populations of infants, and children and young people. These programmes will be delivered by children's services during 2017-20. • By 2018-19, support the work above by better assessing which early intervention programmes are proven to work for different vulnerable populations. By 2019-20 have completed the national rollout of targeted parenting programmes for parents of 3- and 4-year olds with conduct disorder. • Psychosis – by 2017-18, have improved the recognition and treatment of first episode psychosis through early intervention services. • Develop further actions to support health and wellbeing of children and young people, recognising the link between mental and physical health through our Children and Young People's Health and Wellbeing strategy. • Utilise our universal services such as the new health visiting pathways to support good mental health, prevention and early intervention	Children's services focus in the promotion of good mental health based on prevention and early intervention. Children's services are equipped to quickly identify risk factors and implement action, using evidence-based programmes, to support children and families at risk of developing mental health problems. Improvements in partnership working between specialist Child and Adolescent Mental Health Services (CAMHS) and other children's services so children, young people and families get the help they need quickly. Improved longer term life outcomes for vulnerable groups – for example, better mental health, increased attainment, and a reduced chance of involvement in the criminal justice system.

https://consult.scotland.gov.uk/mental-health-unit/mental-health-in-scotland-a-10-year-vision

National indicators

A set of national mental health indicators has been established for:
adults http://www.healthscotland.com/scotlands-health/population/mental-health-indicators-index.aspx

children and young people
http://www.healthscotland.com/scotlands-health/population/mental-health-indicators/children.aspx

Report 2016: A Review of Mental Health Services in Scotland: Perspectives and Experiences of Service Users, Carers and Professionals

This is a 118-page report commissioned by the Scottish Government.

"This review has been undertaken for Commitment 1 of The Scottish Government's Mental Health Strategy for Scotland: 2012-2015 to 'commission a 10-year on follow up to the Sandra Grant Report to review the state of mental health services in Scotland'.

The aim of this review is to encourage reflection on the successes and challenges of the current mental health system in Scotland. This is not a systematic review of the evidence on the provision, impact and effectiveness of mental health services. Instead it highlights the real life experiences of people using services, families and carers, practitioners, commissioners and stakeholders

Our report found broad support among participants for Scotland's national strategic approach to mental health policy-making as responsive, enduring and collaborative. Legislation and many service developments have achieved a substantial positive impact. Public mental health programmes such as the Scottish Recovery Network, See Me, and Choose Life were seen as continuing to have an impact today. Regionally the picture was felt to be more variable, with the need for a more coherent framework to be adopted and implemented consistently, whilst acknowledging the reality of the geographic challenges.

The overall findings in this report indicate that the general direction of mental health services over the last ten years has been positive, with an appreciation that there has been change for the better. There continue to be challenges but respondents provided an extensive range of examples of where they felt progress had been made.

These include (among several others):

- • Specialist trauma services
- • Support for early years including mother and baby units
- • Access to psychological therapies" (p.5)

http://www.ccomssantementalelillefrance.org/sites/ccoms.org/files/Commitment%20One%20Report,%20January%202016.pdf

SurvivorScotland Strategic Outcomes and Priorities 2015-17

Scotland is one of the few countries in the world to have actively taken steps to acknowledge and address the devastating effects of childhood abuse. It has been through the dedication and bravery of survivors who have spoken out about their own experiences and campaigned relentlessly to have their voices heard that the Scottish Government has listened and responded.

An example that relates to trauma informed care:

Priorities 2015-17 Strategic Outcome 3

Safety and Security: Survivors have access to resources and services which are trauma informed and have the capacity and capability to recognise and respond to the signs of childhood abuse.

Why we need to support this outcome

Survivors have told us that they experience variation across Scotland in the accessibility and quality of support available to meet their needs. Services, professionals and communities must be able to recognise and respond to abuse and put in place prevention strategies.

How we will do this:

- Identify, and work in partnership with, relevant policy colleagues across
- government areas to ensure better connections and raise awareness of
- childhood abuse and its negative impacts across a wide range of sectors.
- Support the development, communication and implementation of a national
- training framework, in partnership with NES and experts in the field, that:
- Supports the development, communication and implementation of the
- evidence base for interventions which improve the wellbeing of Survivors .
- Identifies and communicates current capacity, capability and good practice
- of resources and services for Survivors.
- Identifies gaps in current provision and develops a clear plan to address
- these so that resources and services can ensure they are trauma
- informed, aware of the signs of childhood abuse, its negative impacts and
- are able to respond appropriately to improve outcomes for Survivors.
- Support the evaluation of the impact of this framework on outcomes for
- survivors. (p.8)

file:///Users/janetpeters/Downloads/SS%20Strategic%20Outcomes%20and%20Priorities%202015%202017.pdf

Examples of activities in other agencies

Report: Scottish Public Health Network (ScotPHN) 'Polishing the Diamonds' Addressing Adverse Childhood Experiences in Scotland, 2016

A very wise, experienced Health Visitor used the analogy, when talking about children that they are like diamonds:

"Their potential is inherent, but they need to be polished with care and attention".

Sadly, not all of our children in Scotland are currently being 'polished' with enough care and attention, with a significant number being subjected to Adverse Childhood Experiences (ACEs).

The aim of this briefing paper is to give an overview of ACEs and to provide an insight into the following questions:

1. What does the term Adverse Childhood Experiences (ACEs) mean?
2. What harm dose being exposed to Adverse Childhood Experiences cause?
3. How does being exposed to Adverse Childhood Experiences cause harm?
4. Are there some ACEs that have more of a detrimental effect than others?
5. Are some people more likely to be affected by ACEs than others?
6. How common are ACEs and can we measure how many people are affected in Scotland? 7. What is the economic impact of ACEs in Scotland?
8. What can be done about Adverse Childhood Experiences?

On the basis of these considerations, a number of areas for possible Public Health action / intervention are identified for further discussion.

Health-harming behaviours

As described previously, experiencing ACEs is linked to health-harming behaviours. Research in both England and Wales shows this to be true with people with 4+ ACEs showing a much higher rate of self-harm (e.g. drug and alcohol use, prison and smoking).

Commonality

In an English study, almost 50% of people reported experiencing a least one ACE and over 8% reported experiencing four or more. In a Welsh sample, the 16 prevalence was almost 50% of people reported experiencing a least one ACE and 14% reported experiencing four or more.14 This demonstrates how pervasive the experience of ACE is.

Although, data exists on various aspects of household dysfunction in Scotland no published studies exist to date of the prevalence specifically of ACEs in the general population of Scotland. However, if English studies have found 9% of the study population have experienced four or more ACEs, then I think it is safe to assume that the prevalence will be at least as high in Scotland, if not higher with our higher levels of morbidity and mortality, equating to at least 500,000 people.

If the Welsh prevalence of 14% is used this would be nearly 750000 people. If the effects on health-harming behaviours can be assumed to be the same, then those affected can be expected to be:

- two times more likely to binge drink and have a poor diet;
- three times more likely to be a current smoker;
- five times more likely to have had sex while under 16 years old;
- six times more likely to have had or caused an unplanned teenage pregnancy;
- seven times more likely to have been involved in violence in the last year; or
- eleven times more likely to have used heroin/crack or been incarcerated.

This report shows an infographic depicting ACEs in England and the predicted outcome if ACEs were eradicated in England:
http://www.cph.org.uk/wp-content/uploads/2014/05/ACE-infographics-BMC-Medicine-FINAL-3.pdf

Economic impact
The authors note there is very little UK data on the exact economic impact of ACEs in society but if the data gathered by Bellis et al in the English and Welsh studies can be generalised to Scotland then the health and economic impacts and the potential economic savings are likely to be very large indeed.

However, this only looks at the reduction in health-harming behaviours. If ACEs could be eradicated, or at least reduced, then the prevalence of the physical and mental health conditions outlined earlier would likely be reduced and there would be huge associated cost-savings from the associated health and social care costs, particularly for mental health conditions. (p.18)
http://www.cph.org.uk/wp-content/uploads/2016/01/ACE-Report-FINAL-E.pdf

https://www.scottishrecovery.net/wp-content/uploads/2016/06/ACE_Repor_-Final_2016.pdf

Voices of Experience

VOX is Scotland's national voice on mental health – "we represent our members' views to Scotland's politicians and health professionals to make sure Scotland's laws and mental health services reflect service user needs and interests. VOX is Scotland's only national mental health advocacy organisation run by service users for service users".

http://voxscotland.org.uk/about-vox-scotland/

SWEDEN

In 2012 no information in English could be found in this area.

Since then a key issue for Sweden is the huge influx of refugees. In 2015 IIMHL responded to a call for best practice documents in this area. The information on trauma below is related to refugees. We could not find other documents in English.

Report 2016: Seeking Refuge: Unaccompanied Children in Sweden

"Over 35,000 unaccompanied children sought asylum in Sweden in 2015, a stark increase over previous years. Most came from countries where they faced violence and persecution. The majority are from Afghanistan, Syria, Somalia, Eritrea, Iraq and Ethiopia. About half are 15 or younger, and 2,847 are girls. These children travelled on their own to Europe or became separated from their families in transit, and have often experienced trauma and violence.

Sweden has a long tradition of providing sanctuary to people in need of international protection and a well-developed system for unaccompanied asylum seeker and migrant children".

https://www.hrw.org/report/2016/06/09/seeking-refuge/unaccompanied-children-sweden#_ftn1

BOOK 2014: Nordic Work with Traumatised Refugees: Do We Really Care?
Edited by Gwynyth Overland, Eugene Guribye and Birgit Lie. Cambridge Scholars Publishing

It is noted in the introduction:

"*Internationally, there seems to be an increase in the application of trauma-informed approaches in care services.*

Yet, in the Nordic countries, this knowledge appears to be less utilised in care services. Ane Ugland Albaek, Mogens Albaek and Helge Slotten describe a comprehensive programme in Southern Norway based on the principles of trauma informed care. This approach builds on components such as promoting safety, offering trustful relationships, assisting in affect regulation and trauma-informed environments" (p.6).

One chapter focuses on trauma informed care:

CHAPTER THREE 132
CORE PRINCIPLES OF TRAUMA INFORMED CARE
Ane Ugland Albaek, Mogens Albaek and Helge Slotten

http://www.cambridgescholars.com/download/sample/61859

Research 2015

A new research study from Sweden highlights the importance of trauma informed pediatric care, finding that 1 in 3 children experience PTSD following traffic accidents. In the study, 292 children completed a questionnaire after a traffic accident to assess their recovery. One year post-accident, 22% of children reported mental and psychosocial problems and, as other studies have shown, these issues were not related to the objective severity of their physical injuries.

While pediatric providers cannot prevent accidents from happening, the study also found that receiving inpatient care and additional medical procedures further increased the distress children experienced. Doctors and nurses can lessen any medical traumatic stress children and their families may experience by practicing trauma informed care.

https://www.ncb.org.uk/resources-publications

USA

In 2012 it was noted:

"The US leads the world in this area and appears to be the only IIMHL country with a national policy in the area of trauma"[25]

SAMHSA

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.
http://www.samhsa.gov/about-us/who-we-are

As noted in the introduction to the 'Make it so", SAMHSA still leads the world in its work on trauma.

The key policy document is:

Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015–2018
http://store.samhsa.gov/shin/content//PEP14-LEADCHANGE2/PEP14-LEADCHANGE2.pdf

As a public health priority, focusing on trauma is one of SAMHSA's six Strategic Initiatives. Specifically, SAMHSA aims to reduce the pervasive, harmful, and costly health impact of violence and trauma by integrating trauma-informed approaches throughout behavioral health systems. For more information, visit SAMHSA's Trauma-Informed Approach and Trauma-Specific Interventions webpage.

Trauma and Justice

Lead: Larke N. Huang, Ph.D., Director, Office of Behavioral Health Equity
This initiative addresses the behavioral health needs of people involved in - or at risk of involvement in - the criminal and juvenile justice systems.

Additionally, it provides a comprehensive public health approach to addressing trauma and establishing a trauma-informed approach in health, behavioral health, human services, and related systems. The intent is to reduce both the observable and less visible harmful effects of trauma and violence on:

- Children and youth
- Adults
- Families
- Communities

[25] Make it so 2012 http://www.iimhl.com/files/docs/Make_It_So/20120712.pdf

Websites:

- Trauma and Violence
- Criminal and Juvenile Justice
- Disaster Preparedness, Response, and Recovery

http://www.samhsa.gov/about-us/strategic-initiatives

Learn more about:

- Types of Trauma and Violence
- SAMHSA's Efforts to Address Trauma and Violence
- Grants Related to Trauma and Violence
- Publications and Resources for Trauma and Violence
- Alternatives to Seclusion and Restraint

SAMHSA leads federal efforts to promote trauma-informed approaches through campaigns, technical assistance, and other resources. The website provides a huge number of resources and ways to assist individuals, agencies and communities.

Three examples of SAMHSA-led agencies are below.

National Association of State Mental Health Program Directors (NASMHPD)

"This is the only member organization representing state executives responsible for the $41 billion public mental health service delivery system serving 7.3[26] million people annually in all 50 states, 4 territories, and the District of Columbia. NASMHPD operates under a cooperative agreement with the National Governors Association".

For more than 10 years, NASMHPD has been contracted by the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide technical assistance and support to facilities committed to preventing the use of restraint and seclusion.

The National Center for Trauma Informed Care and Alternatives to Restraint and Seclusion offers on-site staff training and technical support to implement trauma-informed, strength-based approaches to prevent aversive interventions. Our in-house team and national consultants have many years of public hospital experience, both clinically and personally. This assistance is funded by SAMHSA and at no cost to states.

(Note: New Zealand (via Te Pou) has used these experts in the past to start the work on reduction of seclusion and restraint).
http://www.nasmhpd.org/

NASMHPD manages a diverse portfolio of programs focused on effectively identifying and responding to the training and technical assistance needs of an array of entities, including: state and local mental health agencies and other systems serving persons with mental health needs; provider organizations; consumers; families; planning and advisory councils, and systems of higher learning. This assistance covers a variety of administrative, policy, financial, clinical, and program areas.

[26] Stuart Gordon, email communication, 2nd July 2016

Examples of frequently-addressed topics include: the prevention of coercive practices such as seclusion and restraint; the planning and implementation of evidence-based practices; successfully achieving the goals of the Federal Mental Health Block Grant Program; promoting an understanding of the impact of trauma and the need for trauma-informed care; clinical protocols and program design that support recovery and enhance resilience for individuals across the lifespan; financing strategies, including Medicaid; workforce development; cross-system collaboration; strategic planning; and consumer empowerment, including the use of consumer-directed care and the expansion of meaningful roles for consumers in all stages of program/service planning, delivery, and evaluation.

The ultimate goal of such training and technical assistance is the development, implementation, and improvement of policies, programs, services, and supports that facilitate the well-being of individuals with mental health needs. NASMHPD's approach recognizes that in order to achieve these goals, training activities must: be customized to meet the unique needs of each group; include the highest levels of subject matter expertise with an unwavering commitment to quality; and involve a broad range of key stakeholders, including consumers who can offer unique knowledge and perspectives.

http://www.nasmhpd.org/content/technical-assistance-programs

NASMHPD oversees the SAMHSA National Center for Trauma Informed Care (NCTIC) (see above)

States' policy activities from NASMHPD

This agency has a webpage devoted to a glossary of Federal and State mental health websites.
http://www.nasmhpd.org/content/mental-health-links

The National Center for Trauma Informed Care (and alternatives to seclusion) (NCTIC)

This agency is funded by the SAMHSA Center for Mental Health Services (CMHS) through a contract with the National Association of State Mental Health Program Directors and its partner, Advocates for Human Potential, Inc.

NCTIC offers consultation and technical assistance, education and outreach, and resources to support a broad range of service systems, including systems providing mental health and substance abuse services, housing and homelessness services, HIV services, peer and family organizations, child welfare, criminal justice, and education[27].

