



Discussion Guide 3

Trauma-informed practice in different settings and with various populations

A Discussion Guide for
Health and Social Service Providers

March 2015



This guide is designed to assist individuals and agencies working toward developing trauma-informed approaches to service delivery and system-wide collaboration. It describes trauma-informed practice as applicable universally in mental health and substance use services; at the same time, it requires consideration of how gender and culture may affect the experience of trauma and be taken into account in trauma-informed approaches. As a principle-based approach, trauma-informed practice can be readily adapted by those working in different settings and with various populations. This guide includes practice examples, suggested resources, and sample questions to stimulate further discussion.

Trauma-informed practice as universal, yet not 'one size'

Given how commonly trauma is experienced among people coming for help in mental health and substance use services, trauma-informed practice (TIP) is considered to be a practice with universal applicability. Many applications of TIP in different settings and with diverse adults, youth, and children have common core relational and integration principles, such as

- *Building awareness* of the effects of trauma
- *Creating safety* and avoiding re-traumatization in service interactions
- *Creating opportunity* for choice and connection in interactions
- *Teaching skills* to manage symptoms/dysregulation/adaptations
- *Integrating and monitoring* trauma-informed practices within a single service and system
- *Creating multi system initiatives to enhance consistency*, helpful staging of programming and treatment, and integration
- *Establishing* widespread and ongoing *training* of staff on trauma-informed practices, and prevention of secondary traumatic stress and vicarious traumatization

At the same time, trauma-informed practice is not a "one size fits all" approach. As we work from common principles, we need to consider how the experience of trauma may differ among groups and for differing contexts. We need to tailor how we apply TIP approaches for various populations, such as girls, men, aboriginal people, refugees, people with disabilities, and transgendered people. In applying TIP principles, we need to attend to the intersections among gender, culture, and other determinants of health. The need to "braid" in gendered and intersectional approaches to trauma-informed practice is commonly acknowledged.

In different settings there are various opportunities to notice and respond to the ways in which people cope with trauma, and to make services safe and welcoming.

Trauma-informed practice in different service and community contexts

Homeless shelters have often shown leadership in working with people with trauma, mental health, and substance use concerns. They have reframed service users' lack of trust, recognizing dangerous, aggressive, dissociating, and self-injurious behaviours as efforts to deal with overwhelming feelings and as coping skills that were at least once useful.^[1] To bring trauma-informed principles into practice they have developed comprehensive trauma-informed organizational self-assessment tools for both service providers and service users.^[1,2]

Outpatient substance use treatment providers have collaborated with community services working on sexual violence to create stages of access for support on trauma, mental health, and substance use concerns experienced by women. These stages start with access to one-hour sessions on coping skills and extend to 12-week outpatient groups using a Seeking Safety model.^[3] In this way, participants can work in a self-determined, paced manner. In evaluation of the stages, participants have identified how the sessions and the group created safety for them to explore more than one issue at a time; helped them learn about the effects of trauma and the skills to manage the effects; reduced stigma and increased self-acceptance; and helped them break through isolation to connect with others and develop hope for future.^[4]

In inpatient mental health settings, a commitment to trauma-informed practice has often involved strategies such as daily community meetings or debriefing meetings for problem solving, involving clients as full participants in planning and decision making for their own treatment, and ensuring that staff are attending regular training to hone their therapeutic and coping skills.^[5] In one inpatient setting, two types of debriefing sessions were used, both of which involved the staff and the client(s) in non-punitive and supportive ways.^[6] The first debriefing was informal, happening immediately after an incident. The second debriefing happened two to three days later, looking more deeply at what happened, and determining whether there were lessons to be derived to support treatment planning. With such approaches, the use of seclusion and restraint has been significantly reduced and the goal of preventing further traumatization achieved.

The principles of trauma-informed practice have been applied successfully in **primary health care settings**,^[7] to **child welfare practice**,^[8] and in many other settings where people with mental health and substance use problems may access assistance. The breadth of the settings involved demonstrates how trauma-informed practice is universally applicable, and its flexibility as a principle-based approach.

