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Guidelines for Trauma-Informed Practices in Women's Substance Use Services

The Jean Tweed Centre



For Women & Their Families

TRAUMA MATTERS

Guidelines for Trauma-Informed Practices in Women's Substance Use Services

March, 2013

This document is dedicated to all the women who have shared their journeys with us. Thank you for your courage—you have increased and enriched our collective knowledge and wisdom. Your strength and perseverance will continue to inspire us and shape how we work.

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www.jeantweed.com

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Other Drug Treatment Funding Program Projects

In parallel with this project, Health Canada's Drug Treatment Funding Program (DTFP) has also supported several other projects that are working toward the shared goal of improving our substance use treatment systems. Additional and current information about this and other DTFP projects in Ontario can be accessed at www.eenet.ca

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Introduction

Trauma Matters: Guidelines for Trauma-Informed Practices

"I came to a realization in group about how substance use and trauma are enmeshed. I've always either worked on one problem or another. Now that I have worked on my trauma I can see how it will impact my addiction."

Trauma Matters focus group participant

The majority of substance-involved women have experienced trauma. ¹

The guidelines set out in this document focus specifically on the intersections of trauma and substance use issues among adult women. ² That focus is not intended to minimize or deny the impact of trauma on men, or on children and youth, or the need for effective service practices for all who have experienced trauma.

Evidence has demonstrated that:

- trauma is pervasive among substance-involved women
- the impacts of trauma are broad, diverse and often life-altering
- trauma and problematic substance use are often interconnected issues
- the voices and wisdom of women with 'lived experience' ³ provide information and perspectives that are critical to trauma-informed practices
- women need to be, and feel, safe in order to begin their recovery work.

In light of that evidence, two overarching principles have informed the development of the Guidelines:

- women have a right to expect substance use services to provide safe environments that respond effectively to the interconnections between trauma and substance use
- substance use service providers have a responsibility to utilize safe, sound, respectful, trauma-informed practices in their work with all substance-involved women.

"We have compelling evidence that women's substance use is linked to their experiences of trauma and violence. Yet service providers and policy makers have not always acted on these known connections. [We] are now finding ways to respond with policies and programs that integrate support on both issues." ⁴

Over the last several years, the impacts of trauma, and the interrelationships between trauma and women's substance use have been identified in both research and clinical practice. Substance use service providers have gained a better understanding of the prevalence of trauma among women they serve and the connections between trauma and substance use.

Many service providers want a better understanding of how they can work more effectively with women who have (or may have) experienced trauma. In Ontario, many of the service providers who want to implement trauma-informed practices need knowledge, tools, and resources to support their efforts. ⁵

“My recovery [from substance use] really started to be solid when I realized the connections with trauma. Before that, the trauma kept putting me down.”

Trauma Matters focus group participant

This document presents *fundamental* information about trauma-informed practices.

It sets out evidence-informed practices for all organizations that are funded by Local Health Integration Networks to provide substance use services for women. The guidelines should be used wherever women receive substance use services—in both mixed-gender and women-only service environments, and in all types of substance use services (e.g. withdrawal management, assessment and referral, residential, and community-based services).

This document may also be helpful to a broader cross-section of service providers.

It can help health care and allied sector services to expand their knowledge and understanding of the intersections between trauma and substance use, and to consider how trauma-informed practices can be used in their work with substance-involved women.

It is important to note that:

This document provides a *foundation* for implementing trauma-informed practices across Ontario’s substance use service system.

The information that it provides will not replace or lessen the need for training and clinical supervision. It is not intended to encourage organizations or their staff to expand their range of practice without first having appropriate training, credentials, and organizational supports.

Provincial guidelines for gender-appropriate women’s services have already been developed for Ontario substance use services.

*Best Practices In Action: Guidelines And Criteria For Women’s Substance Abuse Treatment Services*⁶ was developed by a working group of the Ontario Ministry of Health and Long-Term Care in 2005. Trauma-informed practices are intended to build on the gender-appropriate services already defined in *Best Practices in Action*.

This document is intended for use by staff and organizations that already have skills and expertise in providing services for substance-involved women.

Organizations that implement trauma-informed practices should already be providing gender-appropriate services, as defined in *Best Practices in Action*.⁶

***Trauma-specific* services differ significantly from *trauma-informed* practices.**

This document focuses on the latter. To help service providers understand the differences between the two, it also provides a high level description of *trauma-specific* services. Organizations that are interested in developing *trauma-specific* services will need to do extensive research, and assess their current capacities; they will then need to evaluate potential models of trauma-specific services against those capacities, and identify the planning, development and training activities required.

Endnotes

See Appendix B for full reference information

¹ In the context of this document, 'trauma' refers to psychological and/or emotional trauma, including the psychological and/or emotional impacts of physical trauma.

² For the purpose of this document, the term 'adult women' is defined as women who are at least 16 years of age.

³ The term 'lived experience' is used frequently in this document. It refers to women who have had personal experiences of trauma and problematic substance use.

⁴ Poole, 2011

⁵ Service provider needs for additional support were identified in the 2006 provincial review of substance use services for women.

⁶ Ontario Ministry of Health and Long Term Care, 2005

Section 1:

About the Guidelines

Goal of Section 1

To orient the reader to the content and purpose of this document; how it was developed; its limitations; and key concepts and terminology

How will the Guidelines help to improve services for women?

“Trauma is a public health risk of major proportions ... Moreover, it often compounds medical and psychological conditions and injuries. This information too often goes unrecognized or under-recognized by medical and mental health practitioners. We have a major education, prevention and intervention issue.”¹

This document is intended to help all substance use service providers in Ontario to become more aware of how trauma impacts women who access their services, and to understand trauma-informed practices.

The Guidelines will help all staff who interact with clients to:

- understand how trauma-informed practices can and should be used in every organization in which women receive substance use services
- identify staff learning needs, as well as their needs for clinical and organizational support
- respond more effectively to trauma-related responses and adaptations
- plan and deliver services that are based on trauma-informed practices.

‘Staff who plan and deliver service’ refers to all of those who have contact with clients, and may include volunteers and students, as well as full-time, part-time, and contract staff. ‘Volunteers’ include board or advisory group members.

“Whenever there is a really difficult situation, the impact of trauma ... is usually a factor. Keeping this in mind helps us as staff to not be reactive, to think outside the box of ‘treatment as usual’, to approach a situation from the perspective of the inter-relationship of trauma and substance use.”

Substance Use Service Provider—Ontario 2012

The Guidelines will help organizations to:

- understand why organizational culture, practices, policies, infrastructure, and planning are crucial elements of trauma-informed services
- assess the organization’s current ability to implement trauma-informed practices, and make needed changes
- identify and plan the steps needed to support staff learning about trauma and trauma-informed practices
- work with other organizations to support the use of trauma-informed practices across local, regional, and provincial systems of service and support.

“Becoming trauma-informed translated to high program completion and high program retention.”

Substance Use Service Provider—Ontario 2012

The Guidelines may support service providers and other stakeholders in the broader system of care:

Services that work with substance-involved women

(e.g. health care, social services, early childhood development services, the justice system, child protection agencies, and others) can gain insight into the inter-connections between trauma and substance use, and enhance their understanding of how trauma-informed practices can help make their own organizations more responsive to the needs of substance-involved women.

Academic institutions and organizations (e.g.

bodies that credential and/or support the learning of human services professionals or accredit organizations) can gain a greater appreciation of the impacts of trauma on substance-involved women, and the implications for education, training, and practice.

“Trauma studies have NOT adequately entered general and professional curricula. Many professional caregivers are not aware of the impact of trauma [on physical and psychological health] nor are they knowledgeable about diagnosis or treatment.”²

Policy makers, system planners, funders, and other concerned stakeholders can gain a greater understanding of the importance of trauma-informed practices, and how those practices can be supported—or undermined—at the system level, as well as within individual organizations.

Although the primary focus of this document is **trauma-informed practices**, one section provides basic information about more specialized **trauma-specific services**.

Evidence shows that *trauma-specific* services play an important role in supporting the recovery of women who have experienced trauma. However, not all substance use service providers are positioned to provide those specialized services.

For those that have an interest in doing so, **Section 12** of this document provides basic information about:

- the goals of *trauma-specific services*, and the clinical approaches and models used to provide them
- the specialized skills and knowledge required to deliver *trauma-specific* services
- models and approaches used in *trauma-specific* services
- a list of resources that provides more detailed program/model descriptions.

Limitations of this document

This document should be used as the **beginning** of a learning process about trauma and trauma-informed practices.

The guidelines have been developed based on:

- the best available research evidence
- professional expertise
- practical wisdom at the time of writing.

Service providers will need to stay current with new information and emerging practices. Sources of current and in-depth information can be found in documents listed in **Appendix B** (References) and **Appendix D** (Resources).

The guidelines do not focus on specific ‘types’ of traumatic experiences.

Rather, they focus on the principles and practices that can help service providers address the *impacts* of trauma on women, and the *intersections* of trauma responses and problematic substance use. See **Section 4** and **Section 12** for more detailed information about trauma and trauma-related responses.

The vast diversity of experiences and cultures of the women who access our service system has not been fully explored or addressed in these Guidelines.

Women are not a homogeneous group—service providers have a responsibility to respond to their diversity, in all its forms. All trauma-informed services should take steps to develop cultural competencies in their staff, and in their organizational practices and policies. Service providers will need to ‘braid’ trauma-informed practices with other culturally-informed practices that they currently use to meet the diverse and varying needs of women. See **Section 5** for more information about cultural competence and anti-oppression approaches.

How is this document organized?

This document is comprised of twelve sections which, together, provide information about trauma-informed practices at the clinical, organizational, and system levels. Some basic information is repeated at key points in the document to meet the needs of readers who may choose to focus on particular sections first. Cross-references are provided throughout the document, as a guide to further information about key issues. For maximum benefit, however, it is suggested that readers familiarize themselves with the entire document.

Quick guide to the goals of each section

1. About the Guidelines

Goal: to orient the reader to the content and purpose of this document, how it was developed, its limitations, and key concepts and terminology

2. Basic Concepts: Trauma-Informed and Trauma-Specific

Goal: to provide high-level information about trauma-informed practices, and how they differ from trauma-specific services

3. Why Is Trauma an Important Issue?

Goal: to discuss the prevalence of trauma among substance-involved women and to learn from the feedback of women who have accessed substance use services in Ontario

4. About Trauma

Goal: to orient the reader to the nature and impacts of trauma, how trauma can affect engagement with services, triggers, retraumatization, and strategies to establish safety

5. A Multi-dimensional Perspective

Goal: to identify approaches that respond to the full context of women's lives, including cultural competence and anti-oppression approaches

6. Trauma-Informed Clinical Practices

Goal: to provide direct service staff with accessible, specific, practical information about the principles of trauma-informed care, and how trauma-informed approaches transform clinical practices

7. The Therapeutic Relationship

Goal: to discuss the therapeutic relationship in trauma-informed practices, the risks of vicarious trauma, and some of the strategies that can help to mitigate those risks

8. Developing Staff Competencies

Goal: to describe how organizations can develop and support workforce competencies needed for trauma-informed practices

9. The Trauma-informed Organization

Goal: to describe how organizational culture, policy, and procedures are transformed by trauma-informed practices

10. Linkages with Other Service Sectors

Goal: to identify strategies for collaboration and partnerships that will support coordinated, trauma-informed responses to women's needs across services and sectors

11. Trauma-Informed Practices at the System-level

Goal: to identify the system-level benefits of trauma-informed practices, and the strategies and supports needed to provide them

12. Trauma-Specific Services

Goal: to provide basic information about the types of programming used to deliver trauma-specific services, the staff knowledge and expertise required, and the assessment process for those services

Appendix A: Summary of Guidelines

Provides a consolidated list of all guidelines in the document

Appendix B: References

Provides a list of source documents for the citations in the document

Appendix C: Trauma-Specific Program Models

Provides a list of information sources about evidence-based *trauma-specific* services

Appendix D: Resources

Identifies sources of supplemental information that will help readers to extend their learning. The resource section is not intended to be all-inclusive—the web sites, books, and articles that have been suggested will present a starting point for further learning

How have these guidelines been developed?

The Guidelines have been informed by a wealth of evidence.

They draw upon evidence generated in jurisdictions where trauma-informed practices have been developed and tested, and their effectiveness has been demonstrated. They reflect the excellent work that has been done in Canada and in other jurisdictions.

This document does not attempt to enshrine “best practices”, rather it identifies practice guidelines based on the judgment, experience, perspectives, and/or research of experts and specialists in women’s trauma and substance use.

Evidence was gathered from four primary sources:

- the academic and research literature
- the grey literature (e.g. government reports websites, and policy documents)
- experts who have specialist knowledge of substance use and trauma
- women with ‘lived experience’ of trauma and problematic substance use.

In synthesizing the available evidence, we have been keenly aware of the variations among Ontario’s substance use services, and have focused on practical guidelines that can be implemented in a full range of substance use services.

How will trauma-informed practices build on the strengths of the system?

Many of the trauma-informed practices identified in this document build on evidence-informed practices already in use.

Many can be implemented by reviewing and modifying existing programs, services, policies and procedures, using a trauma-informed lens.

Service providers do not necessarily need to learn a range of new skills in order to adopt trauma-informed practices; instead, many current practices can incorporate a trauma-informed lens. The table on the following page shows examples of ways in which trauma-informed practices are congruent with evidence-based substance use service approaches.

Examples of Congruence Between Trauma-Informed Practices and Evidence-Based Substance Use Approaches

Trauma-Informed Practice	Evidence-Based Substance Use Service Approach
Pacing—avoiding the rush to disclosure (the ‘action stage’ of the trauma recovery experience) and accepting that a woman need not necessarily disclose her experience of trauma	Stages of Change—recognizing that different strategies are necessary based on the woman’s stage of change vis-à-vis her substance use and that action strategies are only appropriate in the action stage of change
Relationship building—accepting the challenge to construct a therapeutic connection over time, recognizing that trustworthiness is built slowly and respectfully by honouring the woman’s background and experiences	Harm reduction principles—finding goals that are consistent with the woman’s current abilities and situation, not necessarily requiring abstinence as a goal
Ensuring safety in the counselling relationship—avoiding aggressively confrontational approaches that can retraumatize and obstruct safety	Motivational Interviewing—avoiding shame, blame, and guilt and focusing instead on learning from setbacks
Providing choice and control	Motivational Interviewing—internalizing the locus of control and highlighting self-efficacy
Building empowerment skills	<p>Motivational Interviewing—building on the woman’s strengths; asking questions that elicit information, rather than telling in an instructional way</p> <p>Harm reduction principles—taking a small steps approach</p>
Using a collaborative approach with women instead of a top-down hierarchical model	Relationship building—the quality of interpersonal relationships may determine whether or not women remain engaged in the process of change; the quality of interpersonal therapeutic relationships may be more important than the concrete services received
Strengths and skills based	Motivational Interviewing—providing a menu of options that respond to concurrent life circumstances; recognizing the need for supports that address a range of areas, such as food security, child care, adequate housing, and poverty

Key concepts in the document

Substance Use

Numerous terms are used to describe the various levels or types of substance use—from occasional or social use to misuse, abuse, and dependence on, or addiction to, substances.

Some of those terms are ill-defined, and many can be stigmatizing. To avoid language that may convey stigma or imply judgment, we have consistently used the following terms in this document: ³

- **‘substance use’** or **‘problematic substance use’** describes any type or level of use—whether substance use is problematic is defined by each woman, in relation to her own experience and goals
- **‘substance-involved’** describes women who are engaged in substance use that may be problematic
- **‘substances’** includes licit drugs (alcohol, tobacco, prescription drugs and solvents) and illicit drugs (such as marijuana, heroin, cocaine, and so on)
- **‘substance use services’** refers to services whose primary goal is to assist people who are experiencing problems with their substance use.

Trauma

Trauma often refers to experiences or events that—by definition—are overwhelming.

Experiences of trauma are more than merely stressful—they can also be shocking, terrifying, and devastating, and can result in profound feelings of terror, shame, helplessness, and powerlessness. ⁴

Trauma can be seen as both an overwhelmingly negative event, and as the impact of that event on a woman. ⁵

We also use the word ‘trauma’ to describe the impact of traumatic events on women.

Trauma is a unique individual experience that may be influenced by an array of factors.

Adult women can be affected by experiences of trauma that have occurred across the life span. They can include a range of adverse experiences in childhood and in adulthood (such as physical and sexual violence, emotional abuse, neglect, and witnessing violence); children may experience disrupted attachment. Both children and adults also experience trauma as a result of accidents, natural disaster, war, dislocation, and events that result in other sudden or unexpected losses.