Created in 2005, NCTIC is a long-term commitment by SAMHSA to improve public behavioral health services to consumers and trauma survivors. It supports several of SAMHSA's strategic initiatives, including Trauma and Justice and Recovery Support.
http://www.samhsa.gov/nctic/about

NCTIC provides training for policy makers, administrators, staff, leaders, peers, and individuals who have experienced traumatic events, as well as to others in order to implement trauma-informed approaches in a range of service systems, including mental health, substance abuse, criminal justice, victim assistance,

[27] http://www.samhsa.gov/nctic/about

peer support, education, primary care, domestic violence, child welfare, and others. Training may be offered virtually through virtual learning networks; webcasts and webinar; in-person over several hours or days to specific programs, agencies, or systems; or via downloadable technical assistance materials. NCTIC also provides technical assistance and consultation to support systems and programs that are committed to implementing trauma-informed approaches to service delivery. Technical assistance may help identify and implement some of the following steps that programs, agencies, or institutions can take to begin the transformation to a trauma-informed environment:

- Adopt a trauma-informed care organizational mission and commit resources to support it
- Update policies and procedures to reflect new mission
- Conduct universal trauma screening for all consumers and survivors
- Incorporate values and approaches focused on safety and prevention for consumers, survivors, and staff
- Create strengths-based environments and practices that invite consumer and survivor empowerment
- Provide ongoing staff training and education in trauma-informed care
- Improve and target staff hiring practices

With a better collective understanding of trauma, more consumers and survivors will find their path to healing and wellness. And with a greater public commitment to trauma-informed programs and systems for survivors, NCTIC lessens and prevents a wide range of health, behavioral health, and social problems for generations to come.
http://www.samhsa.gov/nctic/training-technical-assistance

National Child Traumatic Stress Initiative (NCTSI)

SAMHSA's National Child Traumatic Stress Initiative (NCTSI) improves treatment and services for children, adolescents, and families who have experienced traumatic events.
http://www.samhsa.gov/child-trauma

Congress, recognizing the serious mental health impact of traumatic events on children, adolescents, and families, authorized in 2000 the National Child Traumatic Stress Initiative (NCTSI), as part of the Children's Health Act. NCTSI's goal is to transform mental health care for children and adolescents affected by trauma throughout the country by improving the quality of community-based trauma treatment and services and increasing access to effective trauma-focused interventions.
NCTSI develops and implements:

- Evidence-based interventions to reduce the debilitating mental health impact of traumatic experiences on children and adolescents
- Collaborations with all systems of care where children and adolescents who have experienced trauma receive services
- Successful education and training approaches, including training practitioners in trauma-informed and evidence-based treatment and services
- Data collection and evaluation activities
- Education and awareness raising with policymakers regarding trauma, resilience, and recovery
- Product development for professionals, policymakers, families, youth, and the public
- Partnerships with youth, families, and other consumers

Download the trifold brochure, National Child Traumatic Stress Initiative: Helping Kids Recover and Thrive - 2015 (PDF | 9 MB). This brochure is also available in single-page form (PDF | 944 KB).

A Collaborative Approach

Through this initiative, a collaborative network of experts was created to further the development and dissemination of evidence-based clinical interventions for systems that serve children, adolescents, and families. The National Child Traumatic Stress Network (NCTSN)(link is external) is made up of SAMHSA representatives, in cooperation with four distinct groups of grantees and stakeholders:

- The National Center for Child Traumatic Stress (NCCTS)(link is external)works to promote leadership and collaboration across NCTSN and serves as a national resource center to disseminate NCTSN program and intervention products.
- Treatment and Service Adaptation centers identify, develop, support, and improve treatment approaches for different types of trauma that children and adolescents experience.
- Community Treatment and Services centers provide services to children who have experienced traumatic events by implementing and evaluating the effectiveness of trauma treatment and services in community and service system settings.
- Affiliate members, made up of more than 120 formerly funded NCTSN members, continue to contribute to the national mission and ongoing work in their states and local communities.

NCTSN Contributions

Since the program began in 2000, NCTSN has provided trauma treatment and services to hundreds of thousands of children and adolescents, with more than 200 grants awarded to 180 member centers. For example, funded grant sites during fiscal year 2014 provided evidence-based treatment to more than 41,000 people, including children, adolescents, and their families. During that time, the network provided training in the assessment and treatment of traumatic stress to more than 202,000 people, including mental health professionals, primary care providers and other professionals in child-serving systems, consumers, and the public.
http://www.samhsa.gov/child-trauma/about-nctsi

Trauma-Informed Screening & Assessment

Trauma Screening
Trauma Screening refers to a tool or process that is a brief, focused inquiry to determine whether an individual has experienced one or more traumatic events, has reactions to such events, has specific mental or behavioral health needs, and/or needs a referral for a comprehensive trauma-informed mental health assessment.

Trauma-Informed Mental Health Assessment
Trauma-Informed Mental Health Assessment refers to a process that includes a clinical interview, standardized measures, and/or behavioral observations designed to gather an in-depth understanding of the nature, timing, and severity of the traumatic events, the effects of those events, current trauma-related symptoms, and functional impairment(s). Clinicians use this to understand a child's trauma history and symptom profile; to determine whether a child is developmentally on target in the social, emotional, and behavioral domains; to inform case conceptualization and drive treatment planning; and to monitor progress over time.
http://nctsn.org/resources/topics/trauma-informed-screening-assessment

Examples of Trauma-Focused Mental Health Assessment Tools and/or Processes

- **Assessment-Based Treatment for Traumatized Children**: A Trauma Assessment Pathway (TAP) Model—Developed by the Chadwick Center for Children and Families (2009), with funding from the Substance Abuse and Mental Health Services Administration (SAMHSA), the Trauma Assessment Pathway (TAP) was designed for children 0 to 18 years of age who have

experienced any type of trauma and who may or may not be in the Child Welfare (CW) system. TAP is a multifaceted assessment process enabling clinicians to screen clients and, if appropriate for the treatment setting, to gain an in-depth understanding of the child, developmental level, traumatic experience, and the child's family, community, and cultural systems.

- **Child and Adolescent Needs and Strengths (CANS**)—Trauma Comprehensive Version—"CANS-Trauma" is a flexible, multi-purpose tool utilized in different capacities depending on the needs of a particular child-serving system (Kisiel, Lyons, et al., 2010). The CANS methodology is intended to gather information on a range of domains relevant to the functioning of the child and caregiving system (e.g., trauma experiences, traumatic stress symptoms, emotional/ behavioral needs, risk behaviors, life domain functioning, strengths, and caregiver needs and strengths) and incorporate this information directly into individualized plans of care (Lyons, 2004; Lyons & Weiner, 2009).

- **Transactional Model**—Spaccarelli (1994) proposed a transactional or interactive model for understanding the effects of child abuse (and its associated events) on the presentation of symptoms. This model examines factors related to the abuse of the child, as well as those associated with the investigation (i.e., disclosure events) and related events that may occur subsequent to, and/or due to, the investigation (e.g., placement outside the home and court hearings). Age, sex, and personality factors are identified as possible moderating variables that have the potential to effect the expression of a child's symptomatology. Social support, as well, plays an important role in recovery (Everson, Hunter, Runyon, Edelsohn, & Coulter, 1989). Finally, this model recognizes previous coping styles and cognitive appraisal schemes (i.e., the way a child organizes and understands events in his or her world) in terms of self-talk strategies and symptom maintenance. Individually and collectively, these factors influence expression of abuse/traumatic stress symptoms.
  http://nctsn.org/resources/topics/trauma-informed-screening-assessment/resources

National Child Traumatic Stress Network Empirically Supported Treatments and Promising Practices
The fact sheets linked from this page offer descriptive summaries of some of the clinical treatments, mental health interventions, and other trauma-informed service approaches that the National Child Traumatic Stress Network (NCTSN) and its various centers have developed and/or implemented as a means of promoting the Network's mission of raising the standard of care for traumatized youth and families. A few examples are below:

Intervention Descriptions

Click on each intervention fact sheet, culture specific sheet or training guideline to download detailed information on the intervention as well as where to obtain additional information. Interventions are listed in alphabetical order.

Name of Intervention	Targeted Populations	Modality	Culture-Specific Fact Sheet	Training Guidelines
Adapted Dialectical Behavior Therapy for Special Populations (DBT-SP) (2012) (PDF)	8-21; both males and females; for youth experiencing a wide range of traumas	individual	Yes	--
Alternatives for Families - A Cognitive Behavioral Therapy (AF-CBT) (2012) (PDF)	School-age children; for youth experiencing a wide range of traumas	individual, family	Yes	--
Assessment-Based Treatment for Traumatized Children: Trauma Assessment Pathway (TAP)(2012) (PDF)	0-18; both males and females; for children who have experienced a wide range of traumas	individual, family, systems	Yes	Yes
Attachment and Biobehavioral Catch-up (ABC) (2012) (PDF)	Birth – 24 months; both males and females; for low-income families who have experienced neglect, abuse, domestic violence, placement instability	individual, family	No	Yes

They note that individuals who wish to know the evidence supporting an intervention may search online databases such as the National Registry of Evidence-Based Programs and Practices (NREPP) and the California Evidence-Based Clearinghouse for Child Welfare (CEBC). These websites offer a rigorous review of interventions—and the evidence supporting them—for a variety of child and adolescent mental health problems. Those searching for an intervention to best match the needs of the populations they serve are encouraged to consider other interventions than those summarized here.
http://nctsn.org/training-guidelines

Trauma-Informed Approach

According to SAMHSA's concept of a trauma-informed approach, "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, procedures, and practices; and
4. Seeks to actively resist *re-traumatization*."

A trauma-informed approach can be implemented in any type of service setting or organization and is distinct from trauma-specific interventions or treatments that are designed specifically to address the consequences of trauma and to facilitate healing.

SAMHSA's Six Key Principles of a Trauma-Informed Approach

A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific:

1. Safety
2. Trustworthiness and Transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice and choice
6. Cultural, Historical, and Gender Issues

From SAMHSA's perspective, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Consistent with SAMHSA's definition of recovery, services and supports that are trauma-informed build on the best evidence available and consumer and family engagement, empowerment, and collaboration.

Trauma-Specific Interventions

Trauma-specific intervention programs generally recognize the following:

- The survivor's need to be respected, informed, connected, and hopeful regarding their own recovery
- The interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety
- The need to work in a collaborative way with survivors, family and friends of the survivor, and other human services agencies in a manner that will empower survivors and consumers

Known Trauma-Specific Interventions

Following are some well-known trauma-specific interventions based on psychosocial educational empowerment principles that have been used extensively in public system settings. Note that these interventions are listed for informational and educational purposes only. NCTIC does not endorse any specific intervention.

- Addiction and Trauma Recovery Integration Model (ATRIUM)
- Essence of Being Real
- Risking Connection®
- Sanctuary Model®
- Seeking Safety

- Trauma, Addiction, Mental Health, and Recovery (TAMAR)
- Trauma Affect Regulation: Guide for Education and Therapy (TARGET)
- Trauma Recovery and Empowerment Model (TREM and M-TREM)

http://www.samhsa.gov/nctic/trauma-interventions

Report November 2016: Surgeon General's First Report on Alcohol, Drugs & Health

"In 2015, over 27 million people in the United States reported current use of illicit drugs or misuse of prescription drugs, and over 66 million people (nearly a quarter of the adult and adolescent population) reported binge drinking in the past month.[1] Alcohol and drug misuse and related disorders are major public health challenges that are taking an enormous toll on individuals, families, and society. Neighborhoods and communities as a whole are also suffering as a result of alcohol- and drug-related crime and violence, abuse and neglect of children, and the increased costs of health care associated with substance misuse. It is estimated that the yearly economic impact of substance misuse is $249 billion for alcohol misuse and $193 billion for illicit drug use.[2,3]

Despite the social and economic costs, this is a time of great opportunity. Ongoing health care and criminal justice reform efforts, as well as advances in clinical, research, and information technologies are creating new opportunities for increased access to effective prevention and treatment services. This Report reflects our commitment to leverage these opportunities to drive improvements in individual and public health related to substance misuse, use disorder, and related health consequences.

Most Americans know someone with a substance use disorder, and many know someone who has lost or nearly lost a family member as a consequence of substance misuse. Yet, at the same time, few other medical conditions are surrounded by as much shame and misunderstanding as substance use disorders. Historically, our society has treated addiction and misuse of alcohol and drugs as symptoms of moral weakness or as a willful rejection of societal norms, and these problems have been addressed primarily through the criminal justice system. Our health care system has not given the same level of attention to substance use disorders as it has to other health concerns that affect similar numbers of people. Substance use disorder treatment in the United States remains largely segregated from the rest of health care and serves only a fraction of those in need of treatment. Only about 10 percent of people with a substance use disorder receive any type of specialty treatment.[1] Further, over 40 percent of people with a substance use disorder also have a mental health condition, yet fewer than half (48.0 percent) receive treatment for either disorder.[1]

Many factors contribute to this "treatment gap," including the inability to access or afford care, fear of shame and discrimination, and lack of screening for substance misuse and substance use disorders in general health care settings. Further, about 40 percent of individuals who know they have an alcohol or drug problem are not ready to stop using, and many others simply feel they do not have a problem or a need for treatment[1]—which may partly be a consequence of the neurobiological changes that profoundly affect the judgment, motivation, and priorities of a person with a substance use disorder".

- Report Highlights: At A Glance (PDF | 165 KB): A brief summary of main statistics and messages
- General Findings and Recommendations Fact Sheet (PDF | 455 KB): An overview of the central findings and significant recommendations
- Finding and Recommendation Fact Sheets for Different Audiences: Specific findings and recommendations are described for:
  - Individuals and Families (PDF | 454 KB)
  - Health Care Professionals and Health Care Systems (PDF | 168 KB)

- Communities (PDF | 206 KB)
- State, Local, and Tribal Governments (PDF | 162 KB)

- Reasons for Hope and Optimism
- The Time is Right For a Surgeon General's Report
- The Surgeon General's Report
- Conclusion

References:

1. Center for Behavioral Health Statistics and Quality. (2016). *Results from the 2015 National Survey on Drug Use and Health: Detailed tables*. Rockville, MD: Substance Abuse and Mental Health Services Administration.
2. Sacks, J. J., Gonzales, K. R., Bouchery, E. E., Tomedi, L. E., & Brewer, R. D. (2015). 2010 national and state costs of excessive alcohol consumption. *American Journal of Preventive Medicine, 49*(5), e73-e79.
3. National Drug Intelligence Center. (2011). *National drug threat assessment*. Washington, DC: U.S. Department of Justice.

Footnotes:

i. Binge drinking for men is drinking 5 or more standard alcoholic drinks, and for women, 4 or more standard alcoholic drinks on the same occasion on at least 1 day in the past 30 days.

https://addiction.surgeongeneral.gov/executive-summary

Report 2014: SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

The key questions addressed in this paper are:

- • What do we mean by trauma?
- • What do we mean by a trauma-informed approach?
- • What are the key principles of a trauma informed approach?
- • What is the suggested guidance for implementing a trauma-informed approach?
- • How do we understand trauma in the context of community?

"SAMHSA's approach to this task has been an attempt to integrate knowledge developed through research and clinical practice with the voices of trauma survivors. This also included experts funded through SAMHSA's trauma-focused grants and initiatives, such as SAMHSA's National Child Traumatic Stress Initiative, SAMHSA's National Center for Trauma Informed Care, and data and lessons learned from other grant programs that did not have a primary focus on trauma but included significant attention to trauma, such as SAMHSA's: Jail Diversion Trauma Recovery grant program; Children's Mental Health Initiative; Women, Children and Family Substance Abuse Treatment Program; and Offender Re-entry and Adult
Treatment Drug Court Programs".
http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf

Federal Focus on Trauma Informed Care

More child welfare agencies are using a trauma informed approach to serve children and families. They are considering the impact of traumatic events, such as maltreatment, domestic violence, being

separated from loved ones, and the effects of poverty, on children and families and incorporating practices that acknowledge the effects of current and intergenerational trauma.

During the past decade, the U.S. Department of Health and Human Services (HHS) has emphasized the use of trauma-informed care by agencies and professionals. It funded grants focusing on this approach, such as the Promoting Well-Being and Adoption After Trauma cluster (2013) and the Integrating Trauma-Informed and Trauma Focused Practice in Child Protective Service (CPS) Delivery cluster (2011).
https://cbexpress.acf.hhs.gov/index.cfm?event=website.viewArticles&issueid=132&articleid=3392

HHS also has incorporated trauma-informed care into its guidance to States, including a letter to all the directors of State and Tribal child welfare agencies
http://www.hhs.gov/secretary/about/blogs/childhood-trauma-recover.html

Child Welfare Information Gateway

https://www.childwelfare.gov/

This agency is funded by: Children's Bureau, Administration for Children and Families, and U.S. Department of Health and Human Services.

Trauma-Informed Practice

To provide trauma-informed care to children, youth, and families involved with child welfare, professionals must understand the impact of trauma on child development and learn how to effectively minimize its effects without causing additional trauma. This section provides information on building trauma-informed systems, assessing and treating trauma, addressing secondary trauma in caseworkers, and trauma training. It also offers trauma resources for caseworkers, caregivers, and families.

- Building trauma-informed systems and policy issues
- Screening and assessment of trauma in children and youth
- Treatment
- Resources for caseworkers
- Resources for caregivers and families
- Secondary trauma

This agency has a huge range of resources, for example:

Report 2013: Conceptualizing a Trauma Informed Child Welfare System for Indian Country

"This report focuses on the design and development of trauma-informed systems in Indian Country. Because place matters (in this case, often-isolated and under-resourced reservation communities) and so do the people needing to be served (American Indian and Alaska Native children), trauma informed systems for these special people in their somewhat unique
locales must prioritize a fourth kind of intervention.