Further Reading and Links

Creating Trauma-Informed Child Welfare Systems: A Guide for Administrators (2012)

www.lacdcfs.org/katieA/docs/Trauma_Informed_CW_Systems_Guide.pdf

Handbook on Sensitive Practice for Health Care Practitioners

<http://www.phac-aspc.gc.ca/sfv-avf/sources/nfnts/nfnts-sensi/index-eng.php>

A Long Journey Home: A Guide for Creating Trauma-Informed Services for Mothers and Children Experiencing Homelessness

<http://homeless.samhsa.gov/ResourceFiles/ALongJourneyHome.pdf>

Seeking Safety

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

TIP 57: Trauma-Informed Care in Behavioral Health Services

<http://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816>

Trauma-Informed Care: Best Practices and Protocols for Ohio's Domestic Violence Programs

http://stoprelationshipabuse.org/wp-content/uploads/2013/06/ODVN_Trauma-InformedCareBestPracticesAndProtocols.pdf

Gender-informed, culturally informed, trauma-informed practice

1. Trauma-informed practice with women

Dr Norma Jean Proffit and others who coordinate women's services in Nova Scotia have noted that their work with women starts with the recognition of how common violence and trauma are in women's lives and how these experiences often precede their substance use / mental health concerns and are interconnected with other gendered realities such as higher rates of poverty and key responsibility for caring for children. A key part of creating safety in services involves "normalizing" the fact that often women have experienced or are experiencing violence and trauma, and that there is no pressure to disclose or give details. Earning trust is key to trauma-informed practice with women. Trust can be earned through sharing, co-reviewing, providing clarity, and discussing documents related to the services available to women. This includes the consent process along with how choices are offered, confidentiality, and how the involvement with child protection is described.

Further Reading and Links

S. Covington. *Beyond Trauma: A Healing Journey for Women*. Hazeldon, 2003.

N. Finkelstein et al. *Enhancing Substance Abuse Recovery through Integrated Trauma Treatment*, 2004.

<http://homeless.samhsa.gov/resource/enhancing-substance-abuse-recovery-through-integrated-trauma-treatment-25057.aspx>

Jean Tweed Centre. *Trauma Matters: Guidelines for Trauma-Informed Services in Women's Substance Use Services*, March 2013.

<https://fasdprevention.wordpress.com/2013/04/17/trauma-matters-guidelines-for-trauma%e2%80%90informed-practices-in-womens-substance-use-services/>

L. Haskell. *Bridging Responses: A Front-Line Worker's Guide to Supporting Women Who Have Posttraumatic Stress*. Toronto: Centre for Addiction and Mental Health, 2001.

British Columbia Centre of Excellence for Women's Health. *Trauma-Informed Online Tool*, 2011.

<http://www.coalescing-vc.org/virtualLearning/documents/trauma-informed-online-tool.pdf>

2. Trauma-informed practice with men

A number of experts have identified key considerations in implementing trauma-informed practice with men.^[9-11] Dr. Bruce Dienes of Chrysalis House in Kentville notes that many harmful myths and gendered stereotypes create barriers for men to seek assistance or speak about their experience of abuse.^[9] These include the myth that men who have been abused are likely to become abusers, and that abuse of boys is rare (when it is about 1 in 6). Experts who work with men with histories of trauma note how important it is to include – in trauma-informed approaches with men – attention to redefining masculinity in relation to powerlessness, trust, and expression of emotion.

Further Reading and Links

S. McDonald & A. Tijerino. *Male Survivors of Sexual Abuse and Assault: Their Experiences.* Department of Justice Canada, Research and Statistics Division, 2013.
http://www.justice.gc.ca/eng/rp-pr/cj-jp/victim/rr13_8/rr13_8.pdf

T. Wilken. *Rebuilding Your House of Self-Respect: Men recovering in group from childhood sexual abuse.* 2nd edition. Hope and Healing Associates, 2008.
<http://www.silencetohope.com/>

Healing the Hurt: Trauma-Informed Approaches to the Health of Boys and Young Men of Color
www.fpg.unc.edu/~pas/PDFs/Drexel_HealingtheHurt_FullReport.pdf

R. Falot & R. Bebout. "Acknowledging and Embracing 'the Boy inside the Man': Trauma-informed Work with Men." In N. Poole & L. Greaves, eds, *Becoming Trauma Informed.* Toronto: Centre for Addiction and Mental Health, 2012.