“Thus ‘trauma’ designates both events and their impact, in part because the actual experience... and the assault that experience poses to sense of self, safety, belonging, and connection are intertwined.” ⁶

Recent studies support the conclusion that the impact of trauma is not only cumulative—the more times a traumatic event is experienced the greater the impact—but also additive—exposure to additional different types of trauma is correlated with greater impact. ⁷

“Trauma is the sum of the event, the experience, and the effect.” ⁸

Trauma can occur at both individual level and collective levels.

Individuals can be profoundly affected by collective traumatic events (e.g., war, genocide). There is now considerable evidence that the effects of collective trauma are often transmitted across generations, affecting the children and grandchildren of those who were initially traumatized.⁹

‘Vicarious trauma’ is a concern for people who provide substance use services and other members of the caring professions.

This term describes the impacts of a trauma that is not experienced directly, but through contact with someone who has directly experienced trauma. Vicarious trauma may result from singular, cumulative, or additive contact.¹⁰ See **Section 7** for more information about vicarious trauma.

Trauma-Informed

Trauma-informed practices take into account an understanding of the prevalence and impact of trauma and integrate that understanding into all components of an organization.

Trauma-informed practices require that organizations:

- (1) **realize** the prevalence of trauma
- (2) **recognize** how trauma affects all individuals involved with the organization and its programs or services, including its own workforce
- (3) **respond** by putting that knowledge into practice.¹¹

Trauma-Specific

Programs and services that are *trauma-specific* are designed to focus directly on the impact of trauma and facilitate trauma recovery.

Trauma-specific programs and services can include a continuum of specialized interventions from

screening, to treatment, to recovery supports; they are delivered by a practitioner trained in the use of these interventions.

For more detailed information about the distinctions between trauma-informed practices and *trauma-specific* services, please see **Section 2**.

Evidence-Informed

Evidence is “information such as analyzed data, published research findings, results of evaluations, prior experience, expert opinions, any or all of which may be used to reach conclusions on which decisions are based.”¹²

Evidence-informed practice is comprised of the best available practices “based on available evidence for a specific group under specified circumstances to achieve an identified aim.”¹³

Culture

The concept of ‘culture’, as used in this document, is defined broadly in order to maximize inclusiveness and take into account the diversity of women’s lives.

Culture can encompass issues associated with gender, age, language, ethno-cultural and racial identification, immigrant/refugee status, sexual orientation, ability challenges, literacy challenges, homelessness or being marginally or under-housed, street involvement, criminal justice involvement, poverty and low-income/unemployment, class, and rural, urban, or isolated communities.

Cultural Competence

Trauma may have different meanings in different cultures and traumatic stress may be expressed differently within different cultural frameworks.

These differences make cultural competence critical to the effectiveness of our services. The following definition of cultural competence has been adopted in this document:

“Cultural competence is a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations.”¹⁴

¹³ Dr. Paul McDonald, Co-director Population Health Research Group, University of Waterloo, cited in Bergeron & Albert, 2009

¹⁴ Ontario Federation of Community Mental Health and Addiction Programs, 2009

Anti-Oppression Approaches

Oppression is a type of injustice; it involves the inequitable use of influence, authority, law, or physical force to prevent others from being free or equal.

Many forms of oppression are so pervasive and subtle that they can be invisible; they are often related to cultural constructs about race, ethnicity, creed, class, gender, sexual orientation, gender orientation, immigration status, country of origin, religion, mental health status, age, and/or ability.

Endnotes

See Appendix B for full reference information

¹ Courtois, 2012

² Courtois, 2012

³ In direct quotations, we have used the terminology that was used by the authors of the document quoted.

⁴ Courtois, 1999

⁵ Covington, 2002

⁶ Kammerer & Mazelis, 2006

⁷ Retrieved online from www.samhsa.gov/traumajustice/traumadefinition/definition.aspx

⁸ Finkelhor, Ormrod, Turner & Hamby, 2005

⁹ Bombay, Matheson & Anisman, 2009

¹⁰ Kammerer & Mazelis, 2006

¹¹ Retrieved online from <http://www.samhsa.gov/traumajustice/traumadefinition/definition.aspx>

¹² Public Health Agency of Canada definition, cited in Bergeron & Albert, 2009

Section 2

Basic Concepts: Trauma-Informed and Trauma-Specific

Goal of Section 2

To provide high-level information about trauma-informed practices, and how they differ from trauma-specific services

What are trauma-informed practices?

Practices that are trauma-informed enable service providers to appreciate the context in which a woman who has experienced trauma is living her life.

“A trauma-informed approach emphasizes understanding the individual ... Rather than asking ‘How do I understand this problem or this symptom?’ the service provider now asks ‘How do I understand this [woman]?’ ... This approach shifts the focus to the individual and away from some particular and limited aspect of [her] functioning. It also gives the message that [her] life is understandable and that behaviours make sense when they are understood as part of a whole picture.”¹

Trauma-informed practices have, at their core, six guiding principles:

- 1) acknowledgment
- 2) safety
- 3) trustworthiness
- 4) choice and control
- 5) relational and collaborative approaches
- 6) strengths-based empowerment modalities

Section 6 provides detailed information about these principles and how each one is applied in direct services .

At the organizational level

Trauma-informed practices provide a lens through which administration, management, strategic and program planning, workforce development, resource allocation, evaluation, and service delivery, should be reviewed and assessed. See **Section 8** and **Section 9** for detailed information about practices at the organizational level.

“In a trauma-informed approach, change permeates all levels of an organization or system; all aspects of organizational culture are in alignment.”²

At the direct service level

Trauma-informed practices provide a lens that should guide clinical responses, interventions, and other interactions with women.

See **Section 6** for detailed information about trauma-informed practices in direct services.

“Being trauma-informed means hearing what women are saying, even when they aren’t [actually] speaking.”

Substance Use Service Provider—Ontario 2012

Service providers do not need to be specialists in trauma-specific treatment in order to implement trauma-informed practices.

However, they must understand trauma as a core issue and must have a good understanding of the principles and practices that inform appropriate services for women who have experienced trauma.

Trauma-informed practices do not require disclosure of details about a woman’s experiences of trauma, and do not provide trauma-specific treatment.

The focus of trauma-informed practice is on stabilization, safety, and understanding the links between trauma and substance use—not on the woman telling the story of what happened or processing the details of her experiences.

See **Section 6** for more information about universal trauma-informed screening.

Trauma-informed practices can be implemented in any service setting—in this document, the focus is on service providers funded to work with substance-involved women.

Trauma-informed practices are consistent with, and can build upon, the good clinical practices already in place in many Ontario substance use services. They employ strategies similar to those currently used to help women reduce harm from substance use and achieve stability in recovery.

What are the risks of being uninformed about the impacts of trauma?

When trauma-informed practices are not implemented, services are less effective.

The evidence ^{3,4} suggests that when service providers do not utilize trauma-informed practices or understand the impact of trauma, this can:

- interfere with their responses to help-seeking, and result in their failure to reach many women
- hamper engagement, and may result in increased or earlier ‘drop outs’ from services
- make a lapse or relapse more likely.

“Many women who used to be considered ‘treatment failures’ because they relapsed may now be understood as [women who experienced trauma] who returned to alcohol or other drugs in order to medicate the pain of trauma. Our increased understanding of trauma offers new treatment possibilities for [substance-involved women who have experienced trauma].” ⁵

Service providers who are not trauma-informed may misinterpret or misunderstand trauma-related behaviours.

When the connections between trauma and substance use are not made, service providers may miss opportunities to engage women who need services and to provide effective care.

Services that are not trauma-informed can inadvertently retraumatize women.

Service providers may feel overwhelmed or apprehensive about how to help women understand the connections, or fail to respond to trauma-related behaviours in a helpful way. When interactions with service providers inadvertently replicate women's experiences of trauma, they can perpetuate a damaging cycle, interfere with engaging a woman who is seeking help, or impede her healing and growth.

See **Section 4** and **Section 6** for more information about triggers and retraumatization.

"I was discharged, after the first week, from a treatment program for having too much trauma ... I have not gone back to a residential treatment program because of this experience."

Trauma Matters focus group participant

"In substance abuse settings, strongly confrontational approaches do not respect or support a woman's right to establish her own pace and can damage fragile coping mechanisms. In addition, these efforts can trigger defensive or flight behaviours that prevent a woman from staying in treatment." ⁶

What are *trauma-specific* services?

Trauma-specific services are significantly different from trauma-informed practices.

Substance use service providers who deliver *trauma-specific* services work with women to directly and actively address both trauma and substance use issues in an integrated manner.

Trauma-specific services must be provided in an environment in which *trauma-informed* practices have already been implemented.

They must be provided by staff who have a solid foundation of knowledge and expertise in integrated treatment of both trauma and substance use issues.

See **Section 12** for information about trauma-specific services. More detailed information about those services can be found in the documents and websites listed in **Appendix C**.

The following table provides a quick overview of differences between trauma-informed practices and those that are not trauma-informed: ⁷

Trauma-Informed	Not Trauma-Informed
Recognition of the high prevalence of trauma	Lack of education and awareness of trauma prevalence and the concept of universal practices
Recognition of trauma responses and their intersections with problematic substance use	Misdiagnosis or over-diagnosis of Borderline Personality Disorders, Bipolar Affective Disorder, Conduct Disorder and Schizophrenia
Screening processes that allow a woman to identify (if she chooses to do so) that she has had experiences of trauma	Cursory or no screening for experiences of trauma or intrusive questioning regarding experiences of trauma
Recognition of culture and practices that can be re-traumatizing	‘Tradition of Toughness’ and reliance on confrontational approaches
Power and control are shared; the client and the service provider work together collaboratively	Power and control reside with staff; inflexible emphasis on rules and compliance
Education and training, supported by clinical supervision, enables staff to understand the functions of behaviours and to respond to trauma responses and adaptations	Lack of training leads to client-blaming (viewing women as ‘overly complex’, ‘attention-seeking’, ‘in denial’, ‘not treatment ready’, etc.), or uninformed and inappropriate attempts to ‘treat’ a woman’s trauma responses
Objective, neutral language	Labeling language, such as ‘manipulative’, ‘needy’, ‘provocative’, ‘resistant’, ‘non-compliant’
Transparent systems open to advocacy from and collaboration with relevant and helpful outside parties	Closed system—advocacy is discouraged; attitude of ‘we are the experts’
Demonstrating respect in interactions with women: <ul style="list-style-type: none"> • Private or quiet reminders of schedules, medication time: e.g., asking “Can I help?” • Solution-focused responses that involve the woman and allow for understanding and negotiation • Involving the woman in treatment planning 	Demonstrating lack of respect in interactions: <ul style="list-style-type: none"> • Yelling “Lunch” or “Medications” • Asking “Why did you do that?” or “What is wrong with you?” • Imposing automatic, inflexible consequences for ‘rule violations’ • Telling a woman what is best for her

The following table provides a high level comparison of how *trauma-informed* practices and *trauma-specific* services are delivered by substance use service providers: ⁸

Trauma-Informed Practices	Trauma-Specific Services
A perspective or lens that can and should be integrated at all levels of an organization.	A type of therapeutic intervention, provided by a counsellor who has specialist knowledge and skills, that is designed to treat trauma responses and adaptations, and problematic substance use, in an integrated manner, .
Used with every woman who is seeking substance use services, as a universal practice, whether or not she is known to have experienced trauma.	Provided to a woman who has acknowledged the experience of trauma, and has given informed consent for participation in trauma-specific services.
Universal screening is used to provide an opportunity for a woman to identify that she has experienced trauma, should she choose to reveal it; details of the traumatic event(s) are not sought, or processed.	Assessment is used to learn about a woman's experiences with trauma and substance use issues, and to help her connect with a trauma-specific service that is appropriate to her needs and capacities.
The focus is not on the traumatic events, and the counsellor does not elicit or seek to explore details of the trauma.	The counsellor may go into the details of the trauma with the woman, ensuring that work is done in a paced, grounded, and contained way

The intersections of *trauma-informed* practices and *trauma-specific* services

Trauma-informed practices should be implemented in every substance use service; however, not all organizations will implement *trauma-specific* services.

An organization that does not provide *trauma-specific* programming may still, from time to time, provide individual *trauma-specific* interventions, such as individual counselling. *This should occur only if staff have the specialized knowledge and skills to competently and ethically provide this level of service.*

See **Section 12** for information about the competencies required to deliver *trauma-specific* services.

Some trauma interventions can appropriately be used in both *trauma-informed* and *trauma-specific* services.

For example, since helping a woman establish safety is central to both *trauma-informed* practices and *trauma-specific* services, skills training to help her manage overwhelming emotions, or strategies to increase a woman's current personal safety, can be utilized in both types of services.⁹

See **Sections 4, 6, and 12** for information about safety.

Using trauma-informed practices with every woman

Trauma-informed practices should be used with every substance-involved woman, whether or not she has disclosed that she has experienced trauma. Service providers cannot assume that a woman has not experienced trauma because she does not disclose that experience. Some women may choose not to disclose their experience; others may not have clear memories of the experience or the language that would allow that disclosure.

Trauma-informed practices should be used in all organizations where women access substance use services (including services that are concurrent disorders capable).¹⁰

Given the links demonstrated in research, the likelihood that experiences of trauma have been underreported, and the risks of inadvertently retraumatizing women, experts emphasize that trauma-informed practices should be universal.

Examples of trauma-informed programs in Ontario

Across Ontario, several service providers are already integrating trauma-informed practices into their services for women.

Examples of these practices include:

- training for all staff from experts (e.g., Lisa Najavits, Marsha Linehan) in trauma-informed practices
- providing regular clinical supervision and consultation, and ensuring access to those supports as needed
- building trauma-informed service models with population-specific services (e.g., youth)
- including women with 'lived experience' as peer supports in agency programs.

Work in other jurisdictions

Significant gains in trauma-informed practices have also been made in other Canadian jurisdictions.

For example:

The **British Columbia Centre of Excellence for Women's Health (BCCEWH)** has provided national leadership in supporting practice and policies to improve the health of women. BCCEWH has partnered with academics, policy-makers, service providers, advocates and women who have lived experience to develop women-

centred programs, innovative research, and knowledge translation projects. BCCEWH has generated a substantial body of knowledge and resources. In 2009, for example, a national virtual Community of Practice (vCoP) provided the opportunity for a ‘virtual discussion’ of issues, research, and programming related to girls’ and women’s substance use in Canada, and produced several resources, including:

- *Coalescing on Women and Substance Use Trauma-Informed Approaches in Addictions Treatment (Gendering the National Framework)*
- *Women-centred Harm Reduction: Mothering and Substance Use (Gendering the National Framework)*

Klinic Community Health Centre (Winnipeg, Manitoba) has produced a *Trauma-informed Toolkit*, available online at <http://www.trauma-informed.ca>. The toolkit was developed to help a wide range of health care and other service providers to understand the nature and impacts of trauma, and to implement practices that keep the needs of people who have been affected by trauma at the centre of their work.

The **Laurel Centre** (Winnipeg, Manitoba) has developed an integrated trauma recovery model that uses a feminist approach to practice. The Laurel Centre provides services for women who have experienced sexual abuse in childhood or adolescence. The model uses a five-staged approach, and recognizes that stages may recur and overlap throughout the therapeutic process.

Numerous models have been developed and evaluated in the United States.

Some have been designed specifically for implementation in substance use services, and others more flexibly designed for a variety of service settings, including substance use services. For example:

Seeking Safety is an evidence-based model that was developed by Lisa M. Najavits, PhD. Clinical experience and research studies informed revisions of the manual, resulting in the final published version in 2002. The model has been extensively studied; the evidence-base of published studies includes several pilot studies, controlled trials, multisite trials, and dissemination studies. All outcome studies evidenced positive outcomes. Information about the Seeking Safety model and evidence for its effectiveness is available at <http://www.seekingsafety.org>.

The ***Women, Co-Occurring Disorders, and Violence Study***, funded by the US Substance Abuse and Mental Health Services Administration, piloted interventions to address the needs of substance-involved women who have experienced trauma. In the final phase of the study, 2,729 women were enrolled in 9 sites across the U.S. The study made strides in identifying promising practices in trauma-informed care. It also documented the steps that can be taken by substance use service providers to implement those approaches.

Endnotes

See Appendix B for full reference information

¹ Harris & Fallot, 2001

² Retrieved online from <http://www.samhsa.gov/traumajustice/traumadefinition/definition.aspx>

³ Elliott, Bjelajac, Markoff, Fallot, & Reed, 2005

⁴ Brown, 2000; Brown et al., 1995; Janikowski & Glover, 1994; Melchoir, Huba, Brown, & Slaughter, 1999, cited in Elliott, Bjelajac, Markoff, Fallot, & Reed, 2005

⁵ Covington, 2002

⁶ Moses, 2003

⁷ Adapted from Gillece, 2008

⁸ Adapted from Poole & Greaves, 2012

⁹ Haskell, L. (2003) cited in Poole & Greaves, 2012

¹⁰ The term ‘concurrent disorders capable’ refers to substance use services that have developed the capacity to assist people with both their substance use and mental health problems.