Indigenous healing practices with hundreds of years of tradition must be prioritized and incorporated as facilitators for culturally-competent practice and also as safeguards against colonialism (Gray, Coates, Yellow Bird, &
Hetherington, 2013). The analysis begins with the context of the child welfare system and a special focus on trauma in Indian Country and the child welfare systems structured to address and prevent it" (p.4).
http://digitalcommons.library.tmc.edu/cgi/viewcontent.cgi?article=1257&context=jfs

Report 2015: Preparing a Trauma Consultation in your Juvenile and Family Court

This report explains why juvenile and family courts should be trauma-informed and describes the conceptual and operational framework of the Trauma Consultation Team. Questions are then posed that courts can consider in deciding whether their juvenile or family court is ready for a trauma consultation.
http://www.ncjfcj.org/sites/default/files/NCJFCJ_Trauma_Manual_04.03.15.pdf

Report 2015: Going Beyond Trauma Informed Care (TIC) Training for Child Welfare Supervisors and Frontline Workers: The Need for System Wide Policy Changes Implementing TIC practices in all Child Welfare Agencies

Implications for practice:
"*Because agencies and workers are often entrenched in existing organizational culture, the agency interested in transforming to an agency that practices trauma informed care may find the transformation easier and smoother by employing an outside expert consultant in trauma informed practice (Heffernan & Blythe, 2014). Such a consultant provides both expert insight and encourages the agency to think beyond what they already know.*

By becoming embedded in the agency the consultant can learn from all employees how they currently carryout their daily practices, observing the culture to learn their espoused values and underlying assumptions that guide daily practices, in order to build on the agency's strengths while educating them about trauma theory. The trauma informed consultant can help the agency to reflect on current policies and practices while encouraging the full incorporation of trauma informed policies and practices helping to get everyone's buy-in" (p.51).
http://soar.wichita.edu/bitstream/handle/10057/11285/AGv1%283-4%29Heffernan_Vigianni_2015.pdf?sequence=1

A TARGETed© Approach to Working With Traumatized Youth and Families Program Manual

Illinois Department of Children and Family Services (2016)

Details the implementation process of the Illinois Trauma Focus Model for Reducing Long-Term Foster Care project in order to assist others in adapting the process for local use. This manual discusses staff and client recruitment strategies as well as data-driven decision-making related to program implementation.

http://www.acf.hhs.gov/cb/resource/pii-targeted-approach-program-manual

Report 2015: Understanding the Effects of Maltreatment on Brain Development

Provides basic information on brain development and the effects of abuse and neglect on that development. The information is designed to help professionals understand the emotional, mental, and behavioral impact of early abuse and neglect in children who come to the attention of the child welfare system.
https://www.childwelfare.gov/pubPDFs/brain_development.pdf

http://www.mcsilver.org/wp-content/uploads/2015/05/TIC-Implementation-Report.pdf

Examples of State agencies and activities

Report 2106: Examples of brain science-infused policies from the U.S. and Alberta: U.S. State legislation by the Alliance for Strong Families and Communities

1. In 2013, Wisconsin unanimously passed Senate Joint Resolution 59, stating that all "policy decisions enacted by the Wisconsin state legislature will acknowledge and take into account the principles of early childhood brain development and will, whenever possible, consider the concepts of toxic stress, early adversity, and buffering relationships, and note the role of early intervention and investment in early childhood years as important strategies to achieve a lasting foundation for a more prosperous and sustainable state through investing in human capital." Several states, including California used Wisconsin's language to pass similar legislation. [Values 2 & 4; Principle c]

2. With bipartisan support, the Washington State legislature passed the Early Start bill in 2015, with a $158 million investment in the 2015-17 budget to help ensure all children have a great start. The preamble to the bill included the following language: INTENT. (1) The legislature finds that quality early care and education builds the foundation for a child's success in school and in life. . . .The legislature acknowledges that critical developmental windows exist in early childhood, and low quality child care has damaging effects for children. . . The legislature acknowledges that the early care and education system should strive to address the needs of Washington's culturally and linguistically diverse populations. The legislature understands that parental choice and provider diversity are guiding principles for early learning programs. [Values 2, 3 & 6; Principle c]

3. Louisiana, South Carolina, Illinois, Connecticut, Massachusetts, New Hampshire and Mississippi as part of a national "raise the age" movement are increasing the age of criminal responsibility for juveniles to 18, a result in part, of the growing neurological evidence that young people's brains are different from adult brains. [Values 5 & 7; Principle e] U.S. State-level policy efforts

4. A three-year initiative in Tennessee aims to encourage government and private organizations to revise their policies and create innovative practices focused on ways to strengthen the social and emotional health of families, reduce the impact of toxic stress on young children, and take steps to ensure Tennessee children have safe, stable, nurturing environments. [Values 2, 4, 8, 9 & 10] U.S. National executive action

5. In January 2016, President Obama adopted the recommendations put forth by the U.S. Department of Justice to reform the federal prison system. The recommendations included banning solitary confinement for juvenile offenders in federal prisons citing the potential devastating psychological implications on the adolescent brain. This policy is informed by scientific understandings of development, which include adolescence as an intense period of construction in the building of the brain. [Values 5 & 7; Principle e] U.S. Local legislation

6. Best Starts for Kids is an initiative of the King County, Washington County Executive to improve the health and well-being of King County by investing in prevention and early intervention for children, youth, families, and communities. Voters approved a levy that will generate about $65 million per year and cost the average King County property owner an estimated $56 per year, which is about one dollar per week. It will be the most comprehensive approach to early childhood development in the nation, starting with prenatal support, sustaining the gain through teenage years, and investing in healthy, safe communities that reinforce progress. [Values 2, 4, 9 & 10; Principles c & e] Alberta Provincial legislation and administrative initiatives

7. In 2013, Alberta released a province-wide initiative, Together We Raise Tomorrow: An Alberta Approach to Early Childhood Development to support the well-being, safety, security, education, and health of all children in Alberta by focusing on early childhood development. With this initiative, the government set out to build on the principles of Alberta's Social Policy Framework to create a children's charter, a poverty reduction strategy, and to move forward with the Alberta Approach to Early Childhood Development. With these, the government wishes to "improve maternal, infant and child health to support healthy pregnancies," provide parents with "access to leading edge early years information… to support their child's development," and "assist families experiencing periods of vulnerability to provide healthy, safe, nurturing experiences for their children." [Values 2, 4, & 9; Principles a, b, & c]

8. Alberta's Addiction and Mental Health Strategy is working to transform the addiction and mental health system in the province with the goal of reducing the prevalence of addiction, mental health problems, and mental illness through health promotion and prevention activities. Since the government now knows that "exposure to chronic early stressors creates an exaggerated stress response in the brain and body that may erode the solid foundation on which mental health develops" (Creating Connections: Alberta's Addiction and Mental Health Strategy, 2011), strategic directions include building healthy and resilient communities and fostering the development of healthy children, youth and families. [Values 4, 5 & 10; Principle e]

9. In December 2015, the Alberta Mental Health Review Committee released its Valuing Mental Health report which identifies priorities that include increasing integration of services, measuring progress towards a person-centered system, and a focus on prevention and early intervention. The report specifically identifies actions that include reducing barriers to information sharing and "integrated care planning", "educating the public on brain development, and risk and protective factors related to addiction and mental illness," and, "strengthening skills and abilities of service providers to provide Trauma Informed Care." [Values 2, 5, & 8] Alberta initiatives and reports

10. The Premier's Council on Alberta's Promise Act is an initiative to encourage organizations, corporations and individuals to enhance community resources in order to further the well-being of children. The Act states that the council shall, in the context of furthering the well-being of

children, “provide leadership in promoting the development of community strategies, raise awareness of the shared responsibility of organizations, corporations and individuals, and encourage financial and other support initiatives and research.” [Values 8, 9, & 10; Principle e]

11. The Foundations of Caregiver Support was released in Alberta in June 2015. The intent of the document is to, “provide a base from which to develop caregivers’ capacity to improve positive outcomes for infants, children and youth” who are within Child and Family Services (CFS) custody in Alberta.

The document identifies three pillars of knowledge that are foundational in this pursuit: 1) Child development – brain development and the influence of epigenetics; 2) Trauma – the effect on children; and 3) Loss and grief – experiences of children and youth. The document highlights the critical role of the caregiver in shaping brain architecture. [Values 2 & 5; Principles a & b]
http://alliance1.org/sites/default/files/PDF/designcim_science_infused_policy.finalsept272016.pdf

Philadelphia

Philadelphia I taking a city-wide approach to recover and trauma.

“Welcome to Philadelphia’s Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) Website. The City of Philadelphia has integrated its behavioral health care and intellectual disability services into one comprehensive system”. This is led by Commissioner Arthur C. Evans who is part of the IIMHL network.
http://dbhids.org/

Arthur C Evans Commissioner gave a presentation in 2015 in Vancouver to IIMHL leaders at the Combined Meeting which is part of the week long Leadership Exchange.

“Keywords:

- **Single Commissioner** – policy, strategy / planning, commissioning of services
- **Transformation** – an overt statement of intent (a decade of transformation)
- **Trauma Informed** – practice and development
- **Mental Health Literacy** – public health / community engagement; a priority
- **Recovery** – a core and cohesive concept that connects and engages and normalises people’s experience of challenges in life

He shared how this city approached a transformation; e.g:

- Philadelphia - one of the highest homicide and poverty rates in the U.S. (Since 2001: 4,400 people murdered; more than 20,000 people shot.)
- DBHIDS - reconstituted from 3 city agencies. is responsible for policy and strategic development; the sole purchaser of mental health, disability, alcohol and addiction services across Philadelphia
- Rather than making incremental changes, in 2005 DBHIDS overtly embarked upon a “decade of transformation”; Utilising the Sanctuary Model, Trauma Focused CBT models, and Public Health models to inform change, service development and delivery
- “Our goal isn’t just symptom reduction. It’s recovery, and since people recover in a community, we also need a continuum of recovery support services like housing, education, social support, and employment.”

- Engagement, partnering, supporting community capability / capacity… mental health literacy initiatives led these endeavours. “Mental Health First Aid” is a flagship programme”

http://www.iimhl.com/files/docs/20160204a.pdf

From the DBHIDS website:

The DBHIDS management team and our employees embrace a vision of recovery, resilience, and self-determination. We continue to shift to a model of care directed by the person in recovery. In this model, professional treatment is one aspect among many that supports people in managing their own conditions while building their own recovery resources. This recovery process should be viewed as a lifetime journey.

Transformation to a recovery orientation in both addictions and mental health becomes possible by focusing on the central role of individuals and families in responding to, managing, and overcoming these serious illnesses. This focus must be an organizing point for the entire system.
http://dbhids.org/about/

We provide effective, compassionate care and services for children and adults with intellectual disability, mental illness, and/or substance abuse issues. Working in partnership with individuals, families, and communities, we provide an array of services to help people face the challenges of daily life and take positive steps toward recovery and self-determination.

A vast network of provider agencies offers a full range of treatment options, including individual and family therapy, group therapy, and crisis intervention services to assist individuals and their families in emergency situations. Our services and supports are aimed at promoting resilience, recovery and wellness in children, youth, adults and families. http://dbhids.org/services/

PACTS is a network of child serving systems and organizations, under the leadership of the Philadelphia Department of Behavioral Health and Intellectual disAbility (DBHIDS), that provides the most effective practices for traumatized youth and their families.
http://www.philadelphiapacts.org/

Report 2013: The Practice Guidelines for Resilience and Recovery Oriented Treatment, DBHIDS

The Practice Guidelines represents the evolution of Philadelphia’s behavioral health system. Together people in recovery, their family members, treatment providers, advocates and system administrators have developed a shared vision which has been blended with the lessons learned from Philadelphia’s transformation efforts over the past 30 years.

The guidelines apply to all treatment providers and individuals who are reimbursed for working in a provider organization at all levels of care. However, they are not intended to encapsulate all possible services or supports that promote recovery and resilience.

The guidelines are designed to help our system in delivering services and supports that promote **recovery, resilience**, and **self-determination** in children, youth, adults, and families.
http://dbhids.org/practice-guidelines#tab-id-1

10 core values

One of these is:

Trauma-Informed Approaches: All components of the service system are designed with an understanding of the role that serious adverse experiences can play in the lives of individuals and families. Services are delivered in safe and trustworthy environments and through respectful, nurturing relationships, to promote healing and avoid inadvertent retraumatization. Individuals and families are always assessed for the extent to which the spectrum of traumatic experiences may have affected their lives and their ability to participate safely in care and establish recovery. They are offered services and supports that will help them reduce the destructive effects of traumatic experiences and maximize the growth that can emerge from the healing process.

Four Domains

- Assertive outreach and initial engagement
- Screening, assessment, service planning and delivery
- Continuing support and early re-intervention
- Community connection and mobilisation

To make these practice guidelines useful for real human beings doing real work, the action-oriented strategies within each of the four domains have been organized under **seven functional goals.**

- Provide integrated services
- Create an atmosphere that promotes strength, recovery and resilience
- Develop inclusive, collaborative service teams and processes
- Provide services, training and supervision that promote recovery and resilience
- Provide individualized services to identify and address barriers to wellness
- Achieve successful outcomes through empirically informed approaches
- Promote recovery and resilience through evaluation and quality-improvement processes

http://dev.dbhids.org/wp-content/uploads/2015/07/practice-guidelines-1-1.pdf

Website 2016: Philadelphia Children's Hospital

This website has good information on ACEs and trauma informed care for providers of care.

Providing Psychosocial Care as a Healthcare Provider

As a health care provider, you have an opportunity, and many of the basic skills, to make a difference in how children and their families experience illness, injury, and the medical and psychosocial care they receive.

Opportunities to provide psychosocial care to patients by using trauma-informed care arise at each phase of medical treatment – from new diagnosis or emergent treatment through ongoing treatment of chronic illness or sequelae of injury. However, not every child and family will require the same level of psychosocial care. Similar to a public health prevention model, trauma-informed care can be grouped into three distinct levels, each with differing implications for intervention:

- **UNIVERSAL PSYCHOSOCIAL CARE:** Research shows that the majority of ill or injured child are families are distressed but resilient. Many simply need information, comfort, and support in mobilizing their own resources. The D-E-F Protocol (below) is an excellent guide to helping children and families help themselves after medical trauma.

- **TARGETED PSYCHOSOCIAL CARE:** A smaller number of children and families with acute distress may need to be monitored and may require interventions that focus on reducing symptoms of traumatic stress or promoting adjustment or adherence to medical treatment.
- **CLINICAL PSYCHOSOCIAL CARE / TREATMENT:** Only a small minority of children and families will experience distress severe enough to impede active medical treatment. These families may require intensified psychosocial services and/or mental health treatment.

https://www.healthcaretoolbox.org/what-providers-can-do.html

For more detail:
https://www.healthcaretoolbox.org/what-providers-can-do/d-e-f-protocol-for-trauma-informed-pediatric-care.html

A huge list of resources for trauma informed care
https://www.healthcaretoolbox.org/search.html?q=trauma+informed+care

Pacific County

Report 2015: Adverse Childhood Experiences, Trauma Informed Care, and Resilience: Findings, Policies, and Assessments for Pacific County

http://www.wellspringpacific.org/uploads/5/8/7/9/58797525/pacific_county_aces_report.pdf

This is an excellent reference document. The executive summary states:

The terms adverse childhood experiences (ACEs), trauma-informed care (TIC), and resilience are commonly grouped together – some literature might even use them interchangeably. As knowledge in this subject matter continues to emerge and further research is published, consistency is lacking with regards to the use of the terminology. Washington State currently leads the nation's ACEs efforts in both research and practice; it was the first to pass legislation directed at ACEs prevention.

The state's leading ACEs organizations, the Foundation for Healthy Generations and its subsidiary (the ACEs Learning Institute), are pioneering a new approach to adverse childhood experiences and health called Neuroscience Epigenetics ACEs Resilience (NEAR) Science Education. In this report, we use the term "ACEs" while referring to the study of ACEs and their significance or the adverse experiences themselves; we use "trauma-informed care" and "resilience-based approaches" as intervention strategies to combat the effects of ACEs. Semantics aside, trauma-informed care, resilience, and ACEs are all attempts to look at upstream factors originating in childhood that lead to significantly worse health behaviors and outcomes later in life. As a community, moving forward from adverse experiences and trauma is achieved through building resilience. Though there is much to be discovered about the nature of resilience, it is an unquestionably significant topic of interest for researchers "exploring the channels of moderation and prevention of ACEs for adults and children."

Harvard University's National Scientific Council on the Developing Child promotes the idea that resilience is a tool; and when adopted by children at an early age it becomes a part of their normative behavior as they enter adulthood. Resilience-based approaches to ACEs then become intervention strategies at the individual, family, agency, or community level. These approaches utilize development of resilience in combating the long-term detrimental health effects of ACEs.