Status of Women Canada. *Engaging Men and Boys in Ending Violence Against Women and Girls.*
<http://cjproject.engagingmenandboys.ca/>

3. Trauma-informed practice with aboriginal men and women

The historical and intergenerational trauma related to colonization, the residential school experience, and the '60s scoop, and other trauma experienced by aboriginal people in Canada, are like no other. Trauma associated with continuing family separation, high levels of incarceration, and appallingly high rates of violence against aboriginal women continues.^[12] Thus, trauma-informed, gender-informed, culturally safe practice is critical. Culturally responsive and safe services are being developed and advocated. Janet Pothier of the Confederacy of Mainland Mi'kmaq describes trauma-informed services as those that (a) recognize how we are all bearers of culture, (b) interrupt unequal power relations, and (c) rectify how healthcare has historically not recognized traditional cultural interventions that support healing and wellness.^[13] Approaches that integrate Indigenous cultural interventions and trauma-informed principles are currently being offered in residential treatment settings^[14,15] and in community based services.^[16]

Further Reading and Links

R. Linklater. *Decolonizing Trauma Work: Indigenous Stories and Strategies*, 2014.

This book engages 10 indigenous healthcare practitioners in a dialogue regarding indigenous approaches to helping people through trauma.

<http://fernwoodpublishing.ca/book/decolonizing-trauma-work>

***Trauma Informed Relationships: Building Safety and Trust*, 2013.**

The Saint Elizabeth First Nations, Inuit and Métis Program and Klinik Community Health Centre have developed an online course on trauma-informed practice.

<http://saintelizabeth.com/getmedia/9bee93cf-512d-465c-a1da-ab40e495e8c3/FNIMP-TraumaInformedRelationships-Final-May-29-2013.pdf.aspx>.

***Honouring Our Strengths: Culture as Intervention in Addictions Treatment*, 2012.**

(Online document)

<http://www.addictionresearchchair.ca/creating-knowledge/national/honouring-our-strengths-culture-as-intervention/>

4. Trauma-informed practice with the rainbow community

The rainbow community includes a diverse group of individuals and groups identifying as lesbian, gay, bisexual, transsexual, transgendered, two spirited, intersexed, and questioning (LGBTTTIQ). Common to this diverse community is significant experience of trauma. Lesbian, gay, and bisexual youth report very high rates of verbal victimization^[17] as well as sexual and physical abuse and assault at school,^[18] and sexual orientation victimization among this sub-group has been associated with post-traumatic stress symptoms.^[19] This extends to individuals identifying as transgendered, with increased rates of violence and threats both in school and within their communities with family and friends.^[20]

Further Reading and Links

The Youth Project Nova Scotia links LGBTQ youth with allies who understand safety within Nova Scotia.

www.youthproject.ns.ca/ally/index.php

Trauma among Lesbian, Gay, Bisexual, Transgender, or Questioning Youth

http://www.nctsn.org/nctsn_assets/pdfs/culture_and_trauma_brief_LGBTQ_youth.pdf

C. Taylor & T. Peter, et al. *Every class in every school: The first national climate survey on homophobia, biphobia, and transphobia in Canadian schools*. Final report. Toronto, ON: Egale Canada Human Rights Trust, 2011.

<http://egale.ca/wp-content/uploads/2011/05/EgaleFinalReport-web.pdf>

Rainbow Health Ontario. Online resources for working with members of the rainbow community:

www.rainbowhealthontario.ca/

5. Trauma-informed practice with boys and girls

Trauma-informed services for children and their families and caregivers are provided in ways that

- recognize the universal need for children's or young people's physical and emotional safety
- build self-efficacy and basic self-regulation skills
- create relational and culturally safe ways of determining the need for trauma-specific interventions
- involve parents and caregivers in respectful and non-traumatizing ways

The experiences of and effects of trauma among children and youth are gendered. Boys are more likely to experience physical assault, physical bullying, and physical threats, and are slightly more likely to have witnessed violence.^[21,22] However, girls are more likely to experience sexual victimization, psychological and emotional abuse, Internet harassment, and emotional bullying.