Section 3:

Why Is Trauma An Important Issue?

Goal of Section 3

To discuss the prevalence of trauma among substance-involved women and to learn from the experience of women who have accessed substance use services in Ontario

What does the literature tell us about trauma among substance-involved women?

Trauma has been a 'hidden epidemic' ¹ which has historically not been well recognized by substance use (or mental health) service providers.

Research has shown a high prevalence of experiences of trauma among substance-involved women.

In a study involving six women's treatment centres from across Canada, 90% of women interviewed reported childhood or adult abuse histories in relation to their problematic use of alcohol. ²

The pervasiveness of trauma is supported by other Canadian research. In a 2008 study on the relationship between depression and alcohol use among women, trauma was reported by 80% of participants.

Another 2008 study, which focused on binge drinking and binge eating, found that childhood violence and trauma were reported by 86% of participants. ³

Research in the United States has also demonstrated this high prevalence. In a review of the research on the relationship between problematic substance use and experiences of trauma, ⁴ connections were demonstrated in major (U.S.) studies:

- 1) Interviews were conducted with women participating in 50 different programs and 20 different organizations addressing substance use and mental health issues. Of the more than 1,500 women interviewed, researchers discovered that experiences of trauma were 'the rule rather than the exception'.

Trauma was reported by over ninety-five percent (95.7%) of women who utilized both substance use and mental health systems, and over eighty-two percent (82.5%) of women who utilized substance use services only. ⁵

- 2) The *Women, Co-Occurring Disorders and Violence Study* generated knowledge about the effectiveness of service approaches for substance-involved women who have mental health issues and who have experienced trauma. The study collected data from 2,729 women who identified as having substance use and/or mental health issues.

Among study participants:

- more than 91% reported a history of physical abuse
- 90% reported sexual abuse within their lifetime
- 72.5% had been forced to have sex
- 52.5% had exchanged money, drugs, or material goods for sex
- 84% reported some history of emotional abuse or neglect.

The majority of women who participated in the Women, Co-Occurring Disorders and Violence Study reported abuse to have occurred prior to substance use or mental health issues. Much of the abuse experienced by women in this study began early in life, with the average age of sexual or physical abuse beginning at age thirteen, and emotional abuse and neglect beginning even earlier, at the average age of nine. ⁶

In addition, most women reported multiple attempts at treatment for their substance use and mental health issues and multiple unsuccessful experiences. Researchers suggest that failure to address trauma, both recent and in early childhood, in the context of substance use services may be a factor in difficulty attaining treatment success. ⁷

- 3) Another major U.S. study (*the Adverse Childhood Experiences Study*) demonstrated links between adverse childhood experiences and problematic substance use, as well as a number of other health issues. This epidemiological study gathered data about the prevalence and impacts of adverse experiences in childhood from 17,337 people, (9,367 [54%] women and 7,970 [46%] men) who were accessing general health care services in the United States.

Analysis of the data indicates that 65% of women experienced between one and five types of adverse experiences in childhood; and 25% of women experienced 'contact childhood sexual abuse'. ⁸

What have women told us about Ontario's substance use services system?

To gain better understanding of women's experiences in the Ontario substance use service system, and to discover what has been helpful and unhelpful, focus groups were held in five locations ⁹ with substance-involved women who have experienced trauma. The women who participated were asked to talk about:

- how services have helped or hindered their recovery process from problematic substance use and trauma
- how easy or difficult it was to get information about and access to services that could help them with substance use and trauma issues
- what other types of community services they have accessed and what they found helpful or unhelpful
- what they would change about the substance use service system, if they had a 'magic wand'.

The focus groups produced an abundance of enlightening comments and stories about women's experiences in Ontario substance use services, and highlighted a need for both trauma-informed and trauma-specific services. Our analysis of their input identified several themes (discussed below). Each theme is supported by quotations; we have included multiple comments in many cases so that the words of the women themselves can 'tell the story'.

Awareness and acknowledgment of trauma and its interrelationship with substance use has supported women's recovery

- "Didn't know I had trauma issues until I was in treatment. I now know I need to deal with it."
- "Without addictions counselling I wouldn't have been able to connect my use to trauma. This helped me to realize that this wasn't normal and it helped me to identify and separate the two issues."

- “It took me until three years ago that I could share in a group setting and say ‘trauma’. I feel better saying ‘trauma’, I don’t have to say ‘rape’ or whatever. I can just say ‘trauma’, like car accidents are traumatic.”
- “During treatment we only touched on trauma issues. Very minimal but a good start—enough to rattle the inner cage of trauma that I was trying to block out. I found I had more opportunity to go into this in aftercare.”

However, trauma and its impacts were not identified or acknowledged in some substance use services or in other health care settings

- “The assessment agency didn’t ask about trauma.”
- “The psychiatrist didn’t connect substance abuse and trauma. It was more ‘if you’re feeling depressed, here is a pill.’”
- “I felt like there was a big elephant in the room and no one was naming it.”

Gender-specific, women-only services helped women to feel safe and engage with services

- “One of the things that was important for me was that staff is all female—the staff and the residents.”
- “I like the all woman thing; it made a huge difference and was the decision why I came. It was safe. “
- “The women-only group—women supporting women. I may not have always liked to go, but I always found it helpful.”
- “Co-ed groups would not have opened up the same.”
- “I was able to relate and connect to each woman on a different level.”
- “I’m so glad I was connected, I really needed to be with women only in a small group. I would have really strayed if men were here.”

In some mixed-gender settings, some women felt unsafe, emotionally or physically

- “There was no safety or protection in the co-ed program. Someone was raped.”
- “The co-ed program did not feel safe. There was flirtation, sex, rape, manipulation, staff favouritism between male and female counsellors—I didn’t want to share because if they didn’t know me, they couldn’t hurt me.”
- “Male counsellors and male staff entering rooms [in a residential facility], were not helpful for me.”
- “Being in co-ed facilities retraumatized me. I suffered a lot of abuse and it was too difficult hearing the stories from men—a lot who were abusers.”

Many comments were made about the lack of safety in mixed-gender withdrawal management programs

- “Mixed gender detox prior to coming to women’s residential was a barrier.”
- “Being with males in detox triggered trauma issues.”
- “Men in detox only had sex on their mind, not getting better.”
- “At detox the men were talking to us about sex and about drugs.”
- “Men took over the building in detox.”
- “At detox we were left in the back corner while the men got the whole place.”
- “In detox, I wish the staff had done something about what was going on.”
- “Being in detox was not helpful for me. It would have been better if it was gender specific.”
- “Male staff at detox opening doors [to women’s rooms]—not a safe environment.”
- “Male staff at the detox would open our bedroom doors and walk right in without even knocking first.”
- “I needed to speak to a woman.”

Learning about the impacts of trauma, and its connections with substance use, was a revelation for some women

- “It is really important that addiction and trauma are dealt with together. I never connected the two before, but they go hand in hand.”
- “I came to a realization in group how [trauma and substance use and trauma] are enmeshed. I’ve always either worked on one problem or the other. Now that I have worked on my trauma, I can see how it impacts addiction.”
- “I learned more in the residential setting than in ten years in adult psychiatry.”
- “One counsellor helped me to deal because she was able to recognize that I was having a trauma reaction and was able to help me make the connection to trauma.”
- “It wasn’t until I got here that I realized that substances helped me to hide my trauma.”

The encouragement and respect shown by staff and other clients helped women take the risk to engage with services, and to stay engaged

- “This place was a godsend when I first called in. Every woman that I met here was awesome and encouraged me to seek treatment. It was terrifying to start, but at the end of the 30 days I didn’t want to leave.”
- “The staff heard how scared I was when I called, but she just stayed with me and didn’t brush me off. She is the reason I came here. She was very giving and very genuine and that is the reason why I came.”
- “I felt a sense of longevity and safety—to see familiar faces and seeing people who are recovered is encouraging and impactful. Knowing you are loved. I haven’t felt loved in a long time and now I feel love from myself and from other women. I don’t want to feel like no one loves me.”
- “I don’t feel judged here, it is a wonderful feeling to have that.”

- “It was inspiring to hear others’ stories, coping strategies, being able to practice prior to leaving.”

Learning ways to manage triggers and trauma-responses helped to empower women

- “When I got triggered [and had a trauma reaction] it was helpful to be seen and to be able to reflect on what was happening with me not getting into all the details and staying in the present moment during sessions was really helpful.”
- “Staff recognized it first ... I was having flashbacks, and they helped me deal with them.”
- “I learned skills in how to help yourself when you can’t really pinpoint what you are feeling and going through. I find that empowering and very helpful because they are skills I can take with me when I’m not here.”
- “Eventually I learned to nurture myself and to have a safe little spot in my home—when I’m feeling vulnerable ... I am able to nurture myself.”

When women did not receive help with trauma reactions and triggers, it undermined their recovery efforts

- “Every time I talked I was putting myself out there and I was retraumatizing myself and didn’t know that.”
- “I wish that someone had pulled me aside and said that the ‘right word’ is ‘trauma’...”
- “There were times when I was in facilities and I was having flashbacks ...I was told to just focus on my addiction.”
- “If I ever enter another residential treatment program I want to know counsellors’ qualifications prior to going in. I’ve always felt like I’m uniquely [messed up] because they couldn’t help me because my issues were too severe.”

Some women were unable to obtain services or were discharged from services because they were perceived as too 'hard to serve' or their issues were 'too complex'

- “All this stuff got opened up and they didn’t really know how to deal with it and they rejected me.”
- “I’ve been in and out of treatment programs for four years. No one wants to touch me with a ten-foot pole and it seems to get worse each time. I am struggling to find a place to go.”
- “I went down hard for two years, using daily and I was not welcome anywhere. Even after being clean for one year, it didn’t matter where I went—there wasn’t help for a woman who screamed into her pillow all day long. There was no help ...”

Program structures helped to create safety nets, and support women’s choice and control

- “The structure of the inpatient environment is what made me feel safe.”
- “Having my own room and my own space made me feel safe. Sometimes you just need a place you can go where you know nobody can come in ... that’s why I chose this program over others that don’t have individual rooms.”
- “Living together ... like a family.”
- “A lot of my trauma issues occur overnight. It is wonderful to know that I have support on a 24-hour basis.”
- “The outpatient counselling program allowed me to attend while using and helped me to develop the skills to stop using. The [program] accommodated me while I was using and protected the other women as well and I found that comforting because I was still able to access support while using and I wasn’t shamed, isolated, or rejected when I used or relapsed.”

Program structures can also feel confining

- “Institutionalizing someone for three months is not good ... I’ve never been to jail, but I think that’s what it’s kind of like, you don’t get to go out for a walk or anything.”

Mothering women need practical supports (childcare, children’s programming) and help dealing with child protection services

- “For single moms, it’s difficult to get daycare and the support you need. It’s the children who suffer because moms aren’t able to get help.”
- “Women’s centres need to include childcare because it’s so hard for women to recover when we are expected to be in the kitchen cooking for husband and taking care of kids.”
- “It’s hard to get services if you have children. I have four kids I didn’t want to traumatize by putting them into CAS so I could access help. Once your kids are in the system it’s too difficult to get them back and you risk losing them. You are retraumatized by this process and so are your kids. This prolonged me getting the help I needed. I would keep a strong face, so no one would take my children, but you keep hurting inside. It ate away at me and I would keep going back to the same old stuff. There needs to be a program to include children and to reaffirm to them that they’re OK. To be able to get tools with a trauma focus and to help the kids through it, too.”
- “It’s hard to speak to [the unmet needs as a mothering woman] because then it seems like I am being ungrateful and ‘needy’.”
- “My children being taken, that was trauma.”
- “Can you help CAS understand? In a case conference they said they suspected I was abused as a child. No one asked me if I was abused and if it was OK to talk about it. I felt revictimized.”

Some women needed more information and clarity to establish safety and trust

- “I’m not sure of how qualified the counsellor is on trauma or where the information is going. I’m afraid of my story being told—it’s not like doctor/patient confidentiality.”
- “Knowing where to go to report inappropriate staff behaviour or misconduct. It’s hard to report a counsellor because of the [possible lack of] confidentiality of your report.”
- “Not sure how much of everything I can share with counsellors because I’m not sure of the amount of trauma experience they have. I’m also not sure about boundaries as I am afraid to traumatize the counsellor. Could they handle it?”

Women need more services, more options, and more flexibility—particularly with respect to the time available to obtain help with recovery

- “At treatment, we do not get enough into trauma because of lack of time. I would say ‘I’m fine’ but I’m not.”
- “I looked for help and couldn’t find anything, it was suggested that I get in trouble with the law and have the judge find a place where I could go. This is what ended up happening.”
- “Services are just not there and when they are, there is not enough time to deal with all the issues.”
- “21 days is not long enough to manage and deal with trauma.”
- “I’d like a three-month women-only program to deal only with trauma-specific issues. It’s too distracting to have it with men.”
- “I felt like just as we were getting close to understanding what needs to be worked on, all of a sudden my time was done and I didn’t know what to do. I’m a single mom of four but services outside of the Centre—no other place offers child care. This is a big barrier.”

- “After leaving [residential treatment] my substance use and self harm went through the roof. Extra time to focus would have been helpful.”
- “You build the rapport and trust but then your time is up and that’s it. I felt then I had to start all over again. I’m still trying to figure out what’s available with services that aren’t so brief.”
- “It was hard to transition from one counsellor to the other when my time was up in a specific program.”

Women were discouraged, stigmatized, and shamed by a lack of understanding among medical practitioners and hospital Emergency Departments; the help-seeking efforts of some were rebuffed or blocked

- “I’ve never really sat down and discussed anything with anybody ... I started questioning things and that’s when I decided I really need someone to talk to. I told my doctor, who sent me to a psychologist, who wanted to know again why when it happened so many years ago, why was I bringing it up now?”
- “The Emergency Department couldn’t deal with me. It was sad. I went in a few times scared, telling them I was suicidal, couldn’t eat, couldn’t sleep, was keeping my four-year-old home so I wouldn’t kill myself and they would just say ‘you’re fine and go home.’ It’s like they were waiting for me to commit suicide before they would help. I didn’t know where else to go. I was told ‘you’re the only one able to get yourself out of this’, but I needed someone to help me get out of this.”
- “Right from hospital to ‘rehab’ there needs to be compassion for what we are going through—the words, the non-verbals, everything.”

- “I needed to go to the Emergency Department Crisis Centre last year. The psychiatrist had to be the most rude person ever. He tried to give me medications I didn’t want, and I had to tell him I’m a drug addict and I can’t take them. He looked at me and said ‘if I had your life, I would be depressed too’. It made me shut down. I just wanted help but the door was just shut.”
- “I lived in a small town and I was in the ER frequently. I was treated differently from everyone else there. I was pushed into a corner, or the last one to be seen by the doctor. I may have had mental health issues but I’m not stupid. I could hear and see what was going on.”

Information about trauma-informed services was not readily available to all women; some appeared to find their way to appropriate services through apparently random connections

- “My boss actually found this place for me. Until I built up the courage to ask my boss if he knew anything I hadn’t found [any treatment program] even though I looked for two years.”
- “I was clean for three years and relapsed and I was looking for help and I couldn’t find anything in the phone book and a girlfriend told me about this place and I came.”
- “I used most of my life and thought about going into treatment but didn’t know this existed and I only found out because my counsellor used to work here.”
- “I was at a desperate time in my life and I was looking online for anything that could help me. If someone doesn’t have online access I don’t know how they would find help.”

When women did learn about services that could be helpful to their dual recovery, there were still multiple hurdles to access, including:

Stigma

- “Accessing services in a small town is difficult when everyone knows your business—that’s traumatizing in itself.”
- “There was no way I was going to tell my doctor because of the fear and shame of disclosing what I was going through.”
- “Stigma was a huge barrier, so that’s why I ended up going somewhere far from home.”

Unmet needs for support (e.g., with childcare and transportation)

- “I didn’t want to be away from my kids.”
- “No money for child care or the bus. I couldn’t keep appointments.”
- “Transportation is a barrier—I took three buses to get here every day.”
- “When my car broke down I had no way to get to [groups] for a month.”

Wait time for services

- “When I made a decision to get help it was a seven-week wait to see someone for an assessment.”
- “After making a decision to get help, the long waiting list [of several weeks] for outpatient support was really discouraging.”
- “Waiting for everything ...”

Summary of Focus Group Feedback

The feedback from women highlights the many strengths of the Ontario service system; but it also points to unmet needs and practices that undermine women’s engagement and recovery.