Methods

We reached out to a total of 33 people and were able to conduct a total of 20 interviews, 16 in-person and 4 over the phone.

Findings

From the various community stakeholders we interviewed, we learned that there is a genuine investment within the community to obtain training on ACEs and trauma-informed care approaches. The various stakeholders we spoke with recognized the perilous, intergenerational nature of ACEs within Pacific County. Many organizations have at least one individual who is either currently practicing trauma-informed approaches or is knowledgeable about ACEs. Specifically, we noticed that the School District and Law Enforcement already bring a trauma informed approach to their work, though they might not know it as such. We learned from several department heads that they would like their whole staff formally trained on what ACEs are, in order to implement trauma informed care and resilience based approaches. The sentiment seemed to be the sooner, the better.

Key Recommendations

Full Community Involvement

- Invite underrepresented communities to the table, such as the Hispanic/Latino community, seasonal workers, and the Shoalwater Bay Tribe.
- Center the youth voice by gathering their insight, prioritizing their vocalized needs/interests, and formally including them via a spot on WellSpring's leadership team or a newly formed youth advisory council.

Focus on Pacific County's Strengths

- Identify the community's assets, subject matter experts, and influencers and leverage them in building a community-wide approach to ACEs/TIC/Resilience.
- Build new partnerships and collaborations and revive old relationships, such as previous work with Ron Hertel of the Compassionate Schools initiative from the Office of Superintendent of Public Instruction (OSPI).
- Leverage membership in the Cascade Pacific Action Alliance.

Make ACEs, Trauma-Informed, and Resilience-Based Work Accessible for All

- Make meetings and trainings available via conference call or webinar to accommodate community members and professionals in all parts of Pacific County.
- Make necessary accommodations for community members who may be elderly, non-English speaking, require child care, or have non-traditional/seasonal work schedules.
- Employ a "train the trainer" model to expand training capabilities within community.
- Hold monthly community meetings open to the public.

Apply a Health Equity and Social Justice Lens

- Recognize that the 3 categories of ACEs do not reflect the totality of adverse experiences or trauma experienced by communities that are diverse in terms of culture, ethnicity, family structure, or socioeconomic status
- Acknowledge that poverty is not an ACE, yet it may play a prominent role in the lives of Pacific County community members and should be seriously considered, and that a disproportionate number of minority individuals experience poverty in Pacific County.

Policies

We reviewed a variety of policies, approaches, and strategies that have been implemented or recommended as ways to prevent ACEs and build resilience. Our efforts in this research were to focus on policies and strategies that may be applicable to Pacific County's unique nature.
We selected the following sector-specific policy examples that Pacific County can use as a guide in their work on ACEs response:

- **Education**

  Compassionate Schools: The Heart of Learning and Teaching
  http://www.k12.wa.us/compassionateschools/
  Trauma Sensitive Schools
  https://traumasensitiveschools.org/

- **Health Care**

  The Health Center- Walla Walla, WA http://thehealthcenterww.org/
  Early Learning o Trauma Smart http://traumasmart.org/

- **Social Services**

  NEAR@Home https://thrivewa.org/nearhome-toolkit-guided-process-talk-trauma-resilience-home-visiting/

- **Courts, Child Welfare, Law Enforcement**

  Zero to Three: Safe Babies Court Teams
  https://www.zerotothree.org/resources/services/safe-babies-court-teams
  Healing Invisible Wounds: Policy Brief
  http://www.justicepolicy.org/images/upload/10-07_REP_HealingInvisibleWounds_JJ-PS.pdf
  Trauma and Resilience: A new look at legal advocacy for youth in the juvenile justice and child welfare systems
  http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf414703

- **Behavioral Health**

  Oklahoma Department of Mental Health and Substance Abuse Services: SHARE Model
  https://www.ok.gov/odmhsas/Mental_Health/SHARE/index.html

We also evaluated community level approaches and found the following community-wide initiatives to be applicable and useful to Pacific County:

Washington State ACEs Public-Private Initiative http://www.appi-wa.org/

Okanogan County Community Coalition
http://www.okcommunity.org/

Skagit County Child & Family Consortium
http://www.sccfc.org/

Walla Walla Co Community Network / Children's Resilience Initiative
http://resiliencetrumpsaces.org/
Whatcom Family Community Network http://wfcn.org/

Assessments

We looked for organizational assessment tools that were easy to use, were relevant for many sectors, promoted action and implementation, and valued diversity. In our research, we came across 14

assessment tools (full list in Appendix), and highlighted 3 we thought would be useful for Pacific County.

- Trauma-Informed Organizational Toolkit - National Center on Family Homelessness
http://www.air.org/center/national-center-family-homelessness
- Standards of Practice for Trauma Informed Care - Trauma Informed Oregon
http://traumainformedoregon.org/wp-content/uploads/2014/10/Standards-of-Practice-for-Trauma-Informed-Care.pdf
- Organizational Self-Assessment: Adoption of Trauma-Informed Care Practice - National Council for Behavioral Health
https://www.nationalcouncildocs.net/wp-content/uploads/2014/01/OSA-FINAL_2.pdf

http://www.wellspringpacific.org/uploads/5/8/7/9/58797525/pacific_county_aces_report.pdf

Connecticut

Child Health and Development Institute, Farmington, CT

The Child Health and Development of Connecticut (CHDI), a subsidiary of the Children's Fund of Connecticut, is a not-for-profit organization established to promote and maximize the healthy physical, behavioral, emotional, cognitive and social development of children throughout Connecticut. CHDI works to ensure that children in Connecticut, particularly those who are disadvantaged, will have access to and make use of a comprehensive, effective, community-based health and mental health care system.

http://www.chdi.org/files/7514/4405/4524/Trauma_IMPACT_-_FINAL.pdf

Connecticut has made significant progress to ensure that trauma-informed care is part of its child welfare system. The majority of children in the child welfare system have been exposed to trauma, including physical abuse, sexual abuse, and chronic neglect. The costs of maltreatment and trauma to children, families, and society at large are profound:

- Each year in the United States, more than 6 million referrals are made to the child welfare system and more than 600,000 of these children are determined to be substantiated victims of abuse or neglect.
- Among children in the child welfare system, 85% have been exposed to at least one potentially traumatic event and most have experienced multiple forms of trauma.
- Children exposed to trauma experience significantly higher rates of chronic health and mental health problems, impaired academic performance, and involvement with juvenile justice and adult criminal justice systems.
- The costs to society of children maltreated in a single year are $124 billion in future healthcare and social service costs.

Trauma-Informed Care Leads to Cost Savings and Better Outcomes for Children

As policymakers and providers have gained a better understanding of the adverse effects of trauma exposure and the benefits of treatment, there has been increasing support at the national and state level for early identification, intervention, and development of sustainable systems that support "trauma-informed care." The goal of trauma-informed care is to enhance systems to better understand,

identify, and serve children exposed to trauma through efforts including training, screening, policy development, and access to evidence-based interventions.

Connecticut's Approach to Addressing Trauma

The Connecticut Department of Children and Families (DCF) has emerged as a national leader in addressing childhood trauma. In 2011, the federal government awarded DCF with a 5-year $3.2 million grant to develop the Connecticut Collaborative on Effective Practices for Trauma (**CONCEPT**).

Support for CONCEPT was provided by the Department of Health and Human Services, Administration for Children and Families, Children's Bureau, Grant #90CO1069. Partners include DCF, the Child Health and Development Institute, which serve as the Coordinating Center, and The Consultation Center at Yale University, which serve as the CONCEPT evaluator.
The CONCEPT initiative has helped to advance four core components of a trauma-informed child welfare system:

- **Workforce development**: More than 2,300 DCF staff members have received a required, comprehensive training in childhood trauma using the National Child Traumatic Stress Network's (NCTSN) Child Welfare Trauma Training Toolkit. Training evaluations demonstrate significant improvements in DCF staff knowledge and practices concerning trauma.
- **Trauma screening**: All children aged 6 and older who are placed into DCF care are now administered the Connecticut Trauma Screen (CTS). The CTS is a 10-item screening measure for children 6 to 17 years old that examines trauma experiences and symptoms and can be administered by professionals in child welfare, juvenile justice, health, and behavioral health systems. More than 2,400 children have been screened to date (800 in child welfare), and referrals for specialty trauma-focused services are being made.

- **Dissemination of evidence-based treatments**: CONCEPT has helped to support training of **30 agencies** and more than 600 clinicians to offer Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and the Child and Family Traumatic Stress Intervention (CFTSI). More than 5,500 children across Connecticut have received these treatments, including many involved in the child welfare system. Evaluation outcomes indicate significant reductions in symptoms of posttraumatic stress and depression.

- **Trauma-informed policy**: The CONCEPT initiative has contributed to modifications of 34 DCF policies and practice guides to better address childhood trauma. For example, policies related to immigrant children, foster and adoptive services, and transgender youth and caregivers have been revised to ensure that DCF caseworkers consider children's exposure to trauma and how it may affect their current functioning.

Recommendations for Advancing a Trauma-Informed Child Welfare System
Through CONCEPT, Connecticut has helped improve outcomes for children exposed to trauma by leading enhancements in the areas of workforce development, screening, evidence-based treatments, and policy changes. Recommendations for furthering trauma-informed care in the child welfare system include:

- Expand collaboration between the child welfare and behavioral health systems through cross-training and alignment of case plans and services across systems
- Expand trauma screening for all children who come into contact with the child welfare system, including children under age 6 and children who are not placed out-of-home

- Advance policy and reimbursement strategies that support dissemination and sustainability of evidence-based treatments, including models specifically designed for children under age 6
- Support research to better understand the effects of trauma informed care on child and family outcomes

http://www.chdi.org/index.php/publications/issue-briefs/issue-brief-49

Report 2015: IMPACT: ADVANCING TRAUMA INFORMED SYSTEMS FOR CHILDREN Lang et al

"*There is now emerging evidence that investments in trauma-focused services and systems can be recouped through reduced health care costs in as little as one year. Preventive services that promote a secure relationship between young children and their caregivers can provide a lasting buffering effect to enhance resiliency and may prevent trauma exposure from occurring in the first place. Early identification of children suffering from trauma exposure and enhancing access to effective trauma-informed services can minimize the consequences of trauma exposure and promote healthy development.*

Together, these elements comprising "trauma-informed care" have the potential to improve outcomes for all children and to dramatically reduce service and system utilization costs over longer periods of time. This IMPACT provides a framework for developing a comprehensive and integrated trauma-informed system of care for children. Examples are provided from Connecticut's child-serving systems implementing trauma-informed programs and services. This report is intended to help child serving systems advance trauma-informed care in order to provide more effective and cost-efficient services that result in better outcomes for all children" (p.4)

"Fifteen years ago, the lack of awareness and training about trauma and its impact in the human services could only be described as system-wide dissociation. Today, the growing movement toward trauma-informed care represents a systemic willingness to KNOW about the pain and suffering caused by trauma and begin addressing it in a holistic way that is healing rather than retraumatizing."

Steve Brown, Psy.D. Traumatic Stress Institute Klingberg Family Centers

Progress in Connecticut since 2007

- more than 8,600 professionals have been trained to understand childhood trauma
- at least 35 community agencies or programs at 79 sites have implemented trauma screening
- more than 900 clinicians have been trained through statewide initiatives to conduct trauma assessments and provide trauma-focused EBPs
- more than 50,000 children have been screened for trauma
- more than 8,700 children have received a trauma-focused EBP

http://www.chdi.org/files/7514/4405/4524/Trauma_IMPACT_-_FINAL.pdf

August 2016

The first author contacted Jason Lang of the above Institute via IIMHL Child and Adolescent ongoing group. I asked him what they did to get work underway, and he said:

The first steps that helped get things going:

1 "*We held a statewide Trauma Summit early on that was a catalyst for this work. We invited local stakeholders (providers, child welfare, state partners, family partners, academic experts) and included an outside trauma expert to present on what trauma informed care is and to help facilitate. This generated some good discussion about a) what resources were already available/in place that everybody may not have been aware of, and b) next steps for developing trauma informed systems. I'd suggest that this could be used to develop a steering committee/core team that could continue to drive an ongoing agenda related to trauma informed care.*

2 *The state contributed funding to disseminate a trauma-focused evidence-based treatment for children (TF-CBT) to community providers. This initial dissemination made treatment available across much of the state. This helped address a common concern about trauma informed care ("who do we refer children to?"), since by the time we began training staff in child welfare, juvenile justice, pediatrics, schools, etc. we already had some services in place.*

3 *We began with sustainability – from the initial dissemination of TF-CBT, plans were put in place for a way to ensure that providers had ongoing training/QA/data reporting support to sustain treatment. Collecting and reporting on data from the beginning allowed us to show the benefits to children receiving services, and thus to advocate for continued funding to support expansion".*[28]

To note:

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) is a components-based trauma treatment designed to treat posttraumatic stress and related emotional and behavioral problems in youth ages 3–18. It is appropriate for single incident or multiple trauma exposure as well as for children experiencing complex trauma. TF-CBT is, to date, the most widely evaluated treatment for trauma in children, with over 13 clinical trials demonstrating its efficacy and effectiveness, including two ongoing international clinical trials in progress. It has been used with children exposed to a range of different types of trauma across a variety of geographic, ethnic, religious, and socioeconomic strata.

TF-CBT is composed of several major components designed to be conducted across 12–18 treatment sessions:
Psychoeducation;
Parenting Skills;
Relaxation;
Affective Expression and Modulation;
Cognitive Coping;
development of a Trauma Narrative and Cognitive Processing of the Trauma Narrative;
In Vivo Exposure;
Conjoint Child–Parent Sessions; and
Enhancing Future Safety and Development (PRACTICE).

The components are implemented sequentially, each building off the previous component. For children experiencing complicated or complex trauma, applications of TF-CBT are adjusted to include relaxation training and safety planning at the beginning of treatment, and treatment length is generally longer (e.g., 25 to 30 sessions) (Cohen, Mannarino, & Deblinger, 2012; Cohen, Mannarino, Kliethermes, & Murray, 2012)(cited in Fraser et al).
http://www.traumacenter.org/products/pdf_files/Trauma-informed_child_welfare_MA_G0001.pdf

[28] Jason Lang, email communication, August 2016

Learn more about our current trauma-related initiatives, which include:

- **Trauma Focused Cognitive Behavioral Health (TF-CBT)**
- **Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH)**
- **Child and Family Traumatic Stress Intervention (CFTSI)**
- **The Connecticut Collaborative on Effective Practices for Trauma (CONCEPT)**
- **Cognitive Behavioral Intervention for Trauma in Schools (CBITS)**
- **Connecticut Trauma Screen (CTS)**

Additional trauma-related initiatives CHDI helped support include:

- **Child First**
- **REACT (Responding to Children of Arrested Parents Together)**

http://www.chdi.org/our-work/mental-health/trauma-informed-initiatives/

California

San Francisco: Center for Youth Wellness

Dr Nadine Burke-Harris leads this agency (see TED talk earlier in this report)

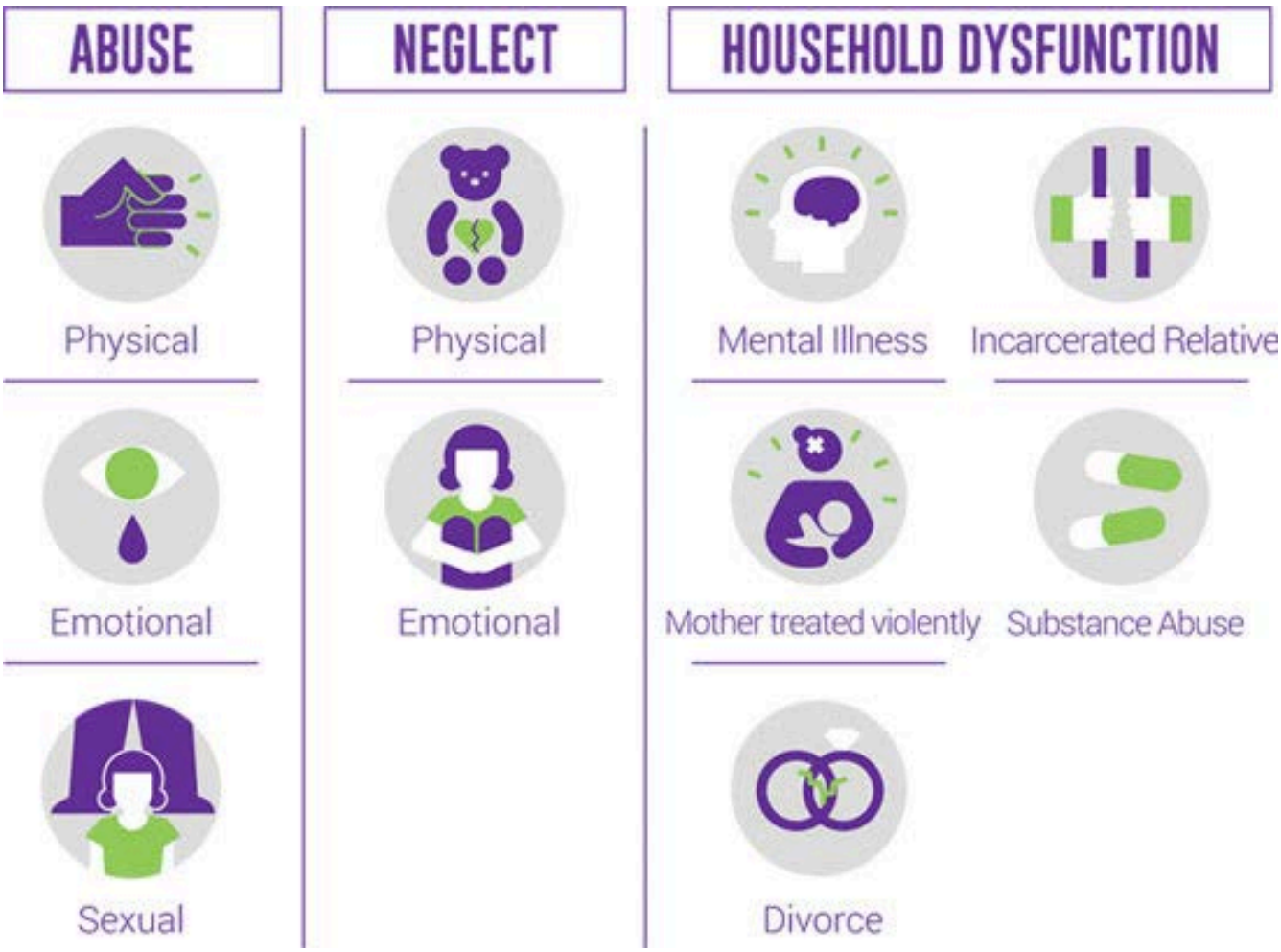
OUR MISSION IN THE FIGHT AGAINST ACES AND TOXIC STRESS IS THREE-FOLD: PREVENT, SCREEN AND HEAL.

