Discussion Guide 4

Trauma-informed practice at the agency, interagency and leadership levels

A Discussion Guide for
Health and Social Service Providers

May 2015

IWK Health Centre

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This discussion guide is designed to assist individuals and agencies working toward developing trauma-informed approaches to service delivery and system-wide collaboration. It describes key components of "becoming trauma-informed" for consideration by agencies in order to shift practices and policies, support worker wellness, refresh agency cultures, and work with others across agencies, sectors, and systems. Trauma-informed practice not only involves working differently with service users, but it also encompasses shifts at the agency, interagency, and systemic levels – as shown in the following figure. This guide includes examples, suggested resources, and questions to stimulate further discussion.

Agency-level work on trauma-informed practice

1. Policy and practice review

Organizations have found it beneficial to have a working group – comprising leadership, supervisors, direct service staff, support staff, and service users – to guide a process of reviewing policies and practices to collectively decide on improvements that will take trauma into account in all aspects of service delivery. Often, this group organizes educational opportunities and leads a review of the ways in which intake, service planning, and service delivery are done, using checklists or questions.[1–3]

To support responsiveness to service users with trauma experiences, agencies will have some broad questions:

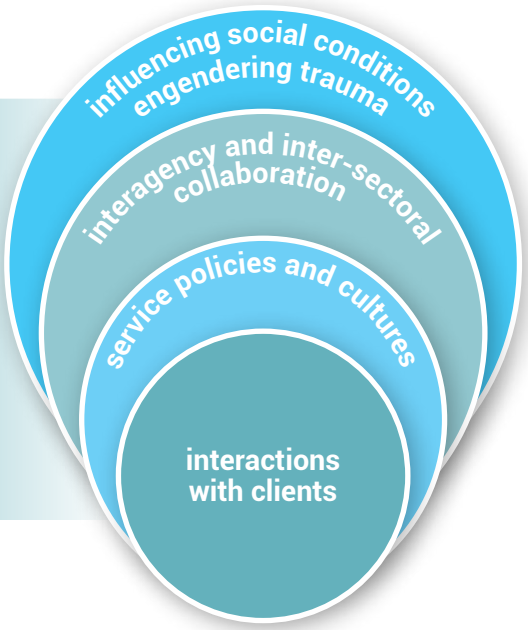
To what extent do the program's activities and settings

- ensure that our waiting areas and entrance spaces are welcoming? This may mean having fewer plexiglass enclosures surrounding administrative support staff and ensuring that staff are welcoming and friendly, as well as attention to the decor of the space, etc.
- ensure the physical and emotional safety of its clients?
- maximize trustworthiness by making the tasks involved in service delivery clear, by ensuring consistency in practice, and by maintaining boundaries that are appropriate to the program?
- maximize clients' experiences of choice and control?
- maximize collaboration and sharing of power?
- prioritize consumer empowerment and skill building?

(abridged from R. Fallot & M. Harris,[2] *Creating Cultures of Trauma-Informed Care: a Self-Assessment and Planning Protocol)*

The foundational component of agency-level work is developing individual and organizational knowledge that trauma is pervasive and that trauma experiences have effects that impact relational engagement, behaviour, and all aspects of health.[4] The creation of a safe, nurturing, and predictable social environment in the agency is a key component, as is helping clients and their families build relationships and increase self-efficacy and hope.

Trauma-informed practice involves work at all these levels. This discussion guide focuses on the agency and interagency levels.



Further Reading and Links

Guidance for implementing a trauma-informed approach: SAMHSA. The Concept of Trauma and Guidance for a Trauma-Informed Approach, 2014.
http://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884

Jean Tweed Centre. *Women, Substance Use, and Trauma: A System Level Perspective.*
http://jeantweed.com/wp-content/themes/JTC/pdfs/One%20pager%20Systems%20Level.pdf

N. Poole & L. Greaves, eds. *Becoming Tra uma Informed*. Centre for Addiction and Mental Health, 2012.
http://www.camh.ca/en/education/about/camh_publications/Pages/becoming_trauma_informed.aspx

2. Service user involvement

In an article entitled "Trauma-Informed or Trauma-Denied . . .," D.E. Elliot and colleagues discuss how it is through the involvement of service users that many of the other principles of trauma-informed practices (TIP) are realized.[5] They note how people with mental health, substance-use, and trauma-related concerns are often not meaningfully involved in service design, delivery, and evaluation, and they advocate for service user involvement as resource advocates, peer counsellors, and evaluation advisors.