Some of those issues can be addressed by using trauma-informed practices in the substance use service system—for example:

- Ensuring that women staff work with women clients
- Helping women to establish safety and deal with trauma-reactions
- Providing clear information about services
- Using more flexible approaches (e.g., length of stay)
- Providing links to ancillary services and supports

Some of the issues that women have identified cannot be directly addressed by the substance use service system, however advocacy may help—for example:

- Stigma, discrimination, and lack of understanding in other health care services, particularly in emergency and acute care services
- Lack of adequate community services and wait times for existing services

We are extremely grateful for the courage and openness of the women who participated in the focus groups for this document.

Endnotes

See Appendix B for full reference information

¹ Courtois, 2012

² Brown, Petite, Haanstra & Stewart, 2009

³ Ibid.

⁴ Sturm, 2012

⁵ Newmann and Sallmann (2004), cited in Sturm, 2012

⁶ Becker et al., 2005, cited in Sturm, 2012

⁷ Gatz et al., 2005, cited in Sturm, 2012

⁸ Anda, no date available

⁹ Focus groups sponsors: Destiny Manor Addiction Treatment Services (*Whitby*); Iris Addiction Recovery for Women (*Sudbury*); The Centre for Addiction and Mental Health Toronto Drug Treatment Court (*Toronto*); The Jean Tweed Centre (*Toronto*); and Womankind Addiction Service (*Hamilton*).

Section 4:

About Trauma

Goal of Section 4

To orient the reader to:

- the nature and impacts of trauma
- how trauma can affect engagement with services
- triggers & retraumatization
- strategies to establish safety

Trauma and substance use

Research has shown that the kinds of trauma experienced by women who develop serious substance use problems:¹

- are often interpersonal in nature, intentional, prolonged and repeated (such as sexual abuse or incest, physical abuse, severe neglect, and serious emotional and psychological abuse), rather than ‘single blow’ traumatic events (such as natural disasters, accidents, or crimes)
- may also include the witnessing of violence, repeated abandonments, and sudden and traumatic losses
- often occur in childhood and adolescence, and may extend over years of a woman’s life
- can frequently include several different kinds of traumatic or adverse experiences, comprising cumulative trauma.

“No listing of symptoms does justice to the private reactions and anguish experienced by many [women who have experienced trauma] and their loved ones.”²

Wide-reaching impacts

Trauma affects the whole woman—the mind-body impact is an interweaving of physical and emotional responses.

Research and clinical experience have identified the broad impacts of trauma on women’s mental health and overall health, as well as on their substance use behaviours.

The effects of trauma can be acute, chronic, and/or delayed, and can include illness, disease, and physical injury, as well as psychological and developmental effects.³

Those effects can manifest as a bewildering array of issues, for example:

- Cumulative experiences of trauma have neurological impacts, and can lead to health risk behaviours or maladaptive coping mechanisms; severe and sometimes chronic dysfunctions can result, including disease, disability, and serious social and mental health problems.⁴
- Research has demonstrated that the experience of trauma in childhood greatly increases risks for Post Traumatic Stress Disorder, tobacco use, alcohol dependence, injection drug use, sexually transmitted diseases, homelessness, and myriad physical health problems, as well as reduced overall quality of life.⁵

- Experiences of trauma have been linked to physical health problems such as sleep disorders, cardiovascular problems, changes in the central nervous system, and gastrointestinal and genito-urinary problems, as well as reproductive and sexual problems.⁶

Trauma-related responses and adaptations

Trauma responses can manifest as problems of intrusion, constriction, and hyperarousal.

These mechanisms, which enabled a woman to survive trauma, can make it difficult for her to respond effectively to the challenges of the present. A woman's attempts to resolve or escape the pain can lead to reliving the event, problematic substance use, and other self-harming behaviours.⁷

Intrusion

- recurrent and intrusive recollections of the event (e.g. images, thoughts, perceptions)
- flashbacks—re-experiencing the abusive experience as though it were occurring in the present
- nightmares—in a dream reliving the experience and waking up very frightened
- emotional and psychological distress when exposed to internal or external cues that symbolize or resemble an aspect of the event
- body memories—body feelings associated with the experience, such as smells, sounds, or tastes which may trigger memories

Constriction

- shutting down for self-protection or avoidance, or numbing of responsiveness
- feeling numb or not having feelings at all
- attempting to avoid thoughts, feelings, or conversations associated with the trauma
- dissociating—observing events as though from outside one's body

- inability to recall aspects of the trauma
- diminished interest or participation in significant events
- feelings of detachment or estrangement
- restricted range of emotional expression
- sense of a 'stunted' future

Hyperarousal

- never feeling really safe
- increased anxiety and response to stimulus
- increased arousal responses such as being easily startled
- reacting irritably or disproportionately to minor things or events
- ongoing, persistent feeling of potential danger
- sleep problems, including difficulty falling asleep or staying asleep
- difficulty with concentration

See **Section 12** for more detailed information about trauma responses.

Traumatic experiences are often shrouded in secrecy and silence, denied, or minimized; this can leave a woman profoundly confused.

Helping women comprehend the impacts of trauma can provide them with important information about the context and function of trauma-related responses and adaptations. For example, naming abuse can counteract deceptive ways in which the experience was presented. Women may have been told that abuse was 'loving discipline' or a 'needed introduction to their sexuality'. They may have been told that 'you pushed me into' violence, or 'you deserved it'.

Naming abuse can help women to understand that their trauma responses and adaptations are normal responses to abnormal experiences.

They may see substance use as a coping strategy that has helped them to deal with their experiences of trauma. Supporting women to have compassion for themselves and their responses will enable them to

move beyond the trauma and anticipate a future with other possibilities for their lives.

Many women use substances to help them manage emotional distress.

For example, it is not unusual for a woman to use alcohol or opioids to deal with hyper-arousal, or for a woman to use cocaine to experience a sense of control and power.⁸

When women stop using substances or moderate use to reduce harm, it is not uncommon for them to experience increases in trauma-based reactions.

It is essential to help women to increase their repertoire with additional and alternative ways to deal with distressing emotions and experiences.

See **Section 6** for detailed information about service practices.

“Often [women who have experienced trauma] think of themselves as a ‘mess’. Events do not seem to make sense, and these [women] see themselves as a chaotic and unpredictable collection of [trauma] responses. As much as needing the solution to a particular problem, [women who have experienced trauma] need to believe that their behavior is intelligible and capable of being brought under their control. A holistic and trauma-focused understanding gives [women who have experienced trauma] a structure for organizing and understanding their experience.”⁹

Trauma-related issues can affect a woman’s engagement with services

The impacts of trauma can negatively affect women’s ability to access, engage with, and benefit from substance use and mental health services.¹⁰

Experiences of trauma can damage a woman’s sense of safety, self and self-efficacy, so she may find it difficult to trust that services will be responsive, effective, and respectful. Since trauma can interfere with a woman’s ability to regulate emotions and navigate relationships, she may find it difficult to comply with program requirements or to engage in a trusting therapeutic relationship. See **Section 7** for information about the therapeutic relationship.

The impacts of trauma can also negatively affect women’s ability to access other types of health care.

Medical care, procedures and personnel can become triggers for trauma responses. Some women develop phobias in which they perceive the body as a source or cause of trauma and related reactions. As a result, some women avoid encounters with providers of medical, dental, or health care services, or neglect self-care or necessary health procedures (e.g. gynecological care, dental and oral health care).¹¹

Harris and Fallot¹² have summarized the key issues that should be considered to appreciate the wide-ranging and profound effects of trauma.¹³ These include:

- **Impact on many life domains.** Trauma exposure increases vulnerabilities to: substance use and mental health problems; a wide array of physical health problems; relationships and interpersonal struggles; eating disorders; compulsive behaviours; and suicidality, among many others.
- **Deep and life-altering impacts.** Women who have experienced trauma may come to see themselves as fundamentally flawed and to perceive the world as a pervasively dangerous

place, especially when trauma has been repeated and prolonged, and especially when perpetrated by those who were supposed to be caregivers or by others in a position of authority.

- **Risk of repeated and continuing trauma.** Individuals who have experienced trauma are at increased risk of perpetrating violence, or of being in situations or relationships where they experience repeated trauma. The impacts of trauma may be transmitted across generations.
- **Increased vulnerability of people who are marginalized.** Women who are poor, homeless, isolated, criminalized, or who have severe mental health problems, developmental disabilities or substance use problems are at increased risk of violent victimization.
- **Impacts on potentially helpful relationships.** Being vigilant is often an important self-protective mechanism for a woman who is coping with trauma. But this coping mechanism can make it more difficult to feel safety and trust and to sustain connections with people who can help and support her, including non-professional relationships (e.g. friends, family) and professional caregivers (e.g. substance use services, other health care services).
- **Impacts of trauma experiences in a service context.** Practices and activities—in substance use services and other health care settings—can inadvertently retraumatize women in the very settings where they are seeking help.
- **Effects of trauma on staff members.** ‘Vicarious’ trauma can deeply affect staff who provide direct services, as well as administrators and support staff.

Building on the strengths of women who have experienced trauma

“As women come to see the power in their defenses and coping strategies, they also come to believe that they have the strength and wisdom to make changes in their lives.”¹⁴

Women who have experienced trauma have an array of personal and interpersonal resources, some of which are not related to trauma.

They have all developed coping skills and resources that allowed them to survive. Trauma-informed practices identify and validate the significance of these strengths and resources. Working with a woman collaboratively to build on strengths enhances self-efficacy and resilience and instills hope.

Validating a woman’s resilience is important, even when past adaptations and ways of coping are now causing problems.

Understanding a trauma response as an adaptation can reduce a woman’s guilt and shame, increase her self-esteem, and provide a path for developing new skills and resources that allow new and more effective adaptations to her current situation.¹⁵

“Being a trauma survivor means that I have remarkable coping skills, intuition, and resiliency. Contrary to what many (including other survivors) may think, trauma survivors can be, and often are highly functioning individuals. Even though we sometimes have an inability to care for ourselves and make safe choices, this does not mean we are strangers to ourselves and do not know our needs.”¹⁶

Reducing risks of retraumatization

“Unless we understand what retraumatization is and how it is manifested, we will not be able to create truly trauma-informed programs, services, service environments and service systems.”¹⁷

In any ‘helping’ environment, women run the risk of being retraumatized.

A woman can be triggered or retraumatized when a situation, interaction, or the environment triggers feelings and reactions associated with the trauma. It is important to identify and remove potential triggers.

“Male staff at detox opening doors [to women’s rooms]—not a safe environment.”

Trauma Matters focus group participant

If a program’s practices act to worsen a woman’s trauma responses or are perceived as dangerous or threatening, they can harm a woman rather than help.

For example, aggressively confrontational approaches that have traditionally been used in some substance use services can trigger trauma responses (such as defensive or flight behaviours) that prevent a woman from staying involved in substance use services.¹⁸

“First, do no more harm. Recognize that harm has been done.”¹⁹

Triggers and retraumatization are usually unintentional.

Often, service providers are unaware of how a situation or behaviour is eliciting a trauma reaction. Actions that may trigger trauma reactions or retraumatize a woman can be obvious or not-so-obvious; for example:

Obvious: gynecological examinations; being placed in restraints; being threatened or harassed

Not-so-obvious: a dental examination or procedure; a hug or reassuring touch; not being believed; a male staff entering a woman’s room (e.g., for ‘bed checks’)

“When the counsellor called us ‘ladies’—that was a trigger. As a kid I was told ‘you’re a lady now’ after the abuse, like it was a rite of passage. I prefer that we’re called ‘women’.”

Trauma Matters focus group participant

The beliefs and attitudes of staff can inadvertently echo or parallel the negative messages that women have received about trauma.

Some substance use program staff may believe that talking about past or current experiences of trauma will distract from recovery, or even be a ‘voice of self-pity’. These ideas and attitudes may echo earlier, silencing messages—they may parallel a woman’s experience of being told to ‘keep quiet’ about the abuse. They may also generate shame, or imply a woman has exaggerated or even caused the trauma, or that she could make it worse by revealing it.²⁰

“There were times when I was in treatment and I was having flashbacks—I was told just to focus on my addiction.”

Trauma Matters focus group participant

The following table illustrates some of the ways that practices in substance use services can trigger trauma responses among women who have experienced trauma in childhood. It should be noted that, although the table refers to trauma in childhood, these types of negative and potentially retraumatizing experiences are equally relevant for women who have experienced trauma during their adolescent or adult lives. It should also be noted that childhood and adult experiences of trauma can also be replicated in other health care service settings. The table has been adapted from the work of Jennings, 2009

Early experiences of trauma can be replicated in service settings

Impact	Early experience	Experience of the adult
Unseen & Unheard	The child's psychiatrist, pediatrician, or mental health staff did not inquire about, or see signs of sexual abuse. The child was misdiagnosed. No treatment, or misguided treatment, was provided.	The woman is not screened or assessed for trauma. Trauma impacts are not identified, are discounted or dismissed. The woman is misdiagnosed. Treatment is misguided, or sometimes harmful.
Isolated	The child was alone and isolated in her experience. She wondered: 'Why just me?' She believed that she was singled out, different from others, the only one in the world to be violated or abused.	There is no discussion with the woman about experiences of trauma. No one talks openly or educates women about the prevalence and impacts of trauma. The woman is left isolated and alone with the experience.
Blamed and shamed	When the child 'acted-out' because of her trauma, she was labeled as 'difficult to handle' or a 'problem'. The child was blamed, spanked, or confined to her room for her anger, screams, and cries. The child's 'bad' behaviours were perceived as arising from something inherently wrong with her. The impact of environmental factors (e.g. trauma) was not recognized or considered.	The woman's trauma-reactions and adaptations are perceived as 'noncompliance', 'treatment-resistance', 'attention seeking', 'manipulation', or 'being unmotivated' or 'hard to serve'. Womens' expression of terror, rage, and grief results in 'consequences', such as loss of privileges, rejection, or expulsion from services. The woman's emotions and behaviours are attributed to her inherent character. Impact of environmental factors (i.e. experiences of trauma) is not considered or recognized.
Unprotected and vulnerable	The child was defenseless against the abuse. Attempts to tell were unheard or ignored. There was no safe place for the child, even in her own home or room.	The woman is vulnerable to abuse or violation from other clients or from staff. Her reports are deemed 'not credible'. Policies fail to effectively protect her.
Powerless	The person who abused the child had absolute power/control. The child's expressions of intense feelings, especially anger directed at parents, were often punished and suppressed.	Program and counselling staff have power, authority, and control over a woman's continued involvement in a program and linkages with other resources. Intense feelings, especially anger at staff, must be suppressed – if expressed, they are punishable by coercion or expulsion.

Focusing on safety

Safety is the first focus of recovery from trauma and substance use issues.

Safety means different things to different women. Rather than making assumptions about what can help a woman feel safe, a counsellor should discuss with her what safety means to her, and work together to define goals and strategies that work for her.²¹

Counsellors should work with each woman to anticipate specific triggers, and help her to identify what will help her to feel safe. Counsellors can also help to support a woman's emotional and physical safety by helping her to develop a basic skill set for dealing with trauma-based reactions and practicing healthy self-care.

"I remember when the counsellor said to me 'well, that makes sense' and they could see that my thought process wasn't as bizarre as I thought it was."

Trauma Matters focus group participant

More information about strategies and tools that women can use to manage triggers and trauma reactions can be found in **Section 6**.

Additionally, excellent resources that provide additional information about how to help women to establish or enhance safety include Seeking Safety manual by Najavits and websites such as www.ibiblio.org/rcip/copingskills.html²²

Providing a safe environment can be especially challenging when women and men receive services in the same service setting.

An organization in Northwestern Ontario has shared some of the strategies they are using to meet the challenges of their mixed-gender residential facility.

Case Example — Safety for Women in a Mixed Gender Setting

Our first obligation is to inform women that, although programming is gender-specific, men are served under the same roof. We take all possible steps to ensure safety—for example:

- The women's residential units are totally separate from the men's units, including all group rooms and living areas.
- Female staff look after housekeeping needs; male staff do not enter clients' rooms.
- Doors between the women's and men's units are locked from 11 pm to 7 am.
- Staff are on duty 24 hours a day; security guards are on site from 4 pm to 8 am.
- All programming is separate. Women's and men's treatment groups are facilitated by staff of the same gender as the group.
- Coping strategies are introduced and taught early.
- Challenging and triggering situations can arise when clients have known each other in the past, and in the shared designated smoking area. If a situation arises during treatment we deal with it immediately.

As an adjunct to safety strategies, women may need help with instrumental supports.

A woman who is in an unsafe relationship, or who does not have housing security or food security may need support connecting with resources that will help her to carry out safety strategies. For example:

- A woman may need information or pro-active, supported linkages that will help her to meet her immediate needs for housing, transportation, food security, health and medical care; linkages with Violence Against Women resources; hospital admission; or assessment for medications.
- Women who are mothering may need help with a variety of supports (e.g. arrangements for care of their children, accessing parenting supports, dealing with child welfare services or custody issues).
- Women may also have responsibilities for providing care to aging parents or other family members who need assistance, or for looking after farm animals or family pets. They may need help finding resources that will allow them to make alternative arrangements for care.