Prevent:
We are helping to prevent toxic stress by raising national awareness among those who have the power to make a difference.

Screen
We screen all kids who walk through the Center's doors for Adverse Childhood Experiences (ACEs) and toxic stress.

Heal
We are a national leader in
developing the best ways to heal kids
experiencing toxic stress.

We are a national leader in developing the best ways to heal kids experiencing toxic stress.



http://www.centerforyouthwellness.org/#

We provide a variety of carefully coordinated mental health and wellness interventions to address the impact of ACEs and toxic stress. These interventions are guided by a multidisciplinary, two-generation approach and include:

- **Assessment:** We screen children for exposure to adversity and assess symptoms of toxic stress in the pediatric setting and use this tool to help us evaluate the well-being of the whole child.
- **Home visits:** We engage families at home and school, as many families lack access to childcare and transportation.
- **Education:** We offer targeted education that helps families better understand the causes and symptoms of chronic stress and provide ways to mitigate the kind of stress that can hurt children's health and well-being.
- **Psychotherapy:** We provide a variety of evidence-supported treatments and promising practices that share core principles of culturally competent, trauma-informed therapy that are appropriate for children and families from diverse cultural backgrounds, including Child Parent Psychotherapy and Cue-Centered Therapy. We do this in partnership with the Child Trauma Research Program at UCSF, led by Dr. Alicia Lieberman, and the Early Life Stress and Pediatric Anxiety Program at Lucile Packard Children's Hospital, led by Dr. Victor Carrion.
- **Psychiatry:** Psychiatrists are provided through a partnership with Department of Psychiatry at University of California San Francisco including the Young Adult and Family

Center (YAFC). They provide medication evaluations of children and caregivers and offer consultation to SMHC Bayview Child Health Center physicians and CYW staff.

- **Mindfulness and coping skills:** Our wellness coordinators receive training to help patients and families build resilience and manage future stressful events through mindfulness techniques. Research has shown that techniques such as breathing retraining, progressive relaxation, meditation and mindfulness-based awareness can increase self-regulation, reduce stress levels, and improve health.
- **Referrals:** In addition to making appropriate referrals for our clinical services, we also coordinate referrals to high-quality institutional partners who also use an ACEs-informed lens in their work.

http://www.centerforyouthwellness.org/what-we-are-doing/clinical-programs/

Report: A Hidden Crisis Findings of Adverse Childhood Experiences in California

The Center for Youth Wellness (CYW) is a health organization embedded with a primary care pediatric home serving children and families in the Bayview Hunters Point neighborhood in San Francisco. We were created to respond to a new medical understanding of how early adversity harms the developing brains and bodies of children. We prevent toxic stress by raising national awareness among those who have the power to make a difference – from parents to pediatricians to policymakers. We screen every young person we see for Adverse Childhood Experiences (ACEs), which we know can lead to toxic stress and poor health outcomes in life. We heal children's brain and bodies by piloting the best treatment for toxic stress and sharing our findings nationally.

A Hidden Crisis shows four years of data collected by the annual California Behavioral Risk Factor Surveillance System. The findings clearly demonstrate a public health crisis with far-reaching consequences on the health and wellbeing of Californians.

The study found that 61 percent of Californians were exposed to one or more types of ACEs such as abuse, neglect or household dysfunction. One in six experienced four or more adverse experiences. Compared to those reporting no ACEs, these individuals are likely to experience more health, social and economic challenges including: heart disease, stroke or asthma; be diagnosed with Alzheimer's or dementia; struggle with depression; currently smoke, binge drink or engage in risky sexual behavior; be the victim of sexual violence; and lack health insurance.

What's more, county-by-county findings detailed in the report show that, even in counties with the lowest prevalence of ACEs, which include San Francisco and Santa Clara Counties, one out of every two people has had at least one adverse experience in childhood.

Recommendations from the report:

- Collect annual state-level data on the prevalence of ACEs
- Increase awareness about ACEs and their impact on health and wellness
- Increase access to health care, including mental health services, for all Californians
- Support efforts to identify evidence-based practices to identify and respond to ACEs
- Advance efforts to integrate behavioral and physical health care practices

https://app.box.com/s/nf7lw36bjjr5kdfx4ct9

Los Angeles

LAUSD Trauma Services Adaptation Center for Schools and Communities (TSA for Schools)

In September 2005, LAUSD was awarded a SAMHSA grant to establish the LAUSD Trauma Services Adaptation Center for Schools and Communities (TSA for Schools). Recently refunded in 2012, and now known as The Treatment and Services Adaptation Center for Resiliency, Hope, and Wellness in Schools, our center is a partnership between LAUSD School Mental Health, USC School of Social Work, RAND Health, UCLA Health Services Research Center, UCLA Child Anxiety Program, and 3-C Institute for Social Development.

With a mission of enhancing schools' ability to provide trauma-informed approaches to assure a supportive and nurturing environment for all students, our primary goals are to: serve as the primary trauma resource site for our nation's schools; develop and disseminate school trauma prevention programs and; create and disseminate web-based training and skill-building programs for youth, teachers and school mental health professionals.

LAUSD TSA Center assists school mental health professionals and school communities to raise trauma awareness and the ability to deliver trauma informed services. LAUSD TSA Center staff is available to assist with specific requests and information relating to training.

Resources for School Personnel
The web pages, articles and other resources on this page are designed for schools and school personnel, toward supporting trauma-exposed youth and creating a trauma-sensitive school environment for all students.

Coping with Emotional Stresses of our Economic Times Flyer
Coping with Emotional Stresses of our Economic Times Flyer(Spanish)
National Child Traumatic Stress Network (NCTSN) School Resources
NCTSN Back to School Resources for School Personnel – Flyer with links
Coping in Hard Times: Fact Sheet for School Staff (NCTSN)
Child Trauma Toolkit for Educators
Child Traumatic Grief Materials Educational Materials
Cognitive Behavioral Intervention for Trauma in schools (CBITS)
Training and Technical Assistance

Cognitive Behavioral Intervention for Trauma in schools
Developed by our TSA for Schools, Cognitive Behavioral Intervention for Trauma in Schools (CBITS) is the only school-based early intervention program proven to be effective in addressing the mental health symptoms of traumatized youth who have been exposed to a wide variety of violence in their community. This program not only addresses trauma symptoms but can impact school performance and overall functioning as well as build resilience in youth and their families. CBITS was initially developed with a public health approach in mind, and made for and by school-based clinicians who serve an ethnically diverse student population, this program has been successfully disseminated in schools across the U.S. and internationally and has been nationally recognized as one of the leading school-based trauma interventions.

The CBITS Program
CBITS is a skills-based group intervention that is aimed at relieving symptoms of Post Traumatic Stress Disorder (PTSD), depression, and general anxiety among children exposed to community

violence and trauma. Designed for use in schools by school based mental health professionals, CBITS was developed in close collaboration with school staff and administrators to alleviate behaviors that interfere with learning and regular school attendance.

CBITS has been implemented in elementary and middle schools across the country, with bicultural and bilingual students (Spanish, Russian, Armenian, and Korean) and multicultural, urban and rural populations, including Native American adolescents. The program has been studied extensively and has been shown in a randomized control trial to reduce Post Traumatic Stress Disorder (PTSD) symptoms and depression.

Target population
CBITS has been implemented in grades six to nine (ages 10-15) with students who have experienced a wide range of violence such as community violence, trauma due to accidents and natural disasters, and trauma involving significant loss.

Intensity
CBITS consists of 10 group sessions (six to eight children per group) of approximately an hour in length, conducted once a week in a school setting. In addition to the group sessions, participants receive one to three individual sessions, usually held before the exposure exercises. CBITS also includes parent education sessions and teacher education sessions. Student case management services and teacher consultation are added as needed.

CBITS Treatment Components
- Education about reactions to trauma
- Learning skills in relaxation
- Cognitive Therapy
- Real Life exposure
- Stress or trauma exposure
- Problem solving

As with other therapeutic interventions, parental permission is required for children to participate in CBITS groups in schools.
http://achieve.lausd.net/Page/2240

Racing ACEs meeting

“Racing ACEs” was a meeting recently in California that included a discussion of critical and practical resources for trauma-informed work.

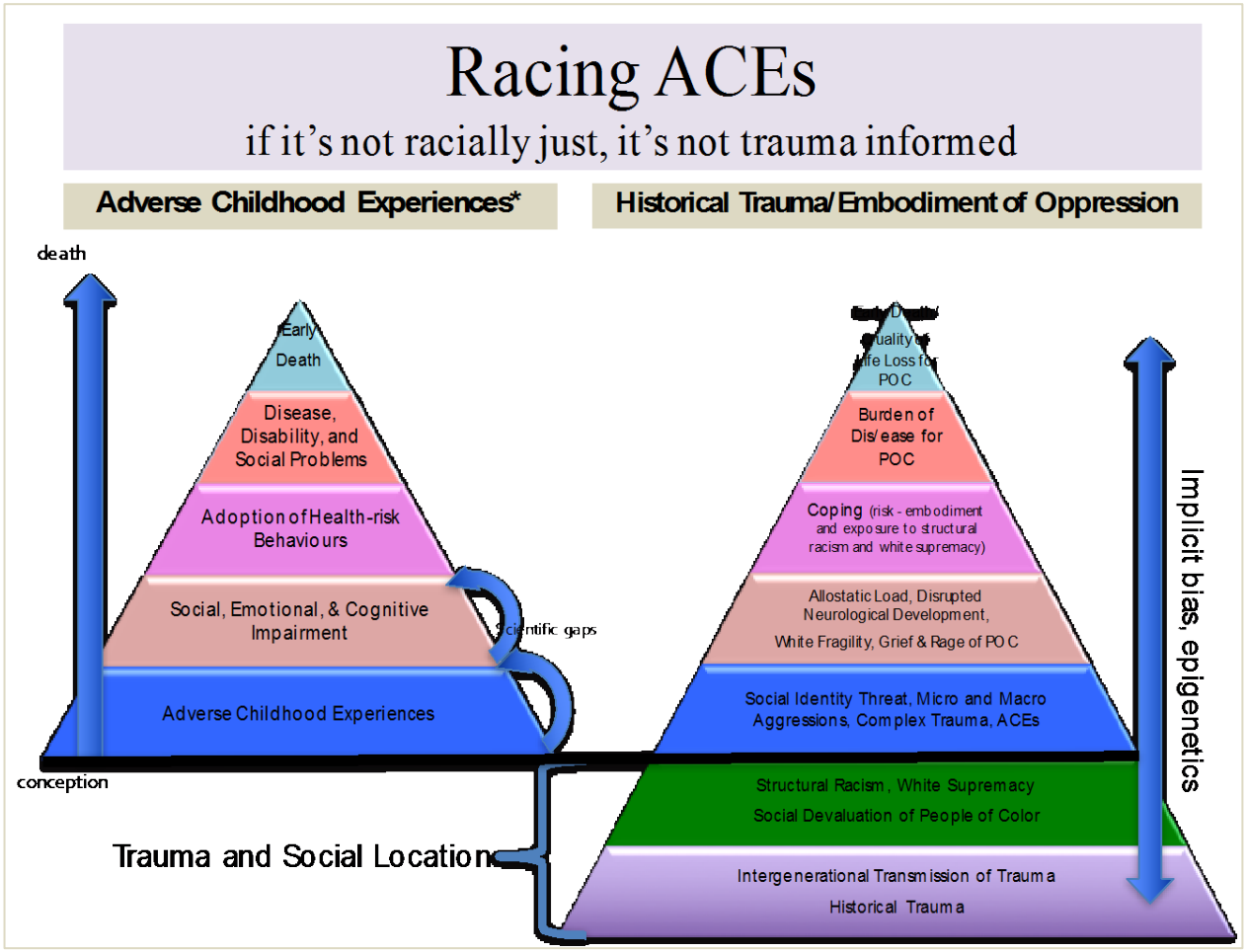
“If it’s not racially just, it’s not trauma informed”

An exploration of how racial justice – its values, investments, strategies and practices – can be centered at the heart of trauma-informed work. The meeting is called “Racing ACEs,” a reference to the CDC-Kaiser Permanente Adverse Childhood Experiences Study. Our work, in a fundamental sense, is to race ACEs so that we can explicate the inequitable burden of racial oppression, as well as the intersections of oppression, privilege and liberation in all their forms.

The ambivalence of ACEs: The ACE Study is a valuable tool that brings a wider audience to what clinicians, researchers, and advocates working in the field of child and adolescent trauma have said for decades – confirming that experiences of violence, neglect, and trauma are harmful to a person’s long-term health.

“If we are truly to center on liberation we need to collectively bring a racial justice lens to specific tropes and tools within that space. This includes re-examining the ACE Study in public practice, taking into account, for example, cultural and racial humility as practiced by the privileged, as well as the tremendous and all-exhausting resilience necessitated by people of color, LGBTQ people, as well as the differently-abled who must daily navigate hostile spaces in public and in private”.

https://acestoohigh.com/2016/10/24/racing-aces-gathering-and-reflection-if-its-not-racially-just-its-not-trauma-informed/#more-6204



Santa Cruz: California Center of Excellence for Trauma Informed

www.trauma-informed-california.org

Presentation: "Working with Elders who have trauma histories" Gabriella Grant, Director

Elder-specific traumatic experiences

- Loss of spouses and peers
- Chronic and life-threatening diagnoses
- Physiological changes, limitations and disability
- Cognitive and memory loss
- Loss of roles and resources
- Increased dependence on caregivers

Trauma complicates aging

- Trauma poses a threat to the successful aging process by interfering with interpersonal relations and productive activity. (Cisler et al, 2010; Rowe & Kahn, 1997)
- Contrary to previous assertions of resiliency in older adult populations, there is reason to suspect greater vulnerability to emotional difficulties following exposure to traumatic stressors in this population. (Grey & Acierno, 2002)

"The over-institutionalization of older adults is in part due to poorly trained service providers that believe the mental disturbances in older adults are untreatable. Allers et al., 1992"

A range of assessment measures and treatments are outlined in this presentation.

http://www.napsa-now.org/wp-content/uploads/2014/11/504-Working-with-Elders-with-Trauma-Histories.pdf

The California Evidence-Based Clearinghouse for Child Welfare (CEBC)

This agency aims to advance the effective implementation of evidence-based practices for children and families involved with the child welfare system.