Reactions to traumatic events are likely to differ based on the child's age. Children 0–6 often recreate the traumatic event in their imaginary play or have nightmares about the event. Children aged 1½–6 were more likely than youth to act out aggressively. Children aged 7–12 were most likely to report feelings of re-living the trauma and difficulty with expressing sadness or anger.^[23]

There is a growing body of research on trauma-informed interventions with children and their families in child protection, child and youth mental health, school, and other settings.

Further Reading and Links

The National Child Traumatic Stress Network. *Creating Trauma-Informed Child-Serving Systems. Service Systems Brief, 2007.*

http://www.nctsn.org/sites/all/modules/pubdlnet/pubdlnet.php?file=/sites/default/files/assets/pdfs/Service_Systems_Brief_v1_v1.pdf

The Chadwick Trauma-Informed Systems Project. *Creating Trauma-Informed Child Welfare Systems: A Guide for Administrators, 2012.*

www.lacdcfs.org/katieA/docs/Trauma_Informed_CW_Systems_Guide.pdf

SAMHSA. *Helping Children and Youth Who Have Experienced Traumatic Events, 2011.*

http://archive.samhsa.gov/children/SAMHSA_Short_Report_2011.pdf

G. Hodas. *Responding to childhood trauma: The promise and practice of trauma-informed care, 2006.*

<http://www.nsvrc.org/publications/reports/responding-childhood-trauma-promise-and-practice-trauma-informed-care>

National Technical Assistance Center for Children's Mental Health. *Trauma Informed Care Perspectives and Resources.* (Online tool.)

<http://gucchdtacenter.georgetown.edu/TraumaInformedCare/index.html>

6. Trauma-informed practice with youth

Adolescence is a time of establishing a sense of identity and independence. While every individual youth is on his/her own path in this journey, youth aged 13–18 are likely to react to traumatic experiences expressing feelings of fear, guilt, and isolation.^[19]

Trauma-informed services for youth are provided in ways that

- recognize the universal need for physical and emotional safety
- create a safe and trustworthy environment to build on and support the youth establishing a sense of self
- create opportunities for the youth to achieve power and control
- build self-efficacy and basic self-regulation skills
- create relational and culturally safe ways of determining the need for trauma-specific interventions

Homeless youth often have experienced traumatic events before leaving their homes, and many are re-traumatized living on the street. The cumulative victimization can leave youth feeling powerless. If they do enter our services, they do so with caution, with the intent to prevent possible further harm.

Further Reading and Links

SAMHSA. *Helping Children and Youth Who Have Experienced Traumatic Events*, 2011.

http://archive.samhsa.gov/children/SAMHSA_Short_Report_2011.pdf

The National Child Traumatic Stress Network. Learning Center for Child and Adolescent Trauma

<http://learn.nctsn.org/course/index.php?categoryid=3>

Homeless Resource Centre

<http://homeless.samhsa.gov/Default.aspx>

7. Trauma-informed practice with refugees

Most refugees experience traumatic events and challenges, such as violence, persecution, multiple losses, social disruption, and economic hardship. Many refugees and non-refugee immigrants who have left their countries to escape social/political turmoil have experienced pre-migratory traumatic events. Refugee and non-refugee immigrants are not a homogeneous group; thus it is important to acknowledge various individual or cultural responses to trauma. Intergenerational trauma may be common for immigrants from the Palestinian, Jewish, Roma, Bhutanese, and Vietnamese communities.

Trauma-informed approaches can involve understanding and validating the impact of multiple stressors, recognizing the meaning of trauma and healing within the cultural context, creating a climate of hope, rebuilding the person's sense of control, and facilitating social support and resilience.^[24] The trauma-informed approach of not forcing disclosure is particularly relevant, as many refugees may be unwilling or unable to share their personal stories.^[23] TIP workers can be alert for signs of post-traumatic stress disorder, unexplained somatic symptoms, sleep disorders, and depression.^[25] They may also find that people who have lived through traumatic events do not necessarily present mental health problems or illnesses if they have solid social and family support systems.