Endnotes

See Appendix B for full reference information

¹ Jennings, 2008

² Courtois, 2012

³ Courtois, 2012

⁴ Jennings, 2008

⁵ Wu, Schairer, Dellor & Grella, 2010

⁶ Poole, 2011

⁷ McEvoy & Ziegler, 2006

⁸ Steward, 2007

⁹ Harris & Fallot, 2001

¹⁰ Poole, 2011

¹¹ Courtois, 2012

¹² Fallot & Harris, 2009

¹³ Fallot & Harris, 2009

¹⁴ Harris & Fallot, 2001

¹⁵ Elliott, Bjelajac, Markoff, Fallot & Reed, 2005

¹⁶ Trauma Survivor, Provincial Trauma Forum, 2007, in Clinic Community Health Centre, 2008

¹⁷ Jennings, 2009

¹⁸ Moses, Reed, Mazelis & D'Ambrosio, 2003

¹⁹ Courtois, 2012

²⁰ Elliott, Bjelajac, Markoff, Fallot & Reed, 2005

²¹ McEvoy & Ziegler, 2006

²² Najavits,

²³ Markoff & Finkelstein, retrieved online at

http://www.healthrecovery.org/projects/trauma_integration/

"Environments feel safe to [women] when their experiences are validated and their real needs are addressed" ²³

Section 5:

A Multi-Dimensional Perspective

Goal of Section 5

To discuss the importance of approaches that respond to the full context of women's lives, including cultural competence and anti-oppression approaches

Understanding and responding to the context of women's lives

Services that work effectively with substance-involved women go beyond a singular focus on problematic substance use, or even a dual focus on trauma and substance use.

To build a strong therapeutic relationship with any woman, service providers need to understand both trauma and substance use issues as part of a 'bigger picture'.

*"Research demonstrates that addiction is rarely, if ever a single-dimension issue for women. Addiction is always a part of a larger portrait that includes a woman's individual history, and the social, economic, and cultural factors that create the context of her life. Therefore, in thinking about treatment for [substance-involved] women, it is essential to start from the premise that theory and practice should be based on a multi-dimensional perspective."*¹

Some of the challenges that should be considered include:

- the impact of stigma
- cultural issues, and the cultural competence of the organization
- her safety, and her need for safety and crisis planning
- the impacts of the social determinants of health, and the practical issues that may arise in respect to housing, income security, food security, and other social determinants
- her access to care, and barriers that may impede her access
- concurrent mental health, physical health, and developmental issues, and links that can be helpful
- the significant impacts of involvement with the criminal justice system or child protection services
- other links that can be made with providers of health care, social services, and other services to support her health and well-being.

Counsellors should work with women to help identify assets—as well as challenges—and to appreciate their resilience.

When the therapeutic relationship recognizes the challenges experienced by each woman and the strengths that enabled her to meet those challenges, the focus can shift to her resilience. The counsellor can help a woman build on the creative coping strategies she has used.

See **Section 6** for more information about how counsellors can help women recognize and build on their strengths and assets.

Vulnerability to trauma increases among those who are most marginalized.

Women are marginalized by a variety of factors: ²

- many women are subjected to bias and discrimination based on cultural constructs such as gender, race, ethnicity, ability, and/or sexual orientation
- many are marginalized by poverty, lack of education, criminalization, and socio-economic or class issues
- responsibilities for the care of children and dependent others are often shouldered with inadequate or no support
- women may lack support from a partner or family, or experience abuse and violence as adults, at the hands of partners and others.

"Knowledge of violence against others in one's community or ethno-racial group can build up 'like drops of acid on a rock, until one drop shatters it'." ³

Some groups of women experience the significant impacts of intergenerational and historic trauma. For example, women who are members of First Nations and Aboriginal communities in Canada have been deeply affected by colonization, residential schools, racism, and poverty.

"The meaning one gives to violence and trauma can vary by culture. Healing takes place within a woman's cultural context and support network, and different cultural groups may have unique resources that support healing. Cultural competence does not require that every service provider have detailed knowledge of every culture, but rather that he or she recognize the importance of cultural context ... ask questions, be open to being educated, and try to understand the woman's experience and responses through the lens of her cultural context." ⁴

Diversity and inclusion

Inclusiveness should be an institutional value and practice of all service providers.

Being inclusive requires sensitivity to the cultural factors that can mediate experiences of trauma. Services are shaped by the dominant culture(s) in our society; as a result, they may unintentionally reinforce the stigma, discrimination, stereotyping, and inequities that are present in society. This can result in exclusionary practices and barriers.

Service providers must identify and change organizational and service practices that may marginalize, devalue, or exclude some women. Understanding and reflecting on how cultural underpinnings and assumptions influence clinical approaches and programs will help staff to be more responsive to all members of the communities they serve.

“Cultural competence is more than the latest buzzword in our field. It is the best way to ensure that the people we serve receive treatment that is meaningful to them.”⁵

Cultural competence is critical to trauma-informed practices.

Dr. Laura Brown emphasizes that working in culturally competent ways requires more than simply following a set of rules about how to work with members of a specific group. All individuals—including both clients and service provider staff—are members of many cultural groups. Dr. Brown describes the influences of these groups as the ‘many strands of identity’.⁶

Many women will see themselves as part of more than one group or culture.

Some of these cultural influences and associations may be immediately visible, and others may reveal themselves over time. Every ‘strand’ of a woman’s cultural identity can be a source of both risk and resilience.

To work in a culturally competent way, service providers must avoid making assumptions about a woman’s culture.

They should start with an understanding that each woman is the ‘expert’ on her life and learn from her, so that they can respond to the cultural influences that she herself identifies and the various impacts of culture as she herself experiences them.

“Being involved in my own cultural practices helped me to feel safe ... nothing was said, but I could feel a sense of release ... I felt respected and like I belonged.”

Trauma Matters focus group participant

“Cultural competence enables all agency staff to work within a woman’s values and reality ... It also acknowledges and incorporates cultural variations in normative acceptable behaviors, beliefs and values ... and incorporates those variables into assessment and treatment.”⁷

Organizations should demonstrate to *all* women that they value their knowledge and experience and want to learn from them, collaborate with them, and share power with them.

Organizational strategies that aim to be inclusive and appreciative of diverse experiences will help to build services that are based on principles of social justice and equity.⁸

Some of the dimensions that service providers should consider when they seek to learn about the communities served include:⁹

- How does the organization provide services to diverse groups?
- What is the environment in which those services are offered?
- How included do women from varied backgrounds feel in services?
- What cultural activities are directed to specific populations?
- How can services be tailored or made more accessible to particular groups?
- Are there staff members who know the language of non-English-speaking women?
- What networks have been created with experts and members of the community who can help the organization to expand its knowledge of the community?

Organizations should support cultural competence among staff.

Dr. Laura Brown encourages counsellors and other direct service workers to be aware of the many ‘strands’ of their own identities (including but not limited to sex and gender, ethnicity, social class, sexual orientation, indigenous heritage, immigration experiences, disability, and spirituality) and understand how those strands of identity intersect.

Dr. Brown also encourages staff to accept the ‘reality of bias’ as an aspect of being human.¹⁰ For example, staff may unconsciously develop an ethnocentric viewpoint—that is, they may not view themselves as belonging to a specific culture and may think that notions of ‘culture’ pertain only to *others*.¹¹ Staff should be encouraged to reflect on cultural differences; this can help them to identify the potential impacts of those differences on their own attitudes and behaviours.

Anti-oppression approaches

Anti-oppression approaches should be used by all service providers with all clients, as a matter of good practice.

It is particularly important that those approaches be used in trauma-informed services because experiences of oppression can amplify the impact of trauma. Oppression can reinforce a woman’s feelings of powerlessness and create barriers to the services and support she needs.

Like cultural competence, anti-oppression approaches require that counsellors avoid making assumptions or responding to stereotypes, and work to see each woman ‘for who she is’. Anti-oppression approaches also require that service providers and program planners reflect on embedded attitudes and organizational policies and practices that could reinforce women’s experiences of oppression.

“Our trauma-informed culture is based on ‘power with’ as opposed to ‘power over’, while also acknowledging power differentials. This means focusing on a woman’s strengths and assisting to build on them.”

Substance Use Service Provider—Ontario 2012

A toolkit developed for victim assistance services identifies anti-oppression approaches that encourage:¹²

- coming from a foundation of honest self-reflection
- asking value-neutral questions and listening to the answers
- examining and resisting societal beliefs about mental health and substance use issues
- understanding oppressions such as racism, sexism, ableism, poverty, homophobia, transphobia, colonization, and how all of those relate to beliefs about mental health and substance use issues
- maintaining an attitude of engaged neutrality when providing services
- focusing on behaviours and context as opposed to labels and diagnoses.

Concurrent mental health issues

Research has demonstrated links between experiences of trauma and mental health problems, as well as problematic substance use.

“In fact, most of the major nonorganic forms of mental distress and disorder have been associated with at least one form of interpersonal victimization in women.”¹³

These include increased depression; anxiety; cognitive disturbances, such as hopelessness and low self-esteem; dissociation; somatization; sexual problems; problematic substance use; and suicidality.

“Sometimes it’s better to have no one at all than to be with people who don’t know what they’re doing.”¹⁴

A woman who has experienced trauma may present with a “bewildering array of symptoms”¹⁵ and elevated levels of stress.

Women who seek help for substance use or mental health problems may not be asked about trauma. Awareness of the prevalence and impacts of psychological trauma are relatively recent—in the absence of that awareness, women’s trauma responses have often been misread or misinterpreted. Psychiatrist and researcher Judith Herman points out that women who have experienced trauma are frequently misdiagnosed and mistreated.

Many women receive multiple diagnoses that do not take into account their traumatic experiences.

The diagnoses they commonly receive (such as borderline personality disorder, somatization or dissociative identity disorder) often have pejorative meanings and can evoke strong negative reactions in caregivers. They may not be perceived to be credible and may be accused of malingering or manipulating.¹⁶

“Once we have labeled a woman as suffering from a major mental illness, whether that label is an accurate assessment or not, we view her reports of sexual and physical abuse through the coloured lens of her diagnosis ... The stigma of her diagnosis is often sufficient to call her account into question.”¹⁷

“I can’t find anyone to work with who understands what is going on with me, who knows what they are doing and can help me work on trauma.”¹⁸

Woman with lived experience

Women who have mental health problems also have a greater risk of being abused.

A woman’s mental health problems, or the medications she takes in relation to mental health issues, may impair her judgment, making it difficult for her to protect herself against violence, attacks, abuse, and coercive sex.¹⁹ Issues such as homelessness, poverty and substance use problems can also contribute to a woman’s vulnerability. Mental health service systems may further replicate women’s experiences of powerlessness through coercive practices such as involuntary hospitalization, the use of restraints, or medication against her will.

“In the system, you must fight every day, every minute, to keep from feeling worthless—to keep your spirit alive.”²⁰

Woman with lived experience

A trauma-informed assessment will help to ensure that the trauma-related responses and adaptations are not misdiagnosed.

It will also help to identify other mental health issues that may also be affecting a woman. Mental health issues should be assessed by a qualified clinician who has a good understanding of trauma-informed practices.

Trauma-informed practices require paced, sensitive screening and assessment to allow underlying trauma-based responses to be identified.

Once a trauma-informed assessment has been completed, service plans can be developed that address mental health issues as well as trauma and substance use issues. Assistance with mental health issues may be provided by concurrent disorders capable services, or through links to appropriate mental health services. Effective links with community resources and holistic, comprehensive treatment planning can help to meet the complex needs of women who have experienced trauma and have concurrent mental health and substance use problems.

"I asked my doctor...and he said because you have a mental illness, it depends on whether a therapist will even take you. I am the black sheep of the system."

Trauma Matters focus group participant

See **Section 6** for detailed information about universal trauma-informed screening and **Section 12** for detailed information about assessment.

Endnotes

See Appendix B for full reference information

¹ Covington, 2002

² BC Association of Specialized Victim Assistance & Counselling Programs, 2007

³ Ibid.

⁴ Elliott, Bjelajac, Markoff, Fallot & Reed, 2005

⁵ Rosenberg, 2011

⁶ Brown , No date available

⁷ Betancourt et al., 2002 cited in Ontario Federation of Community Mental Health and Addiction Programs, 2009

⁸ Ontario Federation of Community Mental Health and Addiction Programs, 2009

⁹ Substance Abuse and Mental Health Services Administration (SAMHSA), 2000

¹⁰ Brown , No date available

¹¹ Haarman, 2004, cited in Ontario Federation of Community Mental Health and Addiction Programs, 2009

¹² BC Association of Specialized Victim Assistance & Counselling Programs, 2007

¹³ Briere & Jordan, 2004

¹⁴ Herman, 1992

¹⁵ Jennings, 1997

¹⁶ Herman, 1992

¹⁷ Harris & Landis, 1997

¹⁸ Jennings, 1997

¹⁹ Morrow, No date available

²⁰ Jennings, 1997

Section 6:

Trauma-Informed Service Practices

Goal of Section 6

To identify and describe core principles for delivering trauma-informed substance use services for women

“Trauma-informed services are not specifically designed to treat ... trauma, but they are informed about, and sensitive to, trauma-related issues ... A ‘trauma-informed’ system is one in which all components of a given service system have been reconsidered and evaluated in the light of a basic understanding of the role that [trauma] plays in the lives of [women] seeking mental health and addictions services...”¹

What does it mean for substance use services to be trauma-informed?

Trauma-informed practices benefit any woman engaged with the substance use service system, whether or not she has experienced trauma, and whether or not her trauma experience is known.

Given the high rates of trauma experienced by substance-involved women, substance use services, including co-ed as well as gender-specific services, should strive to become trauma-informed.

Trauma-informed practices acknowledge the impact of trauma and integrate this knowledge into all aspects of service delivery—from policy development, to management practices, to front line care. Trauma-informed practice is also good practice. It is not necessary for women to disclose trauma experiences (or, in fact, to have experienced trauma) to benefit from trauma-informed practices.

Understanding trauma-informed practices enhances the conversation and the practice of service providers.

When operating from a trauma-informed perspective, service providers can reframe and destigmatize women’s attempts to cope with traumatic experiences. Thus, a woman who might formerly have been seen as ‘non-compliant’ or exhibiting ‘problem behaviours’ is understood instead, within a trauma-informed environment, to be attempting to respond, adapt, or cope with trauma and traumatic experiences. The conversation changes from fault-finding (“What is wrong with this woman?”) to respect and understanding (“What happened to this woman?”).

“It is not unusual for [women] affected by trauma to exhibit a variety of behaviours they can be unfairly judged and perhaps even labeled as resistant, uncooperative, controlling, or manipulative. A service provider [may] become angry with [a woman] who may be trauma affected, question their own ability and doubt the woman’s motivation to change thus creating a potentially toxic situation [for] both.”²

Not only is trauma widespread among substance-involved women, but its impacts can be quite variable.

Some women experience only a few responses as a result of trauma, while others experience a wide range of mild to debilitating responses.

“The impact of traumatic stress can be devastating and long-lasting, interfering with a woman’s sense of safety, ability to self-regulate, sense of self, perception of control, self-efficacy, and interpersonal relationships. Some women have few [responses] after trauma exposure or recover quickly, while others may develop more significant and longer-lasting problems.”³

Trauma-informed knowledge base

Service providers who are trauma-informed incorporate key ideas into their work with women, including the understanding that:

- trauma-informed practices are not the same as trauma-specific services
- working in a trauma-informed way does **not** require disclosure of trauma or ensuring that women seek trauma-specific care—in fact, *until a woman is ready in her own time and her own way* to discuss her trauma experiences with a trusted and skilled service provider, a rush to disclosure is counter-therapeutic and can cause more harm than good
- trauma-informed substance use services have the advantage of being supportive of all women, regardless of whether or not they have experienced trauma.

Listening to the voices of substance-involved women who have experienced trauma can guide service providers.

“They need to realize that there is nothing wrong with us, there is something that happened to us for us to behave the way we do.”

Trauma Matters focus group participant

“Service providers need to look at me and think ‘this person is suffering, this person needs our compassion, not our disdain.’”

Trauma Matters focus group participant

Service providers are equally conscious of what is **appropriate** and **not appropriate** when working with substance-involved women. The following table illustrates some of the differences between trauma-informed approaches and those approaches that are not trauma-informed. The benefits of providing trauma-informed care, regardless of the setting, are many.