The California Department of Social Services (CDSS) provides leadership in targeted efforts to improve the lives of children and families served within the child welfare system. As part of their improvement strategies, CDSS selected the Chadwick Center for Children and Families - Rady Children's Hospital-San Diego, in cooperation with the Child and Adolescent Services Research Center (CASRC), to create the California Evidence-Based Clearinghouse for Child Welfare (CEBC). The CEBC is a critical tool for identifying, selecting, and implementing evidence-based child welfare practices that will improve child safety, increase permanency, increase family and community stability, and promote child and family well-being.

The Program Registry

The CEBC helps to identify and disseminate information regarding evidence-based practices relevant to child welfare. Evidence-based practices are those that have empirical research supporting

their efficacy. The CEBC Program Registry provides information on both evidence-based and non-evidence-based child welfare related practices to statewide agencies, counties, public and private organizations, and individuals. This information is provided in simple straightforward formats reducing the user's need to conduct literature searches, review extensive literature, or understand and critique research methodology. The Not able to be Rated programs are included in an effort to provide the user with the most accurate information possible on child welfare practices that are in common use.

The Selecting and Implementing Programs Section of the Website

The CEBC aims to assist systems and agencies in making critical decisions around the selection and implementation of evidence-based practices. Information about the process of selecting and implementing practices, as well as concrete resources and tools, are housed in this part of the website.
http://www.cebc4cw.org/leadership/overview/

View programs
- Searchable database of child welfare related programs.
- Description and information on research evidence for specific programs.

Search and implement programs
- Guidance on how to make critical decisions regarding selecting and implementing programs
- Tools and materials to provide support for choosing, implementing and sustaining a program.

http://www.cebc4cw.org/

Chicago

Healthy Chicago 2.0 Strategic Plan for the city

The city of Chicago, in partnership and with input from hundreds of key stakeholders, unveiled their strategic plan, Healthy Chicago 2.0 which will guide its work through 2020.
One key outcome is to become a trauma-informed city. Our collaborative has been working closely with the health department and will continue to collaborate and maximize resources to make this vision a reality. We are grateful for the support of all our partners and the department in particular for naming this important priority.

http://www.acesconnection.com/blog/chicago-public-health-department-declares-overarching-outcome-to-become-a-trauma-informed-city

Through our combined efforts, Healthy Chicago 2.0 will result in a number of overall health and system improvements for Chicago residents, including:

1. Increasing life expectancy
2. Reducing obesity
3. Reducing preventable hospitalizations
4. Reducing discrimination
5. Improving overall health
6. Reducing economic hardship
7. Increasing opportunities for children to live healthy lives
8. Institutionalizing a Health in All Policies approach
9. **Becoming a Trauma-Informed City (p.7)**

To further improve health outcomes that are often worsened by exposure to violence, we must work toward making Chicago a Trauma-Informed City. Trauma-Informed is grounded in service delivery, and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and groups.

Functioning as a Trauma-Informed City requires significant changes in attitude, knowledge and practice, with all of our city agencies and community based organizations becoming trained in the impact that trauma has on our residents. Many organizations have already begun this effort by training their staff and community members in the areas of Trauma 101, Mental Health First Aid and Psychological First Aid.

A Trauma-Informed City utilizes this knowledge to develop policies and system improvements that ensure effective responses to recovery from trauma and to prevent individuals from being retraumatized by individuals, schools, churches, organizations and government agencies with which they interact. Chicago will strengthen efforts by collecting new data on the impacts of trauma, discrimination and racism. Chicago will also work toward a shared understanding of how trauma impacts communities and will develop approaches to remediate and build resiliency among those most impacted across Chicago. (p.9)
https://www.cityofchicago.org/content/dam/city/depts/cdph/CDPH/HC2.0Plan_3252016.pdf

Milwaukee

SaintA

SaintA works with children and families. It is in the forefront of therapeutic practices called trauma informed care that apply what neuroscience has taught us about how the brain develops, functions and recovers from trauma to help children overcome adverse experiences and thrive.
See how brains are built:

How Brains are Built: The Core Story of Brain Development
This adversity can include abuse, neglect, exposure to violence, divorce, alcohol and/or drug abuse of a parent, incarceration of and mental illness in a parent. A seminal study of adverse childhood experiences (ACEs), conducted in San Diego, shows their effects are widespread and can last throughout — and even shorten — a life. An ACEs study conducted in Wisconsin had very similar outcomes.

As a result, *all* our services to children and families are based on trauma informed care.
Trauma informed care can be defined in many different ways, which include both philosophy and practices. At SaintA, we believe the following elements are helpful in understanding what trauma informed care is and how to implement it.

1. **Prevalence** — Exposure to and difficulty adjusting to adverse experiences is significantly more common than we previously had known. A keen appreciation for the scope of adverse events, especially on children, is a key element to understanding the needs of people who have been exposed to events such as domestic violence and substance abuse, separation/divorce, mental illness, physical and sexual abuse, emotional and physical neglect, and acts of violence.
2. **Impact** — Trauma occurs when a person's ability to cope with an adverse event is overwhelmed and contributes to difficulties in functioning. The impact of this process is profound, especially when the adverse event occurs during key developmental timeframes. The seminal ACE (adverse

childhood experiences) study shows how early trauma also can have a serious effect on a person's physical health in later life and ultimately impact life expectancy.

3. **Perspective Shift** — A shift in perspective can bring a new reality. Helping those charged with caring for people struggling with trauma by simply changing the question from "What is wrong with you?" to "What has happened to you and how can I support you?" can bring enormous understanding.
4. **Regulation** — Knowledge of the basic architecture of the brain provides both an understanding of the impact of trauma and a key toward effective treatment. Many of the interventions that have been offered to people struggling with trauma have focused on the cognitive or "thinking" parts of the brain. Trauma informed interventions often prioritize enhancing emotional and behavioral regulation. This could include the use of sensory and regulating strategies such as drumming, singing, dancing, yoga, etc., which have been shown to be effective in addressing the impact of trauma.
5. **Relationship** — Relationships are key to reaching a traumatized child and to mitigating trauma. Strong relationships help create resilience and shield a child from the effects of trauma.
6. **Reason to Be** — Reason to be creates a sense of purpose or direction for individuals by ensuring they're connected to family, community and culture. It is bolstered by resiliency – a combination of the individual's internal attributes and the external resources that support them.
7. **Caregiver Capacity** — To effectively work with traumatized individuals, caregivers must take care of themselves and find a work/life balance. Critical is identifying our limits, knowing sometimes we will be pushed beyond them, and what we will do to find balance.

View a downloadable PDF with explanations on the elements.
http://www.sainta.org/trauma-informed-care/

Montana

ElevateMontana

"The prior 3 years to 2015, Montana ranked DEAD LAST in the nation for child health. For this year of 2016 we're 47th. Montana is well under the national average for overall child well-being, too. We also have one of the highest rates for teen suicide, and over 20% of our children below the poverty level".

Our vision is that every community in Montana is committed to the well-being of our children. We believe that all children have a fundamental right to live in safe families and communities, to be emotionally and physically healthy, and to receive the necessary support in order to achieve academic and personal success.

To that end, we are working to provide parents, healthcare professionals and community leaders with tools to make better informed decisions when it comes to parenting and treating youths.

We are individuals, community leaders, teachers, daycare providers, legislators, children-oriented organizations, universities, businesses, judges, law enforcement staff… and people like you. Come join us!

After three *Elevate Montana Summits* accelerating awareness and knowledge of the ACE Study, trauma, and resilience, more than 6,000 people have become change-makers in communities all across Montana to elevate the well-being of our children! We have learned that *Adversity Is Not Destiny*, and that *It's Not The Behavior, It's The Brain.* Using this knowledge, combined with our personal stories and passion, we are, together, creating strategies and solutions to mitigate toxic stress in children and build resilience.

"Compassion Is The Beginning Of Restoration"

The ACE Study (Adverse Childhood Experiences Study) is a scientific study directly linking adverse childhood experiences to negative health and social outcomes in adulthood. The implications are staggering, but the motivation for change is inspiring! Elevate Montana's ACE Study Summit is intended to inform, inspire, and motivate community and state leaders toward actions that will reduce adverse childhood experiences in today's children so they may become healthier adults, which will result in a healthier Montana. Perhaps we may one day truly be a state in which living the American Dream is possible … *even for its children*.

ACE Master Trainer Program

One of the organizations deeply involved in this movement, ChildWise Institute, is working collaboratively with ACE Interface, has established an ACE Master Trainer Program!
Eighteen ACE Master Trainers have been sent out across the entire state to advance awareness and knowledge of the ACE Study and its implications and are facilitating conversations in creating actions to mitigate toxic stress in children. In doing so, we are avoiding and reducing ACEs in our children today so that they will be healthier adults tomorrow. The ultimate result of this work will be a healthier Montana physically, mentally, emotionally, and fiscally.
http://www.elevatemontana.org/

Wisconsin

Home Visiting Programs Address Adverse Early Childhood Experiences

Feb 9, 2016
Resource information on state policies and initiatives that impact infants, toddlers and their families

Building on the seminal findings from the Adverse Early Childhood Experiences (ACE) study, the Wisconsin Department of Health Services (DHS), Department of Children and Families (DCF), and Children's Trust Fund have examined ways to translate this knowledge into policy and practice. The **Wisconsin Maternal, Infant, and Early Childhood Home Visiting (MIECHV)** program is undertaking multiple efforts to advance understanding of adverse experiences during childhood and to promote trauma-informed practices.

The Childhood Experiences Survey (CES), an 11-question ACE survey included in the CDCs Behavioral Risk Factor Surveillance System (BRFSS), is now being administered to all families enrolled in Wisconsin's MIECHV programs within the first 90 days of participation. Wisconsin early childhood leaders believe that home visitors need to know how to use that trauma information in case planning to help the parents realize their strengths and promote resilience in their children.

Supervisors are trained to support their staff as they administer the CES. Mental health consultants also work with the home visitors to help them understand the impact of current and historical trauma on parents. During the 2015 state conference, home visitors met in regional groups to explore the home visitors experiences in talking with parents about traumatic experiences. In response to a concern that assessment might be a burden for programs and home visiting staff, Wisconsin created an Implementation Advisory Network to build a crosswalk of the many assessments used by the home visiting programs in order to streamline the process.

The state is also building its reflective supervision capacity, linking infant mental health consultants to each home visiting program, and growing a cadre of mental health providers with the Wisconsin Alliance for Infant Mental Health Endorsement at Level III or IV. In addition, home visitors are engaged in reviewing program data and creating a plan for how the data can shape practice and lead to improved trauma-informed services.
https://www.zerotothree.org/resources/968-wisconsin-home-visiting-programs-address-adverse-early-childhood-experiences

Texas

Building a Texas System of Care

Similar to Philadelphia, the goal in Texas is to use system of care statewide as an approach to plan and deliver services and supports to children and youth with serious mental health concerns, as well as their families.
http://www.txsystemofcare.org/

Trauma Informed Care Summit August 2016

This Summit brings together individuals, families, professionals, communities and organizations interested in addressing, preventing and treating trauma across the lifespan, as well as disseminate trauma informed care initiatives and best practices to address trauma throughout Texas. The pilot sites for trauma informed care organizational transformation of behavioral health services will be disseminating the progress and lessons learned in transforming behavioral health services in Texas including: mental health services for children and adults, substance abuse treatment and substance abuse prevention services.

Our hope is to launch a trauma informed discussion within the community by sharing the triumphs of the initiative and providing the knowledge of nationally recognized trauma informed experts.
http://www.txsystemofcare.org/initiatives/trauhttp://www.txsystemofcare.org/ma-informed-care-tic/tic-austin2016/

Houston

The Child Trauma Academy (CTA)

CTA is a not-for-profit organization based in Houston, Texas working to improve the lives of high-risk children through direct service, research and education. We recognize the crucial importance of childhood experience in shaping the health of the individual, and ultimately, society. By creating biologically-informed child and family respectful practice, programs and policy, CTA seeks to help maltreated and traumatized children.

The CTA started as a typical center of excellence in an academic setting, initially at The University of Chicago and later at Baylor College of Medicine. Over time however, it was clear that the problems of abuse and neglect in children were much more complex and multi-dimensional in ways that our medical model was unable to address.

A medical school centered work group investigating and solving physiological problems in humans makes sense. Solving problems which involve parenting, education, the law, child protection systems, mental health, law enforcement and a host of related systems across every professional discipline is more challenging. In response to this challenge we have created a collaborative, interdisciplinary virtual Center of Excellence, The ChildTrauma Academy.
http://childtrauma.org/about-childtrauma-academy/

They have a library of articles and reports:
http://childtrauma.org/cta-library/interventions/

Massachusetts

Boston

New England Center and Home for Veterans (NECHV) is a national leader in housing and serving Veterans who are at-risk of homelessness. Located in Downtown Boston and offering services throughout the region, NECHV supports Veterans with innovative services that enable success, meaningful employment, and dignified independent living. NECHV serves over 350 Veterans each day in their home communities. The downtown Boston facility contains 60 affordable apartments, a distinct and separate 24 bed female Veterans transitional dormitory, and over 185 transitional and emergency beds.

Trauma informed care training

The staff at NECHV are undergoing three months of trauma informed care training to help better serve the Veteran guests who walk in our doors 24/7. This training equips everyone from the front desk staff to administrative support to all easily be able to understand, recognize, and respond to different types of trauma our Veterans may be dealing with.

Women Veterans

The U. S. Department of Veterans Affairs (VA) reports that women Veterans have been, and continue to be, an under-served population. Since 1996, NECHV has aggressively developed and implemented new and focused programs of support to ensure that the emerging needs of women Veterans are met. The women Veterans transitional residence at the Center comprises 24 beds and is a safe living separate from any male Veteran housing that provides 24-hour controlled access and security. Case management for the Women Veterans Support Program is sensitive to the unique needs of women in transition. NECHV provides dedicated case managers and addictions counselors who are experienced in the complexities of Military Sexual Trauma (MST), PTS and other concerns specifically related to women Veterans. http://nechv.org/women-veterans-support/

Connecticut

Department of Children and Families

This agency has very extensive information on the subject on its website, for example:

Trauma Informed Care

INDEX

- Effective Treatments for Child Traumatic Stress
  - Child and Family Traumatic Stress Intervention (CFTSI)
  - Child FIRST
  - Creative Alternatives of New York (CANY)
  - Dialectical Behavior Therapy (DBT)
  - Eye Movement and Desensitization and Reprocessing (EMDR)
  - Functional Family Therapy (FFT)
  - Parent Child Interaction Therapy (PCIT)
  - Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
  - Trauma-Focused Cognitive Behavioral Therapy for Childhood Traumatic Grief (TG-CBT)
- Essential Elements of a Trauma-Informed Child Welfare System
- Guiding Principles for Trauma-Informed Child Welfare Practice
- Introduction
- Trauma and Help After a Trauma
- Understanding Child Trauma
- Understanding How Trauma Affects Children and Caregivers
- Why Trauma-Informed Care is Important to DCF

http://www.ct.gov/dcf/cwp/view.asp?a=4368&Q=514042

Examples of other agencies and activities

National Council for Behavioral Health

This agency provides technical expertise to organisations.
An individual's experience of trauma impacts every area of human functioning — physical, mental, behavioral, social, spiritual. The ACE Study revealed that the economic costs of untreated trauma-related alcohol and drug abuse alone were estimated at $161 billion in 2000. The human costs are incalculable.

Trauma is shrouded in secrecy and denial and is often ignored. But when we don't ask about trauma in behavioral healthcare, harm is done or abuse is unintentionally recreated by the use of forced medication, seclusion, or restraints.

The good news is that trauma is treatable — there are many evidence-based models and promising practices designed for specific populations, types of trauma, and behavioral health manifestations.

Check out further resources on trauma under Trauma-Informed Consulting as well as our shareable infographic on How to Manage Trauma and Why Trauma Matters in Primary Care
https://www.thenationalcouncil.org/topics/trauma-informed-care/

Before an organization can begin to establish a trauma-informed system of care, the following conditions must be met:

- "Administrative Commitment" to becoming trauma-informed;
- "Universal Screening" of consumers for trauma history;
- "Training and Education" for all staff in introductory trauma dynamics;
- "Hiring Practices" that ensure all new employees have at least a basic knowledge of trauma dynamics and that the organization has at minimum one or two trauma experts to model and promote a trauma-informed approach for colleagues; and
- "Review of Policies and Procedures" by management, clinicians and consumers to identify and revise those that could be directly or indirectly harmful to trauma survivors. At a minimum, organizations should operate with the assumption that all consumers are trauma survivors and adhere to the maxim "above all else, do no harm."