With immigrant and refugee groups, it may be helpful to address trauma not from an individual perspective but through collective and family-centred interventions. Social support through the involvement of families is important, as traumatic events rarely affect just one member of a family. Incorporating a family-centred approach into psychosocial programs can help to rebuild the sense of trust and connections with others. Support for connecting and participating in community activities, such as community gardens, or volunteering in their communities may be helpful. Refugees and immigrants with trauma histories may not need or choose trauma treatment, and the principles of awareness, safety, respect, choice, and empowerment can go a long way toward supporting health and resilience.

Trauma-informed practice with refugees underlines the need for working collaboratively among mental health service providers and settlement supports to address basic needs such as shelter, employment, and access to healthcare. And it is important to note that complementary therapies – exercise, yoga, art therapy, acupuncture, mindfulness, etc. – have shown positive impact in preventing and supporting refugees and immigrants affected by trauma.

Further Reading and Links

National Center of Trauma Informed Care. *Transcending Violence: Emerging Models for Trauma Healing in Refugee Communities*, 2008.

<http://www.theannainstitute.org/RefugeeTraumaPaperJuly212008.pdf>

K. McKenzie. *Re-Conceptualizing "Trauma": Examining the Mental Health Impact of Discrimination, Torture & Migration for Racialized Groups in Toronto*, 2009.

<http://www.acrossboundaries.ca/conference/Trauma%20Report.pdf>

***Resilience and Recovery After War: Refugee Children and Families in the United States. Report of the APA task force on the Psychosocial Effects of War on Children and Families Who Are Refugees from Armed Conflict Residing in the United States*, 2010.**

<http://www.apa.org/pubs/info/reports/refugees-full-report.pdf>

Canadian Collaboration for Immigrant and Refugee Health. *Guidelines for Immigrant Health, Appendix 11: "Post traumatic stress disorder: evidence review for newly arriving immigrants and refugees,"* 2011.

www.cmaj.ca/content/suppl/2010/06/07/cmaj.090313.DC1/imm-ptsd-11-at.pdf

D. Johnson. *Helping Refugee Trauma Survivors in the Primary Care Setting*. The Center for Victims of Torture, 2005.

http://cvt.org/sites/cvt.org/files/u11/Helping_Refugee_Trauma_Survivors_Primary_Care.pdf

Discussion questions

The following questions are intended to support direct service providers, program leaders, and system planners in reflecting on their current practice, policies, and procedures.

1. Trauma-informed practice is sometimes described as a “universal precaution.” Given the prevalence of trauma, all staff in an organization are highly likely to encounter individuals with histories of trauma. What are some of the shifts that can be made universal in your program delivery and that do not require knowledge of an individual's trauma history but address the needs for safety, choice, and control for this person? Are there possible benefits for individuals who do not have a history of trauma?
2. With what populations or sub-populations does your organization primarily work? Do these groups have unique needs, strengths, or concerns that might indicate the value of a tailored approach to trauma-informed practice? (For example, think about the unique needs of veterans, immigrant women with histories of violence [e.g., intimate partner, sexual violence], children who have been removed from their families and placed in care, etc.)
3. How much choice do your clients have in the services they receive, and when, where, and by whom the service is provided (e.g., time of day or week, office vs. home vs. other locale, gender of provider)? Are you able to work in more flexible ways? What groups might benefit from these types of strategies?
4. Physical and emotional safety is a key principle of trauma-informed practice. What are the barriers to developing safety in your particular service and community context? What are some of the strategies you have used to increase feelings of safety? Have they improved engagement and retention? What else could you be doing?
5. Are there opportunities (e.g., attending a community event, reading a local newspaper, attending a lunch-time seminar or webinar) to make stronger connections with one of the populations or communities that you work with? How can these types of activities contribute to your own learning and support relationship building within the context of trauma-informed practice?