“[When]...the service provider works from the vantage point of being trauma-informed, the understanding that comes from this awareness can reduce frustration, improve communication, enhance the quality of the relationship and increase work satisfaction. Investing in integrating a trauma-informed perspective does not create more work but can instead make the work easier, and more satisfying.”⁴

Guide for Trauma-Informed Service Providers

Trauma-Informed Service Providers DO	Trauma-Informed Service Providers DO NOT
<ul style="list-style-type: none"> acknowledge how common trauma is, and the wide impact it has, including the interrelationship between trauma and substance use 	<ul style="list-style-type: none"> require or expect disclosure of trauma experiences by women
<ul style="list-style-type: none"> use this understanding as a foundation for all aspects of service delivery 	<ul style="list-style-type: none"> engage in trauma-specific work with women, while being prepared to use basic safety and grounding techniques when disclosure occurs (see Disclosure later in this section)
<ul style="list-style-type: none"> recognize a wide range of emotional responses that women may experience as a result of trauma and view these not as ‘problem behaviours’ but as responses to difficult life experiences which may reflect coping strategies that are (or were) in fact survival strategies 	<ul style="list-style-type: none"> ask for or go into details of trauma experiences with a woman who may have begun the disclosure process
<ul style="list-style-type: none"> acknowledge that this range of emotional responses can interfere with or even overcome her ability to achieve goals regarding her use of substances 	<ul style="list-style-type: none"> focus on a ‘diagnosis’ or on the specific nature of the traumatic experience
<ul style="list-style-type: none"> recognize that it can be challenging to establish a therapeutic relationship or connection with women who have experienced trauma 	<ul style="list-style-type: none"> forget that the woman has not yet consented to trauma-specific services

Core principles for trauma-informed service practices

Six core principles have been synthesized from the current research literature on trauma ^{5, 6, 7, 8}, complemented by the guiding principles of evidence-based substance use service approaches widely implemented in Ontario's substance use service system. ⁹

The six core principles for trauma-informed practice within substance use service settings are:

- 1) acknowledgment
- 2) safety
- 3) trustworthiness
- 4) choice and control
- 5) relational and collaborative approaches
- 6) strengths-based empowerment modalities

For each of the six trauma-informed principles, we review:

- the **concepts** underlying each principle
- **practice considerations** (knowledge or things service providers need to understand in order to implement the principle)
- **questions for self-reflection** (to aid in an examination of both individual practices and an organization's services)
- **practice applications** (skills or strategies to implement in order to offer trauma-informed care)
- **practice examples** (concrete examples that can be implemented in an organization)
- **guidelines**, including suggested indicators (practices, processes, and policies that substance use counsellors and their organizations need to incorporate into their work and workplace in order to become trauma-informed, along with examples of possible indicators for achievement of each guideline).

Following our discussion of the six core principles, we also provide an examination of three key issues that must be considered by practitioners who wish to engage in trauma-informed service practices:

- **Disclosure**—because women may experience trauma responses or begin to disclose trauma experiences at any stage of interaction, substance use service providers need to attend to responses or disclosure through the use of appropriate strategies, including self-soothing, grounding, self care, and attention to boundary issues
- **Universal trauma-informed screening**—issues to consider and strategies to use when asking women about their trauma experiences as part of the initial intake and assessment process (distinct from trauma-specific assessment, discussed in detail in **Section 12**)
- **Mothering and family relationships**—perspectives for service providers to consider regarding the unique impacts of trauma on a woman's relationship with her children.

1. Acknowledgment principle: *Trauma-informed practice considerations*

Acknowledgment of the pervasiveness of trauma among women, and in particular its interrelationship with substance use, is the first building block of creating trauma-informed substance use services.

*"All services taking a trauma-informed approach begin with building awareness among staff and clients of: how common trauma is; how its impact can be central to one's development; the wide range of adaptations [women] make to cope and survive; and the relationship of trauma with substance use, physical health and mental health concerns. This knowledge is the foundation of an organizational culture of trauma-informed care."*¹⁰

Acknowledgment Principle — Trauma-Informed Practice Considerations

Practice considerations for the core principle of acknowledgment include:

- 1) understanding the pervasiveness of trauma among substance-involved women
- 2) accepting the pervasiveness of trauma without expecting disclosure of it by women
- 3) reframing trauma responses
- 4) encouraging the process of change

Acknowledgment practice consideration 1:

Acknowledge the widespread link between trauma and substance use.

A first step for service providers working in a trauma-informed way is to acknowledge how common trauma is, and the wide impact it has, including the significant role trauma plays in all aspects of the lives of many substance-involved women—their physical health, mental health concerns, work, self-care, relationships, family of origin involvements, and mothering or other caregiving responsibilities. The trauma experience is also likely to impact recovery from the use of substances.

*"Substances can, in the short term, be very effective in modulating mood. For example, [women] ... may use cocaine and other stimulants to increase their level of energy and concentration and to decrease their sense of emotional numbness. Others may use depressants ... to decrease their physical, emotional and cognitive states of hyperarousal. These substances may temporarily help to decrease their anxiety and pervasive perception of danger."*¹¹

Acknowledgment practice consideration 2:

Don't expect disclosure.

Trauma-informed practices assume that all substance-involved women may have experienced trauma without expecting disclosure of the trauma experience by the women. Such services believe it is always better to acknowledge, as a universal practice, the pervasiveness of trauma experiences rather than asking about trauma in a demanding way, which can trigger women and risks retraumatizing them.

Acknowledgment practice consideration 3:

Reframe perceptions of ‘problem behaviours’.

Trauma-informed service providers accept how common the experience of trauma is, acknowledge the wide impact it has, and then redefine their perceptions of ‘problem behaviours’ (such as ‘non-compliance’ or other difficulties in achieving goals or managing clinical expectations). They see instead a woman attempting to adapt, respond, or cope with traumatic experiences. Trauma-informed service providers also recognize that a woman’s wide range of trauma responses has often been functionally appropriate, and possibly life-saving, given her life circumstances. These responses (including her use of substances) have helped her cope and survive.

Acknowledgment practice consideration 4:

Believe in the process of change.

The experience of trauma can have a strong and long-lasting impact on a woman’s development and can affect her world view, social-emotional responses, her view of herself, and her ability to trust others. It can influence her current understanding, skills, experiences, and feelings. However, with respectful and trauma-informed support, substance-involved women can modify their trauma-based reactions in new and more functional ways. Some women transcend their trauma experiences and experience post-traumatic growth.

“Validating resilience is important even when past coping behaviours are now causing problems. Understanding a [trauma response] as an adaptation reduces a [woman’s] guilt and shame, increases her self-esteem, and provides a guideline for developing new skills and resources to allow new and better adaptations to the current situation.”¹²

Acknowledgment Principle — Questions for Self-Reflection

Some self-reflective questions that support the trauma-informed principle of acknowledgment include:

- Do you recognize trauma responses, even if a woman doesn’t tell you in so many words?
- Are you able to link a woman’s use of substances with her actions or behaviours and understand that these (including her use of substances) may be trauma responses?
- Can you work with a woman in a gentle and respectful way without expecting her to disclose a trauma experience?
- Can you reframe your perception of the actions of substance-involved women and move from considering them ‘non-compliant’ or ‘treatment resistant’ to accepting and working with their actions as trauma responses?
- Can you use motivational strategies to support the hope and optimism needed by substance-involved women who have experienced trauma, in order for them to make changes?

Acknowledgment principle — Trauma-informed practice applications

Acknowledgment of the pervasiveness of trauma experiences among substance-involved women can be reflected in the practices of trauma-informed service providers without expecting, or probing for, a disclosure of trauma.

Acknowledgment practice application 1:

Recognize trauma responses.

When women have experienced trauma, they may also struggle with reminders of those events. Reminders can happen without warning: a sound, a smell, or even a feeling can make women feel the trauma experience all over again.

Trauma responses vary widely from woman to woman, but reactions to reminders can include:

- physical feelings: rapid heartbeat, shallow breathing, or tense muscles
- emotional over-reactions: inappropriate or out-of-proportion anger, fear, irritability in situations or toward people—without even realizing it
- avoiding: staying away from others or putting off daily tasks, in order to avoid reminders
- using alcohol or drugs to try to feel better
- avoiding things or people that remind her of the trauma
- hypervigilance or feeling ‘on guard’ or ‘jumpy,’ making it hard to sleep or concentrate.

Watch for signs of a woman appearing numb, disengaged, or angry, and consider whether interactions with you and your organization could be serving as reminders for her. See **Section 4** for more information about trauma-related responses and adaptations.

Acknowledgment practice application 2:

Examine points of first contact.

It begins at, or even before, the front door. The reception a woman receives the first time she crosses the threshold of a substance-use service conveys a message about how she will be treated there. Identify all points at which women might come into first contact with a trauma-informed practice. This can include:

- the organization’s website,
- any written materials that describe the organization, such as pamphlets, brochures, and other media (radio or TV spots that are made broadly available to the public, and content in Internet inventories such as Connex Ontario, for example)
- personal contact through voicemail messages, telephone response, and the organization’s receptionist, intake workers, or outreach staff.

“It’s welcoming when you know what’s going on and you are informed about simple things like ‘you just may have to wait a little longer.’ It might seem trivial, but it’s so important for us to have the information.”

Trauma Matters focus group participant

Acknowledgment practice application 3:

Build a repertoire of staff responses.

Provide clinical and non-clinical staff with training on the kinds of situations they might encounter, such as women calling or arriving in distress. Clinical staff can work with non-clinical staff to develop scripts, roleplay, or engage in other strategies that will support everyone on staff to engage appropriately with women who have experienced trauma. Assemble a directory of safety referral resources (e.g., women’s shelters).

Acknowledgment practice application 4:

Adapt assessment procedures.

Adapt screening and intake procedures so that women are asked about trauma routinely, without being required to disclose trauma experiences before they are ready. See **Universal Trauma-Informed Screening** later in this section.

Acknowledgment practice application 5:

Be honest with yourself.

Develop a means of self-assessment to help all staff identify their personal capacity to engage with women who have experienced trauma, including the skill of knowing when to ‘do no harm’ by linking women with a clinician who has more highly developed skills and training in trauma.

“The most important thing is validation. Validation. Validation. And the acknowledgment of the things we have been through and why we have done the things we have done. Just how it’s all linked.”

Trauma Matters focus group participant

Acknowledgment Principle — Practice Example

There are a variety of strategies trauma-informed services can implement to ensure that the points of first contact for women reflect and acknowledge a trauma-informed context. Consider these examples:

- All written materials (including information on websites) include information about trauma and use trauma-informed language that demonstrates an understanding of the relationship between substance use and trauma.
- There is a script for voicemail messages and for use by the front desk staff, to ensure that the language used is trauma-informed.
- Messages are very clear. First phone contact with a woman includes all basic and practical information, such as:
 - clear and simple directions to reach the organization
 - what to expect upon arrival
 - the name of the counsellor or other staff she will see
 - how long the first appointment will take
- If there is a wait time for the initial appointment, staff determine if the woman needs interim support and provide “warm” referrals as necessary.
- Opportunities are provided for women to ask questions or express their concerns.

2. Safety principle:

Trauma-informed practice considerations

“Physical and emotional safety for [women] is key to trauma-informed practice because [women who have experienced trauma] often feel unsafe, are likely to have experienced boundary violations and abuse of power, and may be in unsafe relationships [or live in unsafe environments].”¹³

In trauma-informed services, the definition of safety expands beyond physical safety to encompass emotional and cultural safety. Women who have experienced trauma often feel unsafe, not only in situations (including the substance use service setting), but also in relationships (including those with service providers). Trauma-informed services strive to incorporate all facets of safety into every aspect of the services they deliver.

Safety Principle — Trauma-Informed Practice Considerations

Practice considerations for the core principle of safety include:

- 1) recognizing the many aspects involved in creating an environment of safety for women who have experienced trauma, including emotional, psychological, physical, and cultural safety
- 2) emphasizing relationship building, providing flexible services where possible
- 3) ensuring safety for everyone in the organization, including other clients and staff
- 4) finding ways to increase emotional and physical safety for women in co-ed service environments

Safety practice consideration 1:

Safety issues include a wide range of meaning.

Trauma-informed services demonstrate an understanding that women who have experienced trauma need to feel physically and emotionally safe. Safety is created in every interaction and is characterized by physical safety (as perceived by the substance-involved woman) **and** by minimizing or avoiding triggers that could create a trauma response. Safety is also created and demonstrated through cultural sensitivity, including age, race, class, religion, disability status, and sexual orientation.

“Because interpersonal trauma often involves boundary violations and abuse of power ... [services must] establish clear roles and boundaries. Privacy, confidentiality, and mutual respect are also important aspects of developing an emotionally safe atmosphere ... cultural differences and diversity (e.g. ethnicity, sexual orientation) must be addressed and respected.”¹⁴

Safety practice consideration 2:

Engagement and flexibility enhance an environment of safety.

Relationship building is a key component in establishing an environment of safety. Trauma-informed service providers recognize that it can take time to engage with women and ensure that the therapeutic or counselling relationship is secure and clearly defined. Trauma-informed services avoid confrontational therapeutic styles and approaches, authoritarian relationships, and challenges to women to change in daunting or demanding ways that can retraumatize and obstruct safety.

Flexibility is also a key component: trauma-informed services ensure that women feel comfortable in the service environment, and adjust their processes where possible, when either women request it or their behaviour indicates that a change is required.

“[Trauma-informed service providers] recognize [their] potential behaviors (including tone of voice), and situations, such as drug testing, confrontation, restraint, or seclusion, that could retraumatize women in their encounters with staff and slow the process of developing a therapeutic alliance.”¹⁵

Safety practice consideration 3:

A safe environment includes safety for other clients and for staff.

Trauma-informed services emphasize physical, psychological, and emotional safety not only for substance-involved women, but also for staff. All staff in a trauma-informed service should feel supported in their work by colleagues at all levels within the organization. Also, other clients should feel safe to express their ideas, issues, and concerns, while at the same time understanding that there is zero tolerance for hateful or hurtful comments.

“We cannot assume that [women] who have experienced trauma will understand or identify their experiences as trauma, nor will [women] always be compassionate toward the behaviours displayed by others who have experienced it. A client education program is part of the design of a trauma-informed service.”¹⁸

Safety practice consideration 4:

Co-ed services can have extra challenges in creating an environment of safety.

In co-ed environments—especially in residential or withdrawal management services—around-the-clock female staff may not be available; there may only be male staff available for support in the evening. In such cases, organizations should have discussions in staff training sessions or supervision meetings about: ways in which co-ed services can minimize triggers and reduce, if not eliminate, them for women who have experienced trauma; how co-ed services can work toward the goal of having female staff available at all times; strategies for enhancing safety for women when male clients or staff are present. Above all, ask women for their input. See **Focusing on Safety** in **Section 4** for a program example from a co-ed service in Northwestern Ontario.

“As a co-ed service, on a practical level, it is sometimes difficult to have the women not run into males at all, but we try to minimize it; our message is that even if you can’t do it all, doing the best you can is still helpful.”

Substance Use Service Provider—Ontario 2012

Safety Principle — Questions for Self-Reflection

Some self-reflective questions that support the trauma-informed principle of safety include:

- To what extent do your activities and settings ensure the physical, emotional, and cultural safety of women? Can services be modified to ensure safety effectively and consistently?
- In co-ed services, have you had staff discussions about ways to prevent or reduce trauma responses for women who may be triggered by the presence of male staff?
- Have you asked women about their experience of feeling safe in your program? How have you used their feedback to make your program safer?
- Are you attentive to signs of a woman's discomfort or unease? Do you understand these signs in a trauma-informed way?
- Is there adequate personal space for individual women? Can women choose to find a more secure space if they feel unsafe?
- Do women receive clear and trauma-informed explanations about each aspect of service provision? Are rationales made explicit? Are specific goals and objectives made clear? Does each contact conclude with information about what comes next?
- Where and when are services delivered? Are others present (e.g., clients, co-facilitators, security staff, family members)? If so, what impact do they have? Have women been informed of their presence in advance?
- In discussions with women, are you sensitive to potentially unsafe situations in their living arrangements, such as domestic violence or unsafe housing?

Adapted from Fallot and Harris "Creating Cultures of Trauma-Informed Care: A Self-Assessment and Planning Protocol", 2009

Safety principle — *Trauma-informed practice applications*

A trauma-informed service can create and demonstrate the many aspects of safety (including physical, emotional, cultural safety) by engaging in these practice applications.

Safety practice application 1:

Do an environmental scan and develop a checklist

Pay attention to the appropriateness of the physical space. Women who have experienced trauma are often hyperaware of their physical environments. They may have an explicit or implicit sensitivity to the physical environment on their sense of safety and comfort. Conduct an environmental scan to explore and adapt the organization's setting so that:

- the setting demonstrates sensitivity to safety issues for women
- choices for personal safety can be made by women when possible.

This could include:

- choosing colours that are warm but muted
- providing comfort items (such as blankets, soft pillows, or stress balls)
- allotting a separate space for quiet reflection or as an escape from feeling crowded by others
- ensuring that hallways, exits, and entrances have security cameras, are well lit, and are well marked
- pointing out doorways that can provide a safe escape route for women if they feel the need to leave quickly.