The National Council for Behavioral Health, drawing on common elements in the literature, has set forth seven domains for being a trauma informed organization:

Seven Domains for Being Trauma-Informed:

- Early Screening and Comprehensive Assessment of Trauma
- Consumer Driven Care and Services
- Trauma-Informed, Educated and Responsive Workforce
- Provision of Trauma-Informed, Evidence-Based, and Emerging Best Practices
- Create a Safe and Secure Environment
- Engage in Community Outreach and Partnership Building
- Ongoing Performance Improvement and Evaluation

http://www.wellspringpacific.org/uploads/5/8/7/9/58797525/pacific_county_aces_report.pdf

NCBH CONSULTING SERVICES IN TRAUMA-INFORMED CARE

"Addressing trauma is now the expectation, not the exception, in behavioral health systems. Every day, behavioral health organizations are asking the National Council how they can be better prepared to offer trauma-informed care".

Manage Trauma Infographic
The National Council's popular infographic "How to Manage Trauma" presents key facts and stats on trauma in behavioral health and outlines the symptoms and coping strategies.
View and share this infographic.

Packages (examples)
Start today with one or more of the three key trauma-informed care consulting and training packages that the National Council offers:

- **Organizational Self-Assessment and Follow-up**

The National Council's Trauma-informed Care Organizational Self-Assessment is designed to increase your awareness and readiness to adopt the key components of a trauma-informed care organization and to identify what you need to keep doing and reinforcing, stop doing, or start doing the

right thing. Our consulting package is designed to help you complete the assessment, review results, and develop strategies for improvement. We meet face to face with your leadership and core implementation teams, offer in-person site visits and phone consultations, schedule monthly calls to track and discuss progress, and give your team access to key resources.

- **Introduction to Trauma-informed Care**

A day-long training at your site for all your staff provides an overview of trauma across the lifespan, discusses its impact, explains what it takes to be trauma-informed, offers helpful tools (i.e., trauma-focused therapy, alternative healing such as WRAP), and explores proven models of trauma-informed care.

- **Seven Domains of Trauma-informed Care**

The seven domains of trauma-informed care are early screening and assessment, consumer-driven care and services, nurturing a trauma-informed and responsive workforce, evidence-based and emerging best practices, creating safe environments, community outreach and partnership building, and ongoing performance improvement and evaluation. In each of these areas, the National Council offers a half-day education workshop followed by 1-day onsite consulting on the implementation process. We help you set up performance indicators and provide essential tools and resources. https://www.thenationalcouncil.org/areas-of-expertise/trauma-informed-behavioral-healthcare/

Research 2016: University of North Carolina (UNC) School of Medicine at Chapel Hill and Harvard University - NIMH-Funded Study to Track the Effects of Trauma

By carefully tracking 5,000 people after they have experienced a traumatic event, a just-launched NIMH-funded study aims to provide a finely detailed map of the array of factors that play a role in the development of mental disorders that occur in the wake of trauma. Information coming out of the study should provide a much deeper understanding of the mechanisms that give rise to post-traumatic disorders as well as a clearer basis for predicting who will be affected and how best to target treatment.

Following a traumatic event—be it an assault, a car crash, or a combat experience—it is common for people to report a range of symptoms, including hypervigilance, intrusive upsetting thoughts, flashbacks, and changes in sleep and mood. These often co-occur with chronic pain and substance use, as well as other enduring effects from body or brain injuries. Most individuals gradually get better, but a substantial number develop persistent problems, often diagnosed as post-traumatic stress disorder (PTSD). There is no reliable way to predict who will recover without treatment and who will develop lasting problems after trauma. Even when PTSD or other disorders such as anxiety and depression are diagnosed, symptoms differ person to person, as does response to treatment. Researchers at the University of North Carolina (UNC) School of Medicine at Chapel Hill and Harvard University will collaborate in the multicenter Aurora study, initially screening 5,000 people arriving in emergency rooms after trauma.
https://www.nimh.nih.gov/news/science-news/2016/nimh-funded-study-to-track-the-effects-of-trauma.shtml

Website 2016: Community Resilience Cookbook

The Community Resilience Cookbook is a well organized and comprehensive website focused on building community resilience in response to ACEs.

The Cookbook offers a 23-step "recipe" for building community resilience based on the experience of nine different communities across the U.S. that have engaged in community resilience building. Like any good recipe, there is room to make adjustments to fit an individual community's "taste". http://communityresiliencecookbook.org/

"My personal belief—based upon my experience with public health approaches to preventing and treating problems such as cardiovascular disease and cancer that I participated in at the Centers for Disease Control and Prevention (CDC)– is that any approach to a major public health problem ***must necessarily include broad-based public education. In fact, an informed public is often the major driving force for change".***

Rob Anda, MD, MS, Co-Principal Investigator and Co-Founder, Adverse Childhood Experiences (ACE) Study

Here is one recipe that includes the essential ingredients gathered from 9 Tastes of Success from 9 different communities. The recipe is presented in the infographic, followed by a text description to more fully explain each step. Your community may follow this recipe as a guide, or as you take stock of your strengths and resources and find that you want to put together these ingredients in a different order, or using a slightly different set.

1. **Someone starts.** Anyone—a community advocate, a local priest, an artist, a group of pediatricians—starts the conversation and catalyzes, the community's trauma-informed, resilience-building efforts. That person may lead, or someone else may lead from there.

What's important is that the individual or group understand the science of ACEs and be committed to integrating them into all parts of the community.

2. **Local efforts.** Identify any trauma-informed, resilience-building efforts under way locally and engage the leaders of those efforts.
3. **Engage local leaders.** The individual or group identifies a small group (30-50 people) of community leaders from different sectors—education, human services, juvenile justice, mental health—and educates them one-on-one about ACES, trauma and resilience.
4. **Steering committee and Backbone organization.** The most enthusiastic members of this group form a steering committee that drives the initial effort, and that forms, or identifies, a backbone organization to support the effort.

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5. **ACEsConnection group.** Form a local group on ACEsConnection.com.
6. **Make history.** Document your efforts so others can learn from your community's experience.
7. **Collective impact.** Develop a "collective impact" model in which multiple groups or agencies share a mission and develop a collaborative approach to carry out that mission.
8. **Local resources.** Assess your resources—local funding, meeting space, in-kind support, etc.

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9. **Mission, goals, action.** Develop a mission statement, goals and a plan of action; review and update every two years.
10. **Slogan.** Develop a one-line slogan or tagline.
11. **Local data, local urgency.** Use local data to create a sense of urgency.

Focus on hope, resilience and change without losing sight of the deep and long-term impact of childhood adversity. ACEs are not destiny; if the brain can be hurt, it can also be healed.

12. **Communication tools** (Develop PowerPoint presentation, web site, Facebook page, brochures, video).

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13. **Public meetings.** Schedule regular public meetings of the steering committee and make them open to anyone in the community.
    Be open to "uncommon partners" in the work.
14. **Local funding?** Apply to local or regional foundations for initial funding, but don't stop if you don't get funding.
15. **Walk the talk.** Set a goal for all members of your coalition to "walk the talk" of trauma-informed practice in their own agencies and departments.

"*Work small and think big"—that is, put trauma-informed practices in place in your own coalition and day-to-day work while building alliances and momentum for larger-scale change.*

16. **Presenters**. Develop and train a cadre of people who can give presentations to different sectors—nurses, probation officers, pediatricians, Rotary Club, teachers—in the community.
17. **Educate. Present. Educate. Repeat.** Do presentations about ACEs and resilience for all identified sectors in the community—police departments, juvenile court judges, child-care workers. Present to the same groups multiple times; it takes repeated exposures for new information to take hold.

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18. **Local ACE survey**. Develop measures of success: an ACE survey and a "comprehension" survey to assess understanding of ACEs and resilience.
19. **Feedback.** Develop ways to gather feedback (e.g., evaluation sheets at workshops).
    Recognize that deep-rooted attitudes—for example, a belief in individual responsibility and self-sufficiency—may present barriers to understanding
    ACEs and resilience, and that such attitudes take time to change.
    Remember that becoming trauma-informed is a long-term process, and that not everyone will "come on board" right away.

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20. **Summits, learning circles.** Plan public education meetings—monthly "learning circles," annual ACE Summits. Start with "ACEs 101" and move to more complex trainings on impact and implementation.
    Recognize how past trauma—whether economic, environmental or political—affects your community now. Be willing to address these issues in a sensitive and inclusive way.
21. **Media.** Conduct media outreach at every step through local news, including traditional (newspapers, magazines), digital and social media.
    Celebrate progress and successes.

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22. **Official recognition.** Develop an MOU—memorandum of understanding—for local government to provide official endorsement and support of your organization and its goal of creating a trauma-informed, resilience-building community.
23. **Large-scale funding?** Decide whether to seek large-scale funding to support the steering committee and its work.

http://communityresiliencecookbook.org/essential-ingredients/ingredients/

The National Native Children's Trauma Center (NNCTC)

This is a Category II Treatment and Service Adaptation Center within the National Child Traumatic Stress Network. Our center provides national expertise on childhood trauma among American Indian/Alaska Native (AI/AN) children and offers trainings and consultations to community agencies, tribal programs, clinicians, school personnel, technicians, and families on the impacts and prevention of childhood traumatic stress.

Goals

1. Significantly increase and disseminate the number of culturally relevant, evidence-based interventions for use with AI/AN children (particularly interventions to be delivered in schools) and disseminate these interventions nationally, both on and off reservations and within the NCTSN.
2. Develop a network of trained, culturally competent educators, mental health providers, and law enforcement personnel able to meet the needs of AI/AN children who experience traumatic stress.
3. Increase the amount of research detailing the processes through which AI/AN children experience and cope with traumatic stress.

What We Believe

- Tribes know the consequences of trauma in their communities and are intensifying their commitments to community, family, and individual wellness in response.
- Many non-tribal mental health service providers and treatment models minimize the value of tribal holistic practices.
- In the past, tribes have been exploited by universities and other institutional researchers.
- Exploitation remains a concern even with well-intentioned researchers and universities when they are culturally uninformed.
- Tribes exist as sovereign nations and therefore must be the arbiters when questions arise about the types of research that will best serve tribal members.
- Any products or outcomes of research, such as data and other forms of intellectual property, are owned by the tribe.
- Trauma intervention is necessary for and effective with Native American children.

Our Commitment

- We will respond to tribes' identified community needs for trauma interventions.
- We will follow the guidance of the tribe in establishing a collaborative process for implementing, adapting, and evaluating trauma interventions.
- We will safeguard tribal ownership of data collected during the course of institutional and government-sponsored programs and research.
- We will maintain communication with tribal partners beyond project funding periods to advance community wellbeing and best practices in Indian Country.

http://iers.umt.edu/national_native_childrens_trauma_center/default.php

REPORT 2007: Models for Developing Trauma-Informed Behavioral Health Systems and Trauma Specific Services by Ann Jennings

For Abt Associates Inc, SAMHSA or NASMHPD

This 144-page report is a seminal document which outlines:

"This 2007 technical report identifies revised criteria for building a trauma-informed mental health service system, summarizes the evolution of trauma-informed and traumaspecific services in state mental health systems, and describes the increasing numbers and range of trauma-based service models and approaches available for implementation by state service systems, provider agencies and communities across the country.

This report includes updated author descriptions of trauma service models identified by states and organizations for the 2004 technical report; author descriptions of evidence based and promising practice models identified in SAMHSA's Model Programs and National Registry of Evidence-Based Programs and Practices; author descriptions of empirically supported treatments and promising

practices identified by the National Child Traumatic Stress Network, and empirically supported treatment approaches and promising practices reported by state trauma-informed contacts. All models were designed explicitly to address trauma in the lives of children, their parents or caregivers, and adults."

The trauma-informed and trauma-specific models described in this manual are manualized or packaged in a way as to make them accessible to review and implementation by State Mental Health Authorities and agencies serving adults, children and families/caregivers in public mental health and substance abuse service systems. They are listed alphabetically and organized in the following categories:

- Trauma-Informed Models for Service Systems and Organizations: Adults
- Individual Trauma-Informed Service Models for Adults
- Trauma-Specific Service Models for Adults
- Manualized Adaptations to Trauma-Specific Service Models for Adults
- Trauma-Informed Models for Service Systems and Organizations: Children
- Trauma-Specific Models for Parenting
- Trauma-Specific Service Models for Children and Parents, Family, Caregivers Family/Parents/Caregivers
- Trauma-Specific Service Models for Children
- Trauma-Specific Peer Support and Self Help Models

http://www.theannainstitute.org/MDT2.pdf

Veterans Affairs

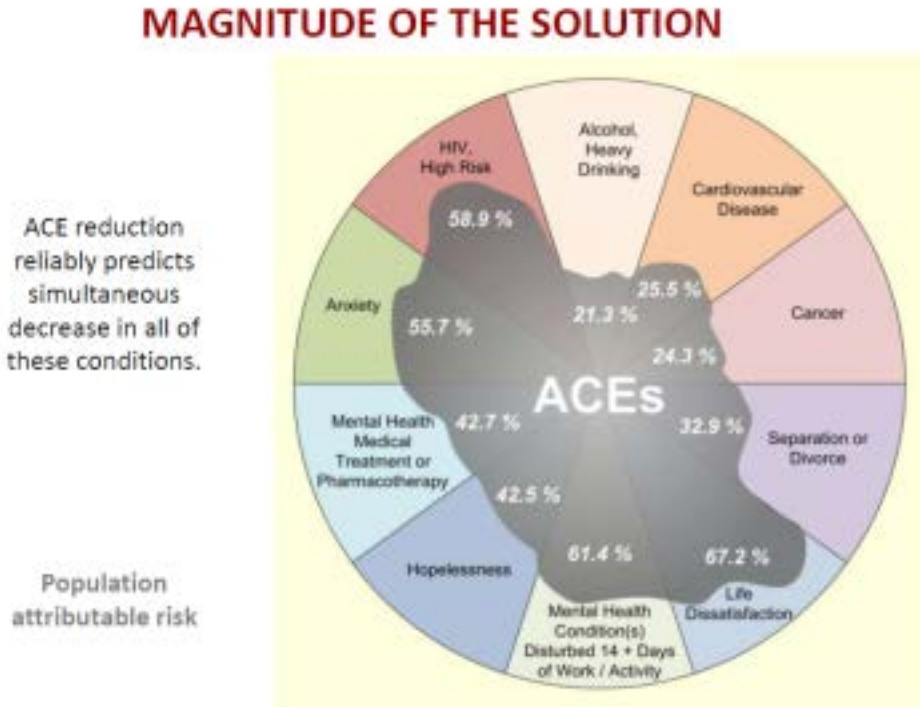
FACT SHEET TRAUMA-INFORMED CARE FOR WORKING WITH HOMELESS VETERANS

This is a 5-page Factsheet for key tips when working with veterans.
http://www.va.gov/homeless/nchav/docs/Trauma-Informed%20Care%20-%20Fact%20Sheet.pdf

The American Academy of Pediatricians

This agency has endorsed a public-health approach, according to James Perrin, associate chair of MassGeneral Hospital for Children and past AAP president, which includes strengthening family support, screening to identify vulnerable children and families and targeted interventions.
http://protomag.com/articles/scars-that-dont-fade

"Let's put this another way: A huge chunk of the billions upon billions of dollars that Americans spend on health care, emergency services, social services and criminal justice boils down to what happens – or doesn't happen — to children in their families and communities".



The pediatricians mentioned in this article know that, and they also know that if they intervene early enough to stop or prevent childhood trauma by building resilience factors in children and families, children won't suffer, and they'll have happier, healthier lives as adults.

Pediatricians aren't just about sore throats and ear infections anymore, says Gillespie. "This is a culture shift. We're here to support families."

https://acestoohigh.com/2014/07/29/to-prevent-childhood-trauma-pediatricians-screen-children-and-their-parentsand-sometimes-just-parents/

About NREPP
The National Registry of Evidence-based Programs and Practices (NREPP)

This is SAMHSA's evidence-based repository and review system designed to provide the public with reliable information on mental health and substance abuse interventions. All interventions in the registry have met NREPP's minimum requirements for review. The programs' effects on individual outcomes have been independently assessed and rated by certified NREPP reviewers.

The purpose of NREPP is to help people learn more about available evidence-based programs and practices and determine which of these may best meet their needs. NREPP is one way SAMHSA is working to improve access to information on evaluated interventions and reduce the lag time between creation of scientific knowledge and its practical application in the field.

Some intervention developers elect to participate in NREPP through self-nominations. Other interventions may be identified through literature searches or by SAMHSA; these can be reviewed

based on documents in the public domain. There will always be some interventions that are not submitted to or reviewed by NREPP, and not all programs that are submitted are reviewed.

New program profiles are continually being added, so the registry is always growing.

To Find an information there are several search categories available:
http://nrepp.samhsa.gov/AdvancedSearch.aspx#hide2
http://nrepp.samhsa.gov/01_landing.aspx

A search for 2016 resources highlighted one example:

The Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders (IOP)

This 176-page package provides a structured approach for treating adults who abuse or are dependent on stimulant drugs. The approach followed in the treatment package was developed by the Matrix Institute in Los Angeles, California, and was adapted for this treatment package by the Knowledge Application Program of the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration (SAMHSA).