Service users, service providers, and health system planners can all benefit from learning how to participate meaningfully and respectfully in TIP planning processes. Some jurisdictions have offered training in Appreciative Inquiry for all types of participants in agency and system planning on TIP.[6] In the Women, Co-Occurring Disorders and Violence Study (WCDVS) in the US, the consumers/survivors / recovering women who participated in the planning of the study, service integration, and delivery models, had the opportunity to attend a leadership academy and a trauma studies seminar program to support their skills in guiding service delivery development.[7,8]

Further Reading and Links

National Association of State Mental Health Program Directors. *Engaging Women in Trauma-Informed Peer Support: a Guidebook*. NCTIC, 2012.
http://www.nasmhpd.org//content/engaging-women-trauma-informed-peer-support-guidebook

Critical Appreciative Inquiry. In J. Cockell & J. McArthur-Blair, *Appreciative Inquiry in Higher Education: A Transformative Force*, 51–74, 2012.

Society for Community Research and Action. Resolution on Self-Help Support Groups.
http://www.scra27.org/what-we-do/policy/rapid-response-actions/resolution-self-help-support-groups/

3. Preventing secondary traumatization by supporting worker health

Service providers can be affected by their work when they are providing support to people who have experienced trauma in their lives. Some of the terms used to describe how service providers can be affected are vicarious trauma, trauma exposure response, secondary trauma, burnout, compassion fatigue, and empathic stress. Many practitioners have experienced or witnessed varying degrees of trauma, and many more have been exposed to repeated stories of trauma and violence. Given this, self-awareness and understanding of vicarious trauma are critical components of trauma-informed agency-level approaches. *Vicarious traumatization* refers to "the cumulative transformative effect on the helper working with the survivors of traumatic life events."[9] The effects of vicarious trauma occur on a continuum and are influenced by the amount of traumatic information a practitioner/worker is exposed to, the degree of organizational support in the workplace, personal life support, and personal experiences of trauma.

In a study of clinicians, researchers found that practices such as developing mindful self-awareness, embracing complexity, having active optimism, and practising holistic self-care were protective against secondary traumatization.[10] They also found that empathic engagement with traumatized clients appeared to be protective: it is less about exposure to the stories of survivors than a lack of authentic connection that creates risk. That risk of vicarious trauma is more likely to be avoided when authentic connection is possible.

Agency-wide interventions to support worker health have been tested against focusing only on individual self-care. One example is the Resilience Alliance Intervention, which involves staff at all levels of a child welfare organization (child protection specialists, supervisors, managers, and deputy directors). Staff learn resilience skills and safely discuss challenges and concerns with their peers while they maintain a focus on the team and on core concepts of optimism and collaboration.[11] Positive outcomes related to resilience, perceived co-worker and supervisor support, and decreased negative perceptions of themselves and their work were documented over multiple offerings of the Resilience Alliance Intervention training.

Further Reading and Links

K. Saakvitne and L. Pearlman. *Transforming the Pain: A Workbook on Vicarious Traumatization*. New York: Norton, 1996.

L. Van Dernoot Lipsky. *Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others*. San Francisco: Berrett-Koehler, 2009.

B. Rothschild and M. Rand. *Help for the Helper: The Psychophysiology of Compassion Fatigue and Vicarious Trauma*. Norton, 2006.

The Best Start Resource Centre. *When Compassion Hurts: Burnout, Vicarious Trauma & Secondary Trauma in Prenatal and Early Childhood Service Providers, 2012*.
http://beststart.org/resources/howto/pdf/Compassion_14MY01_Final.pdf

***M. Gilbert & D. Bilsker. Psychological Health and Safety: An Action Guide for Employers.* Ottawa: Mental Health Commission of Canada (MHCC), 2012.**
http://www.mentalhealthcommission.ca/English/system/files/private/document/Workforce_Employers_Guide_ENG.pdf

National Child Traumatic Stress Network. *Secondary Traumatic Stress: A Fact Sheet for Child-Serving Professionals, 2011.*
http://www.mindfuljourneycounselingstowe.com/upload/2ndary%20Traumatic%20Stress.pdf

J. Richardson. *Guidebook on Vicarious Trauma: Recommended Solutions for Anti-Violence Workers.* Health Canada, 2001. See The Self-Care Checklist, p. 30.
http://publications.gc.ca/collections/collection_2008/phac-aspc/H72-21-178-2000E.pdf

4. Agency culture

Principles of Trauma-Informed Practice include:[2]