References

1. Guarino, K., et al. Trauma-Informed Organizational Toolkit for homeless services. Rockville, MD: Center for Mental Health Services, SAMHSA, and the Daniels Fund, NCTSN and WK Kellogg Foundation, 2009.
<http://www.performwell.org/index.php/find-surveyassessments/trauma-informed-organizational-toolkit>
2. Hopper, E.K., E.L. Bassuk, and J. Olivet. "Shelter from the storm: Trauma-informed care in homelessness services settings, *The Open Health Services and Policy Journal* 3 (2010): 80–100.
3. Najavits, L.M. *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*. New York: Guilford Press, 2002.
4. Poole, N., and D. Pearce. *Seeking Safety, An integrated model for women experiencing post traumatic stress disorder and substance abuse: A pilot project of the Victoria Women's Sexual Assault Centre, Evaluation Report*. Victoria: Victoria Women's Sexual Assault Centre, 2005.
5. Bloom, S.L., et al. "Multiple opportunities for creating sanctuary." *Psychiatric Quarterly* 74(2) (2003): 173–90.
6. Azeem, M.W., et al. "Effectiveness of Six Core Strategies Based on Trauma Informed Care in Reducing Seclusions and Restraints at a Child and Adolescent Psychiatric Hospital." *Journal of Child & Adolescent Psychiatric Nursing*. 24(1) (2011): 11–15.
7. Schachter, C., et al. *Handbook on Sensitive Practice for Health Care Practitioners: Lessons from Adult Survivors of Childhood Sexual Abuse*. Ottawa: National Clearinghouse on Family Violence, 2008.
8. Chadwick Trauma-Informed Systems Project. *Creating Trauma-Informed Child Welfare Systems: A Guide for Administrators.*, San Diego: Chadwick Center for Children and Families, 131, 2013.
9. Poole, N., et al. Trauma informed practice in different settings and with various populations, in *Trauma Informed Practice in Nova Scotia Webinar Series*. (Online), January 29, 2015.
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11. Rich, J., et al. *Healing the Hurt: Trauma-Informed Approaches to the Health of Boys and Young Men of Color*. Philadelphia: Drexell University School of Public Health, Drexel University College of Medicine, The California Endowment, 2009.

12. Haskell, L., and M. Randall. "Disrupted attachments: A social context complex trauma framework and the lives of Aboriginal Peoples in Canada." *Journal of Aboriginal Health* 5(3) (2009): 48–99.
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14. Honouring Our Strengths: Culture as Intervention in Addictions Treatment. Cited March 28, 2015.
Accessed from <http://www.addictionresearchchair.ca/creating-knowledge/national/honouring-our-strengths-culture-as-intervention/>.
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16. Bryans, M., et al. *Supporting Pregnant and Parenting Women who Use Substances: What Communities are Doing to Help*. Vancouver: BC Centre of Excellence for Women's Health, CanFASD Research Network, 2012.
http://www.canfasd.ca/files/What_Communities_Are_Doing_to_Help_February_7_2013.pdf:
17. D'Augelli, A.R., A.H. Grossman, and M.T. Starks, "Childhood Gender Atypicality, Victimization, and PTSD Among Lesbian, Gay, and Bisexual Youth." *Journal of Interpersonal Violence* 21(11) (2006): 1462–82.
18. Friedman, M.S., et al. "A meta-analysis of disparities in childhood sexual abuse, parental physical abuse, and peer victimization among sexual minority and sexual nonminority individuals." *American Journal of Public Health* 101(8) (2011): 1481–94.
19. Dragowski, E.A., et al. "Sexual Orientation Victimization and Posttraumatic Stress Symptoms Among Lesbian, Gay, and Bisexual Youth." *Journal of Gay & Lesbian Social Services* 23(2) (2011): 226–49.
20. Stoitzer, R. "Violence against transgender people: A review of United States data." *Aggression and Violent Behavior* 14(3) (2009): 170–79.
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22. Finkelhor, D., et al. "Polyvictimization: Children's Exposure to Multiple Types of Violence, Crime, and Abuse. In *Juvenile Justice Bulletin*. Washington: US Department of Justice, 2011.
23. SAMHSA. *Helping Children and Youth Who Have Experienced Youth Who Have Experienced Traumatic Events*. Washington: SAMHSA, 2011.
24. Agic, B. "Trauma-informed care for refugees. In N. Poole and L. Greaves, eds, *Becoming Trauma Informed*, 123–36. Toronto: CAMH, 2012.
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