Based on the environmental scan, develop a monthly checklist that can be incorporated into the health and safety monitoring process of the organization.

"They always had blankets, that was so helpful. I feel like I need to cover up, even if it's just my coat. I remember my counsellor's office, there was a couch and a pillow and a blanket, and I always took the blanket because I didn't want anyone to see my face while I was talking. It really, really helped."

Trauma Matters focus group participant

Safety practice application 2:

Be welcoming, clear, and consistent

Safety is demonstrated and established through intake procedures (and all ensuing service activities) that are respectful, welcoming, warm, and friendly. Safety, especially emotional safety, will also be enhanced if staff:

- provide clear information about programming in conversations with women, backed up with large display calendars showing program outlines (for example), and providing program handouts
- are reliable in follow through, for example by always returning calls within a reasonable period of time
- give a respectful amount of time, whenever possible, when it is necessary to cancel or change an appointment
- demonstrate predictable expectations
- schedule appointments consistently.

"It's really important to know that your appointment is the same day, same time, every week because you're so traumatized, you can't think straight. It has to be the same every week."

Trauma Matters focus group participant

Safety practice application 3:

Provide information that can alleviate anxiety or stress

Early contacts with women can be expanded beyond information gathering to include:

- introductions to other staff in the organization
- discussions of confidentiality processes and protocols, including the legal limits on confidentiality
- clarification of expectations
- a description of other people who might be part of the service experience (e.g., co-facilitators, support staff, family members).

Safety practice application 4:

Incorporate safety information at every opportunity

For example, include discussions about safety during information sessions and orientations for both individual work with women and group sessions (if offered by the organization). Ask women about their perceptions of safety and what could ensure or increase it for them. Engage all group participants in discussions of tolerance and compassion for other program participants. The organization's pamphlets, posters, website information, and other resources can include a statement about safety 'rights and responsibilities'.

Safety practice application 5:

Take into account all aspects of emotional safety

For women who have experienced trauma, emotional safety can be enhanced by the trauma-informed practice principles of trustworthiness, collaboration, choice and control, relational approaches, and empowerment modalities (as outlined later in this section of the document). Trauma-informed service providers who respond appropriately to trauma responses also facilitate emotional safety for women.

Safety practice application 6:

Honour her range of emotions

It is likely that, in the substance use service setting, many women will experience trauma-based reactions or emotions. Provide women with the opportunity to show distress and other uncomfortable emotions. When a woman feels she can express her feelings without fear of judgment, this is a tacit validation of her experiences.

Safety practice application 7:

Be open to cultural impacts

Trauma, and healing from trauma, varies within cultural context. Trauma-informed service providers will have the knowledge and skills to work within each woman's culture by staying open, educating themselves on cultural variations and responses, asking questions about her culture, and understanding how their own cultural background can influence interactions with a woman. For example:

- in some cultures, women are discouraged or forbidden to speak of rape or sexual abuse and some women may not have an understanding of the concept of trauma
- residential services and others that do bed checks need to be conscious that in many cultures, it is never acceptable for a man to enter a woman's bedroom—this in itself can be triggering or retraumatizing for women
- if food or beverages are available, have choices that reflect cultural preferences and tastes—in many cultures food defines a welcoming environment
- advocate on behalf of women who speak English as a second language or are newly negotiating Canadian human and social services.

Cultural Safety — Practice Example

“At our centre in Northern Ontario, when people from remote and isolated areas participate in residential treatment services, they leave with numerous new coping strategies and tools. However, trauma work cannot be rushed, or completed within the time frame of residential treatment.

The greatest challenge is the lack of support in remote and isolated communities—often, the nursing station is the sole support. There have been a few people who feel fortunate to have an Elder as the source of their support or someone they can go out on the land with.

Unresolved trauma continues to plague families and communities; the impacts of intergenerational trauma have been well documented. It is not uncommon for people who have experienced trauma and substance use to relapse and reconnect with us more than once, before they continue their healing path.

The positive is that people do reconnect with this Centre. Some people have been supported by engaging in ongoing healing and post treatment services. Some Aboriginal clients have incorporated traditional practices into their daily lives. We embrace Aboriginal culture at this Centre and introduce the Healing Circle and the practice of smudging for those who are interested in participating in it.”

Safety Principle — Practice Example

Here are examples of some very simple steps trauma-informed services can take that will demonstrate to women that their safety is a primary concern:

- Take a look at the organization's signage. Make sure signs are legible, clear, and use welcoming language that avoids commands ('do's' and 'don'ts') and, instead, makes reference to 'rights and responsibilities'.
- Some women will feel more comfortable with locked doors while others prefer open environments. Ask women if they have a preference and provide alternatives, if possible. Ensure that, in every case, exits are easily accessible.
- Walk through waiting areas, the reception area, group spaces, and interview rooms, with trauma-informed eyes. Are they comfortable and inviting? Ask women for their observations of, and experience with, the organization's physical space.
- Do the same outside. Walk around the parking lot, the perimeter of the building, and the exits and entrances. Are they open and well-lit? Again, ask women for their observations and experiences with the exterior of your building.
- Washrooms should be easily accessible and well-monitored for safety, (without being intrusive or violating privacy)—especially in co-ed environments.

3. Trustworthiness principle: *Trauma-informed practice considerations*

"Women living with [substance use issues] and trauma are likely to have more severe difficulties and use services more often than women with either of these problems alone. In addition, trauma [experiences] and the absence of a safe environment are major obstacles to treatment and recovery. [Women] often feel service providers are not safe, trustworthy, or understanding." ¹⁶

Although connected to the trauma-informed practice principle of safety, the trustworthiness principle focuses on task clarity, consistency, demonstrating predictable expectations, and establishing clear interpersonal boundaries.

Trustworthiness Principle — Trauma-Informed Practice Considerations

Practice considerations for the core principle of trustworthiness include:

- 1) understanding the patience and respect required to build a therapeutic relationship with women who have experienced trauma
- 2) determining and communicating clear boundary guidelines

Trustworthiness practice consideration 1:

Establishing a therapeutic connection can be a lengthy and challenging process.

Trauma-informed service providers accept the challenge to construct a trustworthy therapeutic connection with women, and acknowledge that it takes time to build a relationship based on respect, trust, and safety. Trauma experiences undermine a woman's ability to trust, making the process of seeking help very difficult.

"Being vigilant and suspicious are often important and thoroughly understandable self-protective mechanisms in coping with trauma exposure. But these same ways of coping may make it more difficult for [women] to feel the safety and trust necessary to building helpful relationships." ¹⁷

A woman who has experienced trauma may make tentative contacts a number of times before she is able to fully engage in services. She may feel unworthy, uneasy about engaging, or unaware of available services that might be helpful, since she may not have an awareness of the impact trauma has had on her. Trauma-informed service providers recognize that applying pressure, or expecting her, to form a relationship quickly are counter to trustworthiness.

"You have to build a trusting relationship because if you don't have that then you won't stay connected. You want to make sure the person isn't judging you because the biggest thing that women are worried about is the judgment."

Trauma Matters focus group participant

Trustworthiness practice consideration 2:

Give thoughtful reflection to ways to establish clear boundaries.

Trauma-informed services establish, communicate, and maintain clear boundaries between women and all staff.

"Services should provide detailed information and involve women in making choices about options, convey concern and caring, be respectful of boundaries, and provide hope for change." 18

In some substance use services, this may be more challenging if, for example, staff and clients participate in the same self-help programs. In all cases, service providers need to spend time reflecting on appropriate guidelines and make this information clearly available to women.

"There needs to be emotional boundaries too. I have a really hard time with counsellors that talk about themselves too much. I don't think it's healthy. It always ends up being emotionally loaded for me when a counsellor is saying, 'you know I went through this too.' It has to remain about you, you're coming in because you're traumatized, and a counsellor should be aware of that."

Trauma Matters focus group participant

Trustworthiness Principle — Questions for Self-Reflection

Some self-reflective questions that support the trauma-informed principle of trustworthiness include:

- Do you create an atmosphere of trust by making the tasks involved in service delivery clear, by ensuring consistency in practice, and by maintaining appropriate boundaries?
- Are you conscious of body language/facial expressions that erode trust?
- If you say you will do something, do you do it promptly and report back to the woman to whom you made the commitment? Do you call back within the time you committed to and are you easy to reach?
- If a woman discloses her trauma experiences, do you raise the topic again at an appropriate time, respect her response to either discuss her experience or not, and offer to provide support?
- Are there ways to modify services to ensure that tasks and boundaries are established and maintained clearly and appropriately?
- Have you had discussions among staff about ways your program can maximize honesty and transparency?
- When, if at all, do boundaries veer from those of the respectful professional? Are there pulls toward less professional contacts (e.g., personal information sharing, touching, exchanging personal contact numbers, contacts outside professional appointments)?
- Is unnecessary disappointment on the part of women avoided?
- What is involved in the informed consent process? Are the goals, risks, and benefits clearly outlined and do women have a genuine choice to withhold consent or give partial consent?

Adapted from Fallot and Harris "Creating Cultures of Trauma-Informed Care: A Self-Assessment and Planning Protocol", 2009

Trustworthiness principle — *Trauma-informed practice applications*

Similar to the trauma-informed practice principle of safety, developing a trustworthy therapeutic relationship can take time; however, trust will be enhanced when a service provider's approach is respectful, clear, and consistent.

Trustworthiness practice application 1:

Be clear about programming and all aspects of service delivery.

There are several issues to consider regarding clarity of information and predictable expectations about programming. Provide a clear description of services, including criteria for admission, discharge, timing, and length of time commitment. Describe client rights and responsibilities, and any limitations on either. Take the time to describe fully the need for, and what is involved in obtaining, informed consent. Make sure all the woman's questions are answered. Check in often with her and explore her comfort level with the process.

Trustworthiness practice application 2:

Be consistent.

Whenever possible (in individual work with women, in particular) be consistent with appointment times, so that a woman can rely upon this time as hers. If a commitment is made (for example, to make a referral or find out some kind of information), keep it.

Trustworthiness practice application 3:

Be reflective and self-aware

Service providers need to develop clear, consistent boundaries with all clients in the service setting. This is especially important for women who have experienced trauma. Spend time in clinical supervision having discussions with colleagues about boundary issues. Set up a personal inventory that all staff can use as a performance measure to check against their own actions and conduct.

Trustworthiness practice application 4:

Be clear and explicit about the limits of confidentiality.

Describe the importance of documentation to women, while emphasizing the legal obligations of service providers to report information to police and child welfare authorities (for example) or to provide information in the case of court orders. Show each woman the information that will be gathered, where files are kept, and provide her with the opportunity to ask questions about information gathering and record keeping.

Trustworthiness practice application 5:

Provide on-going support with 'warm' referrals

If a woman agrees to a referral to another service provider (e.g., for trauma-specific support), help to build trust in the transition process. For example, set up a meeting when all three of you can be present.

"If a woman needs a referral to a trauma-specific place, in her own time, I think it's a good idea to ask her, 'Would you mind if this agency is involved with us?' Bring it to where she's safe. Or have whoever is her primary counsellor be in the room with the trauma-specific person and then say to her, 'Would you feel okay if I was to step out of the room so you can talk to this person?' See how she feels about it."

Trauma Matters focus group participant

Trustworthiness Principle — Practice Example

Trauma-informed services can keep in mind the ‘**Six Ws**’ when they are communicating program descriptions or information about service provision to women. Provide clear information about:

- **What** will be done
- by **Whom**
- **When**
- **Why**
- under **What** circumstances
- **With** what goals

Also, try these ideas:

- Provide information both verbally and in writing.
- Keep the written portion short and include your name and contact information.
- Encourage women to get in touch right away if they have questions or concerns.
- In community-based services, between established appointment times, give a quick ‘how are you doing’ phone call or email — this can immeasurably enhance the trusting relationship you are trying to develop.

4. Choice and Control principle: *Trauma-informed practice considerations*

“Choice and control are major issues for [women who have experienced trauma], since they may have had little of either within ... relationships and situations. In trauma-informed services, a woman must be a full partner in determining her goals and how she participates in services, with the paramount aim of increasing her ability to make these choices.”¹⁹

Substance-involved women who have experienced trauma often feel as if their lives are out of control and as if they have not been able to make safe choices, either in the past and in the present. Women may also feel they lack control over their emotions, and have no choice about when or how these emotions are expressed. Trauma-informed services ensure that women have choice and control, wherever and whenever possible, over the process of service provision as a means of supporting women to gain choice and control in other areas of their lives.

Choice and Control Principle — Trauma-Informed Practice Considerations

Practice considerations for the core principle of choice and control include:

- 1) understanding the connections among choice, control, and safety
- 2) acknowledging the strong emotional and psychological impacts that enhanced choice and control can have for women who have experienced trauma

Choice and Control practice consideration 1:

Fostering choice and control enhances safety and engagement.

Providing an environment where women can exercise choice and control over their service involvement not only enhances women’s sense of self-determination, self-efficacy, and dignity, but also creates an environment in which they will feel, over time, a sense of the safety and trust needed to develop new responses to their trauma experiences. The experience of choice and control within the service setting also supports the engagement and retention of women in services, which positively affects outcomes.

“[Trauma-informed] substance use treatment services that are emotionally and physically safe opportunities for learning and building coping skills and for experiencing choice and control all make a significant difference in [a woman’s] engagement, retention, and outcomes.”²⁰

Choice and Control practice consideration 2:

Fostering choice and control is an empowerment strategy.

A woman who has experienced trauma will often have deeply imbedded feelings of helplessness, shame, and guilt. These feelings can be diminished, and her sense of empowerment increased, by increasing her range of choice in all aspects of her life. Discussing options and choices is, therefore, an essential activity that can help women empower themselves.

Trauma-informed services create predictable environments that allow women to rebuild a sense of efficacy and personal control over their lives. Helping women develop stronger self-capacity is also one of the most effective ways to help remediate trauma responses and the crises, or other negative experiences, which can arise from these responses.

"When [women who have experienced trauma] seek help, they often face a hierarchy of expertise the [woman] usually ends up at the bottom of this hierarchy with little voice or choice in what happens in her treatment process. Keeping [women] part of the process ensures they are part of their own recovery." ²¹

Choice and Control Principle — Questions for Self-Reflection

Some self-reflective questions supporting the trauma-informed principle of choice and control include:

- How much choice do women have over the services received, and over 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)?
- Is each woman informed about all the choices and options available?
- Do women choose how you make contact with them (e.g., by phone or text, email, surface mail to home or other address)?
- How much control does the woman have over starting and stopping services (both overall service involvement and specific service times and dates)?
- To what extent are women's priorities given weight in terms of services received and goals established? Are your services contingent on participation in other services?
- Does your service give the message that women have to 'prove' themselves in order to 'earn' other services or supports?
- Do women get a clear and appropriate message about rights and responsibilities? Or does your program communicate that its services are a privilege over which individual women have little control?
- Are there negative consequences for exercising particular choices? Are these necessary and consistent or arbitrary? Is the woman aware ahead of time of the consequences of different actions?
- Do women have choices about who attends various appointments and meetings? Are support persons permitted to join planning and other appropriate meetings?

Adapted from Fallot and Harris "Creating Cultures of Trauma-Informed Care: A Self-Assessment and Planning Protocol", 2009

Choice and Control principle — *Trauma-informed practice applications*

Substance use services that follow the Stages of Change model will find this approach consistent with the trauma-informed practice principle of choice and control.

Choice and Control practice application 1:

Avoid rushing to the action stage.

Pace provision of services according to each woman's need (or desire) to move forward, to remain in a stage of consideration (or contemplation), or to retreat to an earlier stage. Provide as many choices as possible about service options or linkages; then, support women to select the choice that fits best for them.

Choice and control practice application 2:

Ask women for their input.

Wherever possible, elicit a woman's own views on service delivery methods and which counsellors are most helpful to her, especially ensuring that female staff are always available. Ensure there are mechanisms to invite the input of women with lived experience, recognizing that women who have experienced trauma contribute to greater understanding of trauma-informed services.

Choice and Control practice application 3:

Ask permission.

Some standard practices and procedures in substance use services may be perceived as intrusive or invasive by women who have experienced trauma. Ensure that women feel comfortable, and make adjustments, to processes whenever possible if women seem uncomfortable or openly request a change. Above all, 'inform before performing'; that is, always let women know what to expect and give them the choice to proceed or to refuse.

Choice and Control Principle — Practice Example

Can your program build in small choices that make a big difference to women? There are some small changes that every substance use organization can make on their journey to becoming a trauma-informed service, simply by asking women the following kinds of questions:

- When would you like me to call you again?
- Is this the best number to reach you at?
- Is there another way, such as text or email, that you would like me to reach you? Or would you prefer to get in touch with me?
- Can I leave a message?