- Trauma awareness
- Safety and trustworthiness
- Opportunity for choice, collaboration, and connection
- Strengths-based skill building and empowerment
- Recognition of cultural, historical, and gender issues
- Promotion of service user and peer involvement

Organizations and agencies committed to trauma-informed practice emphasize the importance of applying the trauma-informed principles of awareness, safety, trustworthiness, choice, collaboration, and empowerment at the agency level – not just at the level of client interactions with clients. Trauma-informed agencies have a culture that reflects these principles of trauma-informed practice.[2]

Co-learning, flattening of hierarchy, and fostering of agency-wide emotional intelligence have all been cited as indicative of trauma-informed organizations.[12]

Organizations have used communities of practice to voluntarily learn together about trauma, to discuss and plan service adjustments, to monitor and discuss service improvements, and to continuously renew learning.[13] Communities of practice support the development of trauma-informed agency cultures in how they support co-learning, sharing of expertise, and engagement, with evidence of best and promising practice.

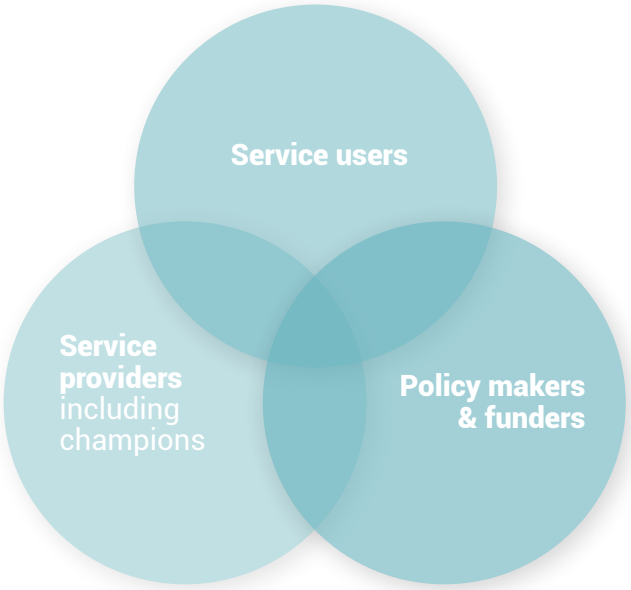
Involving clients, staff, leaders, and partners from the community and from other systems in learning together, and in debriefing critical incidents,[14] can also contribute to a trauma-informed culture at the agency level.

Further Reading and Links

The Sanctuary Model
http://www.sanctuaryweb.com/Home.aspx
On this website and in the book *Restoring Sanctuary: A New Operating System for Trauma-Informed Systems of Care*, Sandra Bloom and her colleagues describe organizational level commitments that support the implementation of trauma-informed practice.

Interagency-level work on trauma-informed practice – "Relational System Change"

A multisite study of trauma-informed service delivery with women in the US described the implementation of a model of change for integrating services across systems and sectors. [15] The authors found that it was important for groups of individuals from different parts of the system to work together to have the opportunity to explore core values and beliefs, system mandates, and restrictions in a context of listening and appreciation for both what was working and what needed challenging and changing. They included service users and service providers as well as policy makers and funders in strategic discussions (carefully attending to safety, listening, and respect) and cross-training.



The study found that this work resulted in

- understanding the centrality of trauma for service users
- increased comfort by service providers in working in a transdisciplinary way with service users
- increased understanding and reduction of barriers to making referrals between services, and increased centrality of trauma/violence service providers
- increased integration among mental health, substance use, violence, and parenting services to create a continuum of care for women and their children
- reduced structural barriers, through changes in policies such as licensing and funding, and through changes to agency contracts to support integrated, trauma-informed care
- increased availability of trauma-specific and trauma-informed services

Interagency working groups, networks, and other mechanisms that reduce isolation and share responsibility for creating systems of care and promoting social justice are key to implementing trauma-informed policy and practice. The US National Center for Trauma-Informed Care (NCTIC) notes:

> Trauma-informed care is as much about social justice as it is about healing[16]

Further Reading and Links

SAMHSA, National Centre for Trauma-Informed Care. *Changing Communities, Changing Lives,* September 2012.
http://www.nasmhpd.org/sites/default/files/NCTIC_Marketing_Brochure_FINAL(2).pdf

Leadership-level action to guide relational system change

Leaders now need to understand and enact new ways of operating in a networked world characterized by "openness, sharing of intellectual property and resources with others, connecting with higher purpose and interdependence between teams, competing organisations and whole sectors; nationally and globally."[17] (p. 15)