The Matrix IOP package comprises five components:

- Counselor's Treatment Manual
- Counselor's Family Education Manual (this document)
- CD-ROM that accompanies the
- Counselor's Family Education Manual
- Client's Handbook
- Client's Treatment Companion

The Matrix IOP model and this treatment package based on that model grew from a need for structured, evidence-based treatment for clients who abuse or are dependent on stimulant drugs, particularly methamphetamine and cocaine.
http://store.samhsa.gov/shin/content//SMA13-4153/SMA13-4153.pdf

ZERO TO THREE

This agency works to ensure that babies and toddlers benefit from the early connections that are critical to their wellbeing and development.

Zero to Three is well-aware of the ACEs work and works to assist parents, babies and children towards health

Overview

- Our ***mission*** is to ensure that all babies and toddlers have a strong start in life.
- At ZERO TO THREE we ***envision*** a society that has the knowledge and will to *support all infants and toddlers* in reaching their full potential.
- ZERO TO THREE has advanced the proven power of nurturing relationships by transforming the science of early childhood into helpful resources, practical tools and responsive policies for millions of parents, professionals and policymakers.

- We take a unique approach to child development by connecting those who can truly make a difference in the life of a child with the research, resources and tools they need.
- We lead a number of private and public initiatives while frequently partnering with other leaders in the child development field.
- The ZERO TO THREE Policy Center is an independent, non-partisan research-based voice that educates the public and political leaders about the unique developmental needs of babies and toddlers. We advance policy solutions designed to support and strengthen families, raise awareness and promote action on behalf of babies and toddlers.

https://www.zerotothree.org/about/about-us

Education: The Treatment and Services Adaptation Center

"Promoting trauma-informed school systems that provide prevention and early intervention strategies to create supportive and nurturing school environments".

https://traumaawareschools.org/

The Treatment and Services Adaptation Center website is supported by a team of clinicians, researchers, and educators who are respected authorities in the areas of school trauma and crisis response.
Becoming a trauma-informed school requires a layered approach to create an environment with clear behavior expectations for everyone, open communication, and sensitivity to the feelings and emotions of others.

Audio Hear Joshua Kaufman describe the components of a trauma-informed school.

There are many ways to weave trauma-informed approaches into the fabric of schools, including strategic planning by administrators, staff training, and direct intervention with traumatized students. To move toward a trauma-informed school environment, it is important to build knowledge and communication in these areas:

- Impact of Trauma on Students
- Trauma Services in Schools
- Threat Assessment
- Student Behavior
- Secondary Traumatic Stress
- Bullying and Cyberbullying

https://traumaawareschools.org/traumaInSchools

Hopeworks ‘N Camden

Youth leadership

“We found that our youth leaders were much more effective,” he said. “Before, staff members and I would go talk to folks. People would say, ‘What a great presentation.’ Then we’d go back [to the same organization or audience], and nothing was different.”

The youth suggested more interactive ways of presenting material—the cup game, for instance, and a balloon toss in which volunteers are given different, conflicting instructions for playing, leading to follow-up discussion of how children exposed to trauma grow up with different “rules.” The youth also brought the power of lived experience.

“When I give a speech to teachers at a school, they think, ‘Oh, that would never work with my kids,’” Rhoton says. “When we have a young person who says, ‘I have an ACE score of 7, and this is how the safety plan helps me,’ that’s different.”

Youth Healing Team members learned the basic training information—definitions of trauma and adversity, the ACE survey, self-care strategies. Their one-hour version incorporates clips from Madea movies, a student-written rap, reflection, questions and a demonstration of “the huddle,” a check-in ritual that starts every day at Hopeworks. When the Youth Healing Team began its trainings, members frequently disclosed their own histories: homelessness, violence, abandonment. But they discovered that such sharing didn’t necessarily lead to the outcomes they wanted.

“If a young person told a trauma story, we were guaranteed two things,” Rhoton says. “Everyone would cry, and no one would change their behavior.” Audiences listening to such “horrific/heroic” stories tended to focus on the speaker’s survival rather than their own experiences of trauma or capacity to help others.

But when the youth focused on the science of ACEs and the tools that build resilience, their listeners’ questions changed. Teachers began to ask, “How do I do this in my classroom if I have only ten minutes? How can I do this with kindergarteners?”
http://marc.healthfederation.org/shared-learnings/youth-leadership-ace-and-resilience-movement

The Institute for Educational Research and Service (IERS) McGill University

Since 1957, the Institute for Educational Research and Service (IERS) has provided grant-funded training and technical assistance to P/K-16 schools and community agencies across the United States. Our work spans the topics of child development, school safety, childhood trauma, suicide and bullying prevention, and victim advocacy, among others. The Montana Safe Schools Center focuses on students in the state of Montana, and our Montana Victim Advocate Academy trains victim advocates statewide.

The National Native Children's Trauma Center focuses on American Indian/Alaska Native communities across the U.S.

Located in McGill Hall, we are a part of the University of Montana's College of Education and Human Sciences.

ERS staff members are trained educators, counselors, and psychologists who work closely with community agencies, schools, administrative personnel, tribal programs, clinicians, technicians, and families to identify their needs and the needs of the community in addressing school safety and child traumatic stress. Below is a list of some of the interventions and trainings we offer, along with a short description of each. If you are interested in having IERS offer trainings or consultation in your school, agency, or community, please contact Associate Director Leona Hastings.

- Trauma-Informed Positive Behavioral Interventions and Supports (TI-PBIS)
- Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
- Students, Trauma, and Resilience (STAR)
- Secondary Traumatic Stress (STS) and Self-Care
- Think Trauma! Training for Juvenile Justice
- Child Welfare Trauma Training Toolkit
- Attachment, Self Regulation, and Competency (ARC)
- Applied Suicide Intervention Skills Training (ASIST)
- Suicide Alertness for Everyone (safeTALK)
- Question, Persuade, and Refer (QPR)
- Bullying prevention and intervention (Steps to Respect)
- Psychological First Aid (PFA)

http://iers.umt.edu/interventions_and_trainings.php

Under the agency above is the:

Webinar 2013: Implementing a Trauma-Informed Approach for Youth across Service Sectors

The webinar was planned jointly by the Interagency Working Group on Youth Programs (IWGYP) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

Conclusion

This brief provides an overview of the webinar content as presented by experts in the field regarding the concepts and prevalence of trauma, principles for understanding trauma, and practices for addressing trauma and working with youth who have experienced trauma. LS and NC, two young people formerly involved with the foster care system, provided much insight on their experiences with multiple traumas. Their shared comments provide important information and practice-based evidence and strategies that child and youth serving systems could incorporate into their work with children and youth who have experienced trauma.

Some of the practical applications they described as beneficial to them include:

- Staff working in schools need to be aware of, educated and informed on the effects of trauma for children and youth, and trained in the causes of disruptive behaviors and ways to address these behaviors that do not re-traumatize children and youth;
- Aftercare teams need to provide consistent and ongoing planning with youth to address the after effects of trauma, (e.g., anxiety, sadness, depressions, feelings of hopelessness, anger, shame, guilt) and to build upon their strengths to instill good self-esteem and a belief that they are worthy of and can achieve goals in their life;

- Aftercare teams need to provide ongoing assistance for children and youth to learn skills for daily life, safety planning to address potential re-traumatization, and development of goals for the “here and now” and in their future;
- Aftercare teams need to provide quick response for children and youth who have been traumatized when reports or incidents of child abuse and/or neglect occur. Teams need to remember that these children and youth have been placed in unfamiliar surroundings and they do not feel safe or trust the people or environment immediately. They must rely on the aftercare teams to provide a trusting relationship with staff that will provide safety, protection and security in their lives;
- Aftercare teams need to work across systems to advocate for children and youth who have experienced trauma, and to assist them with the work needed for their daily care and consistent planning for life transitions.

Many strategies for coping with trauma have been noted in this brief, as well as the experiences of LS and NC which can inform child and youth serving systems on the successful practices and strategies that could improve the experience of children and youth who are coping with and healing from trauma. The resources noted below offer a starting point for deeper understanding of trauma and trauma-informed approaches.
http://youth.gov/docs/Trauma_Informed_Approach_508.pdf

Appendix 1

RESILIENCE Questionnaire

Please circle the most accurate answer under each statement:

1. I believe that my mother loved me when I was little.
Definitely true Probably true Not sure Probably Not True Definitely Not True

2. I believe that my father loved me when I was little.
Definitely true Probably true Not sure Probably Not True Definitely Not True

3. When I was little, other people helped my mother and father take care of me and they seemed to love me.
Definitely true Probably true Not sure Probably Not True Definitely Not True

4. I've heard that when I was an infant someone in my family enjoyed playing with me, and I enjoyed it, too.
Definitely true Probably true Not sure Probably Not True Definitely Not True

5. When I was a child, there were relatives in my family who made me feel better if I was sad or worried.
Definitely true Probably true Not sure Probably Not True Definitely Not True

6. When I was a child, neighbors or my friends' parents seemed to like me.
Definitely true Probably true Not sure Probably Not True Definitely Not True

7. When I was a child, teachers, coaches, youth leaders or ministers were there to help me.
Definitely true Probably true Not sure Probably Not True Definitely Not True

8. Someone in my family cared about how I was doing in school.
Definitely true Probably true Not sure Probably Not True Definitely Not True

9. My family, neighbors and friends talked often about making our lives better.
Definitely true Probably true Not sure Probably Not True Definitely Not True

10. We had rules in our house and were expected to keep them.
Definitely true Probably true Not sure Probably Not True Definitely Not True

11. When I felt really bad, I could almost always find someone I trusted to talk to.
Definitely true Probably true Not sure Probably Not True Definitely Not True

12. As a youth, people noticed that I was capable and could get things done.
Definitely true Probably true Not sure Probably Not True Definitely Not True

13. I was independent and a go-getter.
Definitely true Probably true Not sure Probably Not True Definitely Not True

14. I believed that life is what you make it.
Definitely true Probably true Not sure Probably Not True Definitely Not True
https://acestoohigh.com/got-your-ace-score/

Appendix 2

Implementation of a trauma informed care approach for an organisation

From:

Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

10 IMPLEMENTATION DOMAINS

Governance and Leadership

- How does agency leadership communicate its support and guidance for implementing a trauma-informed approach?
- How do the agency's mission statement and/or written policies and procedures include a commitment to providing trauma-informed services and supports?
- How do leadership and governance structures demonstrate support for the voice and participation of people using their services who have trauma histories?

Policy

- How do the agency's written policies and procedures include a focus on trauma and issues of safety and confidentiality?
- How do the agency's written policies and procedures recognize the pervasiveness of trauma in the lives of people using services, and express a commitment to reducing re-traumatization and promoting well-being and recovery?
- How do the agency's staffing policies demonstrate a commitment to staff training on providing services and supports that are culturally relevant and trauma-informed as part of staff orientation and in-service training?
- How do human resources policies attend to the impact of working with people who have experienced trauma?
- What policies and procedures are in place for including trauma survivors/people receiving
- services and peer supports in meaningful and significant roles in agency planning, governance, policy-making, services, and evaluation?

Physical Environment

- How does the physical environment promote a sense of safety, calming, and de-escalation for clients and staff?
- In what ways do staff members recognize and address aspects of the physical environment that may be re-traumatizing, and work with people on developing strategies to deal with this?
- How has the agency provided space that both staff and people receiving services can use to practice self-care?
- How has the agency developed mechanisms to address gender-related physical and emotional safety concerns (e.g., gender-specific spaces and activities).

Engagement and involvement

- How do people with lived experience have the opportunity to provide feedback to the organization on quality improvement processes for better engagement and services?
- How do staff members keep people fully informed of rules, procedures, activities, and schedules, while being mindful that people who are frightened or overwhelmed may have a difficulty processing information?
- How is transparency and trust among staff and clients promoted?
- What strategies are used to reduce the sense of power differentials among staff and clients?
- How do staff members help people to identify strategies that contribute to feeling comforted and empowered?

Cross Sector Collaboration

- Is there a system of communication in place with other partner agencies working with the individual receiving services for making trauma-informed decisions?
- Are collaborative partners trauma-informed?
- How does the organization identify community providers and referral agencies that have experience delivering evidence-based trauma services?
- What mechanisms are in place to promote cross-sector training on trauma and trauma informed approaches?

Screening, assessment and treatment

- Is an individual's own definition of emotional safety included in treatment plans?
- Is timely trauma-informed screening and assessment available and accessible to individuals receiving services?
- Does the organization have the capacity to provide trauma-specific treatment or refer to appropriate trauma-specific services?
- How are peer supports integrated into the service delivery approach?
- How does the agency address gender-based needs in the context of trauma screening, assessment, and treatment? For instance, are gender-specific trauma services and supports available for both men and women?
- Do staff members talk with people about the range of trauma reactions and work to minimize feelings of fear or shame and to increase self-understanding?
- How are these trauma-specific practices incorporated into the organization's ongoing operations?

Training and Workforce Development

- How does the agency address the emotional stress that can arise when working with
- individuals who have had traumatic experiences?
- How does the agency support training and workforce development for staff to understand and increase their trauma knowledge and interventions?
- How does the organization ensure that all staff (direct care, supervisors, front desk and reception, support staff, housekeeping and maintenance) receive basic training on trauma, its impact, and strategies for trauma-informed approaches across the agency and across personnel functions?
- How does workforce development/staff training address the ways identity, culture, community, and oppression can affect a person's experience of trauma, access to supports and resources, and opportunities for safety?

- How does on-going workforce development/staff training provide staff supports in developing the knowledge and skills to work sensitively and effectively with trauma survivors.
- What types of training and resources are provided to staff and supervisors on incorporating trauma-informed practice and supervision in their work?
- What workforce development strategies are in place to assist staff in working with peer supports and recognizing the value of peer support as integral to the organization's workforce?

Progress monitoring and quality assurance

- Is there a system in place that monitors the agency's progress in being trauma-informed?
- Does the agency solicit feedback from both staff and individuals receiving services?
- What strategies and processes does the agency use to evaluate whether staff members feel safe and valued at the agency?
- How does the agency incorporate attention to culture and trauma in agency operations and quality improvement processes?
- What mechanisms are in place for information collected to be incorporated into the agency's quality assurance processes and how well do those mechanisms address creating accessible, culturally relevant, trauma-informed services and supports?

Financing

- How does the agency's budget include funding support for ongoing training on trauma and trauma-informed approaches for leadership and staff development?
- What funding exists for cross-sector training on trauma and trauma-informed approaches?
- What funding exists for peer specialists?
- How does the budget support provision of a safe physical environment?

Evaluation

- How does the agency conduct a trauma-informed organizational assessment or have measures or indicators that show their level of trauma-informed approach?
- How does the perspective of people who have experienced trauma inform the agency performance beyond consumer satisfaction survey?
- What processes are in place to solicit feedback from people who use services and ensure anonymity and confidentiality?
- What measures or indicators are used to assess the organizational progress in becoming trauma-informed?

http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf

Appendix 3

One example of a community tool prior to implementing trauma informed care

The Trauma System Readiness Tool (TSRT)

To note:

The Trauma System Readiness Tool (TSRT) was developed by the Chadwick Trauma Informed Systems Project (CTISP) as part of the National Child Traumatic Stress Network, with funding from the Substance Abuse and Mental Health Services Administration (SAMHSA). The TSRT is part of the larger Trauma-Informed Child Welfare Practice Toolkit that includes a number of resources that can be utilized by child welfare systems as they move towards becoming more trauma-informed. These include:

- Creating Trauma-Informed Child Welfare Systems: A Guide for Administrators
- Guidelines for Applying a Trauma Lens to a Child Welfare Practice Model
- Desk Guide on Trauma-Informed Mental Health for Child Welfare
- Desk Guide on Trauma-Informed Child Welfare for Mental Health

The TSRT is a self-report measure that was designed for child welfare systems to use as they assess the trauma-informed nature of their own system.

The TSRT was designed to be administered to multiple informants across all levels of the organization, including caseworkers, supervisors, managers and administrators. It can be completed across regions within a state or county. Results from the TSRT provide cross-informant data to each system detailing how front-line case workers' responses from the survey are similar to or different from those of supervisors and administrators.

The TSRT was designed to align with the Essential Elements of a Trauma-Informed Child Welfare System developed by the Child Welfare Committee of the National Child Traumatic Stress Network (NCTSN). These include:

1) Maximize physical and psychological safety for children and families
2) Identify trauma-related needs of children and families
3) Enhance child well-being and resilience
4) Enhance family well-being and resilience
5) Enhance the well-being and resilience of those working in the system
6) Partner with youth and families
7) Partner with agencies and systems that interact with children and families

http://surveygizmolibrary.s3.amazonaws.com/library/113599/TraumaSystemReadinessTool2.pdf