In this new networked world, leaders need to act as connectors and curators of knowledge,[17] getting involved in learning and planning with people at all levels of systems such as the mental health and substance-use system, and to explore how to best achieve the paradigm shift toward trauma-informed practice. Whole-system change toward a trauma-informed approach has been possible when leaders act as connectors and enablers of early adopters; implementing the Signs of Safety approach within the Western Australia child welfare system is an example.[18] They achieved whole-system change in a practice-led way, with leadership fostering and supporting champions for change and change agents from within the workforce. These practice leaders have led ongoing small-group discussions in deliberative spaces where critical thinking, reflection, and feedback on practice change is encouraged. They use training, supervision, and role modelling within an enabling environment to make change, recognizing that the majority of learning is acquired not through formal learning but through work-based activities and through networking and collaboration. In this way, the emergent innovative practice is best embedded at the local level. Leaders are instrumental in supporting the necessary training, coaching, and supervision, and in aligning policies and procedures to new ways of working that emphasize coordination and collaboration.

Further Reading and Links

SAMHSA. *Trauma-informed Care in Behavioral Health Services*. Treatment Improvement Protocol (TIP) Series 57, 159–72, 2014.
http://store.samhsa.gov/shin/content/SMA14-4816/SMA14-4816.pdf

World Health Organization and Alliance for Health Policy and Systems Research. *Systems Thinking for Health Systems Strengthening*, 2009.
http://www.who.int/alliance-hpsr/resources/9789241563895/en/

UK National Health Service. *The New Era of Thinking and Practice in Change and Transformation: a Call to Action for Leaders of Health and Care,* 2014.
www.nhsiq.nhs.uk/download.ashx?mid=10240&nid=10086

Discussion questions

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

- Has your organization been supported in doing a trauma-informed agency assessment? If so, are leaders, clients, partners, and all levels of staff involved?
- How do staff receive training, coaching, mentoring, and debriefing on the impact of trauma and strategies for trauma-informed approaches across the agency? How do responses to this question vary by different people with different functions in the agency?
- Are communities of practice or other dialogic methods being used to support co-learning, mentoring, and discussion of actions?
- Is there a system in place for communication with partner agencies?
- Are there mechanisms for cross-agency and cross-sectoral training and discussion in place? Do they appreciate what each partner does and promote shared expertise about trauma-informed practice?
- What processes are in place to monitor your agency's progress in becoming trauma-informed? What indicators are used to assess progress?

Selected resources

Coalescing on Women and Substance Use
www.coalescing-vc.org
The "Developing Trauma-Informed Practices" section of this site gives an overview of agency- and system-level trauma-informed care. It provides links to recommended readings and web resources about strategies for developing trauma-informed services.

SAMHSA's National Center for Trauma-Informed Care
www.samhsa.gov/nctic/
This comprehensive website from the US Substance Abuse and Mental Health Services Administration provides information on trauma-informed practices and implementation.

Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol
This tool, developed by Community Connections leaders in Washington, DC, uses the principles of trauma-informed practice as a foundation for agency assessment.

SAMHSA's National Centre for Trauma-Informed Care. *Changing Communities, Changing Lives*
http://www.nasmhpd.org/sites/default/files/NCTIC_Marketing_Brochure_FINAL(2).pdf

Klinic Community Health Centre. Trauma-informed: The Trauma Toolkit, Second edition,
http://trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed_Toolkit.pdf

References

1. Brown, V.B., M. Harris, and R. Fallot. Moving toward trauma-informed practice in addiction treatment: *A collaborative model of agency assessment, Journal of Psychoactive Drugs,* 45(5) (2013): 386–93.
2. Fallot, R., and M. Harris. *Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. 2.2*, 1–18, 2009.
3. Poole, N., et al. *Trauma Informed Practice Guide.* Victoria, BC: British Columbia Centre of Excellence for Women's Health and Ministry of Health, Government of British Columbia, May 2013.
4. Conradi, L., and C. Wilson. Managing traumatized children: a trauma systems perspective, *Current Opinion In Pediatrics*, 22(5) (2010): 621–25.
5. Elliott, D.E., et al. Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women, Journal of Community Psychology 33(4) (2005): 461–77.
6. Cockell, J., and J. McArthur-Blair. "Collaborative teams and groups." In J. Cockell and J. McArthur-Blair, eds, A*ppreciative Inquiry in Higher Education: A Transformative Force,* 173–91. San Francisco: Jossey-Bass, 2012.
7. Prescott, L., "Consumer/survivor/secovering women: A guide for partnerships in collaboration." In *Women, Co-occurring Disorders and Violence Study Coordinating Center.* Substance Abuse and Mental Health Services Administration, 2001.
8. Mockus, S., et al. "Developing consumer/survivor/recovering voice and its impact on services and research: Our experience with the SAMHSA Women, Co-occurring Disorders and Violence study," *Journal of Community Psychology* 33(4) (2005): 51–525.
9. Thorndike, F.P., R. Wernieke, M.Y. Pearlman, and D.A.F. Haaga. "Nicotine dependence, PTSD symptoms, and depression proneness among male and female smokers," *Addictive Behaviors.* 31 (2006): 223–31.
10. Harrison, R.L., and M.J. Westwood. "Preventing vicarious traumatization of mental health therapists: Identifying protective practices," *Psychotherapy: Theory, Research, Practice, Training* 46(2) (2009): 203–19.
11. ACS-NYU Children's Trauma Institute. *Addressing secondary traumatic stress among child welfare staff,* 5. New York: NYU, n.d.
12. Bloom, S.L., and B. Farragher. *Restoring Sanctuary: A new operating system for trauma-informed systems of care*. New York: Oxford University Press, 2013.
13. Bopp, J., and N. Poole. "Repairing the Holes in the Net: Using Communities of Practice to Strengthen Collaboration." *In Collaboration and Complexity: Seeking Out New Forms of Life.* Canadian Collaborative Mental Health Care Conference (June 27, 2013). Montreal.
14. 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.
15. Markoff, L.S., et al., "Relational systems change: Implementing a model of change in integrating services for women with substance abuse and mental health disorders and histories of trauma," *Joumal of Behavioral Health Services & Research* 32(2) (2005): 227–40.

16. Blanch, A. *Changing Communities Chnging Lives.* SAMHSA's National Centre for Trauma-Informed Care, September 2012.
17. Bevan, H., and S. Fairman. *The new era of thinking and practice in change and transformation: A call to action for leaders of health and care*. London: National Health Service, 2014.
18. Salveron, M., et al. "'Changing the way we do child protection': The implementation of Signs of Safety within the Western Australia Department for Child Protection and Family Support," *Children and Youth Services Review.* 48(0) (2015): 126–39.

Acknowledgements

Many people have contributed their time and wisdom to the development and review of these discussion guides: Bernadette MacDonald, Tri-County Women's Centre; Betsy Prager, Addictions Services, Amherst; Bonnie C. Conrad, IWK Health Centre; Brandon Churchill, IWK Health Centre; Bridget McFarthing, Nova Scotia Community College; Bruce Dienes, Chrysalis House; Carmen Celina Moncayo, Immigrant Services Association of Nova Scotia; Christine Toplack, MD, Wolfville; Dale Gruchy, Nova Scotia Health and Wellness; Dana Pulsifer, Annapolis Valley District Health Authority; Daniel Abar, Chisholm Services for Children; Dianne Crowell, Second Storey Women's Centre; Donna Hughes, Halifax Regional School Board; Elizabeth King, MD, Annapolis Royal; Erinn Hawkins, IWK Health Centre; Glenda Haydon, Avalon Sexual Assault Centre; Gwyneth Dwyn, Annapolis Valley Health; Holly Murphy, IWK Health Centre; Jackie Stevens, Avalon Sexual Assault Centre; Jackie Thornhill, Connections; James Dube, University of Victoria; Janet Pothier, The Confederacy of Mainland Mi'kmaq; Jean Morrison, Annapolis Valley Health; Julie MacDonald, Child and Adolescent Services, Cape Breton Region; Kimberley MacLean, IWK Health Centre; Louise Smith MacDonald, Every Woman's Centre, Sydney; Margaret Mauger, Colchester Sexual Assault Centre; Maureen Banfield, Halifax Regional School Board; Melissa Davidson, Amherst Community Centre; Nancy Poole, BC Centre of Excellence for Women's Health; Nancy Ross, Dalhousie School of Social Work; Nancy Stewart, Annapolis Valley Health; Nicole Blanchard, Department of Community Services; Norma Jean Profitt, South West District Health Authority; Patrick Daigle, The Youth Project; Rhonda Fraser, Transition House Association of Nova Scotia; Shaughney Aston, Acadia University; Shireen Singer, IWK Health Centre; Stacy McRae, Chisholm Services for Children; Tracey Gerber, Mental Health and Addictions, Yarmouth; Wanda Jackson, Progress Centre for Early Intervention.

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