"If you live in an abusive environment, most of your phone calls are screened and emails constantly checked, so it's definitely very important to have the choice over how you're contacted. It's so bad, some women I know say, 'I'll be at that phone booth at this hour, call me then.'"

Trauma Matters focus group participant

In residential services, the search of belongings is a necessary practice, but it can be turned into a more trauma-informed process by:

- explaining the process and the reason for it
- informing women ahead of time that this will happen
- ensuring that the search is conducted in a private space
- engaging women in the process as active participants by (for example) suggesting that she open her bags for you
- following up with women, to ensure that they feel safe, comfortable, and have a complete understanding of why the search was undertaken.

5. Relational Collaborative approaches: Trauma-informed practice considerations

“The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon empowerment of women and the creation of new connections.”²²

Strong relationships between service providers and women who have experienced trauma are the basis of helping and recovery. Trauma-informed services promote collaboration between women who are seeking services and the systems and policies that affect their care. However, service providers recognize that there will always be a power imbalance in their relationships with women and will try their best to acknowledge this and reduce the imbalance, flattening the hierarchy wherever, and as much as, possible.²⁶

Relational and Collaborative Approaches — Trauma-Informed Practice Considerations

Practice considerations for the core principle of relational and collaborative approaches include:

- 1) recognizing the place of relational approaches in providing respectful and compassionate care
- 2) acknowledging that collaboration between service providers and women has far-reaching impacts

Relational Collaborative practice consideration 1:

The experience of trauma impacts women’s relational abilities.

Trauma has a tremendous negative impact on the ability to form appropriately trusting relationships; so, establishing trust in service providers is an essential component of the recovery process. Trauma-informed services recognize both sides of this reality. On the one hand, recovery takes place in the context of relationships with self and others. On the other hand, women who have experienced trauma need time and respectful understanding to develop the trust needed to form healthy relationships with clinicians, themselves, and others.

Relational Collaborative practice consideration 2:

Collaboration contributes to trustworthiness and safety.

Collaboration equalizes power imbalances as much as possible and fosters the safety required for a therapeutic connection. Trust is established and the sense of choice and control is fostered when decision-making is shared and all efforts are made to decrease traditional hierarchal imbalances between service providers and women.

“Trauma-informed services create safe environments that foster a [woman’s] sense of efficacy, self-determination, dignity, and personal control. Service providers try to communicate openly, equalize power imbalances in relationships, allow the expression of feelings without fear of judgment, provide choices as to treatment preferences, and work collaboratively ... the experience of choice, collaboration and connection is reparative for [women] with experiences of trauma.”²⁴

Relational and Collaborative Approaches — Questions for Self-Reflection

Some self-reflective questions supporting the trauma-informed principle of relational and collaborative approaches include:

- Does your organization place an emphasis on the importance of building relationships with women?
- Are all clinical staff encouraged to devote the necessary time it takes to build a therapeutic relationship with women who have experienced trauma?
- Do women have a significant role in planning and evaluating your program's services?
- How often do you do evaluations?
- How are these built in to your program's activities?
- How do you ensure that feedback from women is acted upon and how do you communicate this to them?
- What happens to these data or suggestions made by women?
- In service planning, goal setting, and the development of priorities for service provision, are a woman's individual preferences given substantial weight?
- Are women involved as frequently as feasible in service planning meetings?
- Are their priorities elicited and then validated in formulating the plan?
- Does your program cultivate a model of 'doing with' rather than 'to' or 'for' women?
- Does your program communicate a conviction that the woman is the ultimate expert on her own experience?
- Do you identify tasks on which both you and women can work simultaneously (e.g., information-gathering)?

Adapted from Fallot and Harris "Creating Cultures of Trauma-Informed Care: A Self-Assessment and Planning Protocol", 2009

Relational Collaborative approaches — *Trauma-informed practice applications*

Substance use services that use motivational interviewing strategies will find this approach consistent with the trauma-informed practice principle of relational and collaborative approaches.

Relational Collaborative practice application 1:

Take time to establish respectful therapeutic relationships.

Therapeutic relationships that are authentic and respectful are characterized by clear boundaries, offer consistent practices with clearly outlined tasks, and foster growth through nonjudgmental engagement and encouragement. A key building block for a respectful therapeutic relationship is to acknowledge that building trust with women who have experienced trauma is likely to take both time and persistence. Also, remember that the relationship may be tested repeatedly by a woman until she feels secure.

Relational Collaborative practice application 2:

Collaborate in all interactions.

Collaboration between service providers and women who have experienced trauma means that women:

- are offered choices in their service experience
- manage the pace of their service experience
- are offered the opportunity to determine their own needs when it comes to treatment planning.

Service providers who are collaborative will treat women as equals, highlighting their strengths and resources.

"I was referred to a sobriety house and the counsellor I was paired with decided to experiment on me and told me to spill out all the details of my trauma and triggers ... I started having bad flashbacks and self-harming on the street so then she told me to 'put it in a box' and we were never coming back to it. It was very triggering for me and I trusted her. She seemed like she was able to help me. I didn't understand what was happening and then I was told by others in the house that this is why I don't have friends and why no one is talking to me. I wound up leaving. I didn't understand what was going on and once they opened up the box, they didn't want to deal with me."

Trauma Matters focus group participant

Relational Collaborative practice application 3:

Be conscious of, and cautious about, eye contact.

Appropriate eye contact can demonstrate empathy and respect. But respect a woman's decision not to make eye contact and understand where this decision is coming from. Women from some cultural backgrounds find it difficult or inappropriate to make eye contact. Some women who have experienced trauma are ashamed or frightened to make eye contact.

"When I was talking about my trauma I wouldn't make eye contact, because of the shame that's involved. I had so much shame that I looked down because I was afraid that if I looked up, I thought my counsellor would be judging me."

Trauma Matters focus group participant

Relational Collaborative Approaches — Practice Example

Keep in mind motivational interviewing skills. Many of the characteristics of the trauma-informed counsellor are similar to those of the motivational interviewer, including the ability to:

- demonstrate empathy and respect
- talk openly
- be self-aware, including body language and facial expressions
- feel comfortable with the unknown
- stay calm and demonstrate emotional regulation
- show genuine interest by being a good listener.

Flexibility is another key attribute. Ask yourself if you have the willingness, and/or can garner the organizational support, to change normal routines or procedures to accommodate (for example) a woman's discomfort with the set-up of the physical space.

6. Strengths-based empowerment modalities: Trauma-informed practice considerations

"[Women who have experienced trauma] often cycle in and out of public mental health and substance abuse systems for years, using a tremendous number of services without experiencing any improvement. As treatment systems erode trust, self-efficacy, and a sense of safety, women begin to disengage and may refuse assistance." ²⁵

Basic tenets of all service provision are to focus on a client's strengths and to encourage empowerment and self-efficacy. These are especially important with a woman who has experienced trauma, as she may view herself as lacking the possibility for self-actualization due to her experiences. Service provision that is not trauma-informed can contribute to a woman's sense of debility rather than building her strengths.

Strengths-Based Empowerment Modalities — Trauma-Informed Practice Considerations

Practice considerations for the core principle of strengths-based empowerment modalities include:

- 1) recognizing the crucial role that self-efficacy plays in supporting change for women who have experienced trauma
- 2) emphasizing hope, optimism, and resilience.

Strengths-based empowerment modalities Practice consideration 1:

A focus on strengths and empowerment is the key to change.

Trauma-informed services that work from a strengths-based perspective understand this as an integral part of relationship and trust building. Trauma-informed services focus on a woman's capacity for personal growth as the primary building block for change.

"Conversations with [women who have experienced trauma] should be nonjudgmental and occur within a context of compassion, empathy, and humanity. The primary focus is on rapport and relationship building, as well as [the woman's] own capacity for survival and healing. This non-authoritarian approach views [the woman] as the expert in her own life." ²⁶

Strengths-based empowerment modalities Practice consideration 2:

Foster a climate of hope, optimism, and resilience.

Trauma-informed services honour women's past experiences, focus on the future, and utilize skills building to develop resiliency. Women's strengths are recognized and their courage acknowledged in the steps taken to endure and reach out for support.

"Focusing on their strengths engages [women who have experienced trauma] in their own process of change by instilling hope about the ultimate possibility of changing and creating a better life for themselves and their family." ²⁷

Strengths-Based Empowerment Modalities — Questions for Self-Reflection

Some self-reflective questions supporting the trauma-informed principle of strengths-based empowerment modalities include:

- How can your services be modified to ensure that experiences of empowerment and the development or enhancement of a woman's skills are maximized?
- In routine service provision, how are each woman's strengths and skills recognized?
- Does your program communicate a sense of realistic optimism about the capacity of women to reach their goals?
- Does your program make every attempt to prioritize a woman's growth as an individual, instead of focusing on basic functioning?
- In each contact with your service, how can women feel validated and affirmed?
- How can each contact be focused on skill-development or enhancement?
- Does each contact aim at two endpoints whenever possible: (1) accomplishing the given task, and (2) skill-building on the part of each woman?
- Does your program foster the involvement of women in key roles wherever possible (e.g., in planning, implementation, or evaluation of services)?
- Do women who have experienced trauma have a significant voice in the planning and evaluation of services?
- Have you built in ways of getting input from women and their voices of experience? Do you provide opportunities for regular input and feedback about service provision via suggestion boxes, surveys, evaluations, focus groups, or similar mechanisms?

Adapted from Fallot and Harris "Creating Cultures of Trauma-Informed Care: A Self-Assessment and Planning Protocol", 2009

Strengths-based empowerment modalities — *Trauma-informed practice applications*

Women need support to increase their self-efficacy in order to build new skills to recover and heal from trauma, as well as from the negative impact of mental health problems, inadequate or stigmatizing service provision, and problematic substance use.

"It's all about building hope and giving the woman a voice and building on her strengths so that she is confident. Instilling that little mustard seed of hope."

Trauma Matters focus group participant

Strengths-based empowerment modalities practice application 1:

Support women to develop a full range of empowerment skills.

Trauma-informed service providers support women to identify their strengths and the challenges they have overcome. For women who have experienced trauma, several skills are important in the process of empowerment, including:

- increased self-knowledge
- building self-esteem and self-trust
- developing interpersonal skills such as limit setting and assertiveness
- learning how to more clearly express and communicate her needs and desires
- perceiving others and situations more accurately
- working towards mutuality and reciprocity in relationships
- enhancing life skills and mothering and other caregiving responsibilities (where relevant).

*Strengths-based empowerment modalities
practice application 2:*

Support women to take the next step in becoming empowered.

Make every effort to listen to the insights and feedback about service provision from women who have experienced trauma. This could be done through membership on an Advisory Committee (for example). But there are many less potentially intimidating ways for women to provide feedback or to participate in planning, such as suggestion boxes, surveys (online and anonymous), written evaluations, or occasional focus groups, all of which demonstrate a willingness on the part of service providers to listen and make changes. Follow through on suggestions and relay the follow-through to women. If the organization cannot act on a suggestion, explain why.

"I was on anti-depressants and anti-anxiety medication for PTSD and this was helpful, but [a substance use treatment] program I was in always accused me of abusing these medications. That didn't help at all."

Trauma Matters focus group participant

*Strengths-based empowerment modalities
practice application 3:*

Recognize that changing substance use has impacts on trauma responses

Reducing substance use can result in a woman experiencing more trauma-based reactions. Be careful to gauge this dilemma and incorporate ways to measure small steps to ensure that women feel safe and hopeful about change.

*Strengths-based empowerment modalities
practice application 4:*

Support hope and optimism—for both the woman and the service provider

It is critical to communicate hope for change and optimism about the future; it is equally important for service providers not to feel hopeless or helpless. Be encouraged by small changes, not hopeless and discouraged by the perceived absence of complete change.

"It's nice to be somewhere where you are not 'condemned' or have the finger pointed."

Trauma Matters focus group participant

Strengths-Based Empowerment Modalities — Practice Example

There are many ways a trauma-informed service provider can demonstrate commitment to the practice principle of strengths-based empowerment modalities.

Here are some ideas:

- Do an environmental scan. Take down posters, pamphlets, brochures, or other written materials that contain 'do/do not', 'must/must not', and 'cannot' messages.
- Update handouts, manuals, and other written materials to replace the 'rules' with 'rights and responsibilities' whenever possible.
- Rewrite relapse/lapse policies to consider lapses without punitive consequences. Instead, encourage the view that lapse/relapse can be an opportunity to learn about and develop alternate ways to cope with triggers.
- Pay attention to language (for example, in residential or withdrawal management services, refer to urine test results as 'positive or negative for substances' rather than 'dirty' or 'clean').

GUIDELINES for ACKNOWLEDGMENT PRACTICES

GUIDELINE #1

Points of first contact are examined and are found to convey a trauma-informed approach.

Suggested indicators:

- The organization's website contains trauma-informed language and indicates that all staff engage in trauma-informed practices.
- All publically available written information about the organization has been reviewed to ensure that it contains trauma-informed language and indicators of trauma-informed practices.
- Voicemail messages and all initial phone contacts with women use trauma-informed language and indicators of trauma-informed practices.

GUIDELINE #2

Non-clinical staff who have first contact with women are supported to respond appropriately.

Suggested indicators:

- Training is provided to reception and other non-clinical staff to enable them to understand the links between substance use and trauma.
- Scripts are developed to ensure their conversations with women are trauma-informed and use trauma-informed language.
- An on-going mechanism is implemented to support non-clinical staff and allow them to practice and enhance their trauma-informed skills and abilities.

GUIDELINE #3

Assessment procedures are adapted to incorporate trauma-informed screening.

Suggested indicators:

- Assessments have been adapted to include universal trauma-informed screening processes.

GUIDELINE #4

A self-assessment process is developed to allow staff to identify their capacity to work effectively with women who have experienced trauma.

Suggested indicators:

- Clinicians, counsellors, and program staff have an opportunity to reflect on personal limitations that can interfere with their effectiveness in working with women who have experienced trauma.
- Appropriate clinical staff are identified as internal referral sources in these situations.

GUIDELINES for SAFETY PRACTICES

GUIDELINE #5

An environmental scan of the physical space is conducted.

Suggested indicators:

- The organization's signage is welcoming, includes trauma-informed information, and indicates cultural sensitivity.
- Comfort items are provided.
- Private spaces are provided as needed and monitored for safety.

GUIDELINE #6

All service activities have been reviewed to ensure that they are welcoming, clear, and consistent.

Suggested indicators:

- Appointment times are scheduled consistently.
- Information about programming is clear, and questions from women responded to promptly.

GUIDELINE #7

Early contacts with women are broader than information gathering only.

Suggested indicators:

- Women are introduced to other staff and are clear about who will be present during service provision.
- Confidentiality protocols are clearly explained and questions from women are given prompt attention.

GUIDELINE #8

Clinicians and other staff have undertaken a review of practices to ensure emotional safety.

Suggested indicators:

- Staff convey emotional safety through trustworthiness, collaboration, choice and control, relational and empowerment modalities.

GUIDELINE #9

Clinicians and other staff ensure that safety issues are addressed at every opportunity.

Suggested indicators:

- Staff have reviewed policy and procedures and attended orientation/training sessions to ensure that safety is a topic of primary discussion.
- A statement of client safety 'rights and responsibilities' has been developed and is widely available.
- Women are asked about their safety needs and their concerns or suggestions are addressed.
- All clients are engaged in safety discussions and have a clear understanding of safety 'rights and responsibilities'.

GUIDELINE #10

Clinicians and other staff demonstrate comfort with trauma-based reactions.

Suggested indicators:

- Staff can respond to trauma-based responses with empathy and a calm, respectful demeanour.

GUIDELINE #11

Clinicians and other staff have reviewed their practices to ensure that cultural safety has been taken into account.

Suggested indicators:

- Culturally appropriate conversations and linkages are made.

GUIDELINES for TRUSTWORTHINESS PRACTICES

GUIDELINE #12

Each woman is provided with clear information about service provision.

Suggested indicators:

- All women receive a clear description of services and understand the criteria for admission, timing, and length of time commitment.
- The concept of informed consent has been fully explained.
- Staff do frequent check-ins with women to ascertain their comfort levels and ensure that they have a clear understanding of service provision.
- Staff ask women for their questions and ensure that their concerns or suggestions are addressed.

GUIDELINE #13

Clinicians and other staff act consistently in all interactions with women.

Suggested indicators:

- Goals and tasks are clarified.
- Commitments made to women are always kept.
- Appointment times are scheduled consistently.

GUIDELINE #14

Boundary guidelines have been established and clearly communicated.

Suggested indicators:

- All staff members understand the limits of appropriate physical and emotional contact with women and conduct themselves accordingly.
- All staff members recognize the limits on self-disclosure and conduct themselves accordingly.
- All staff members understand the limits of their extracurricular contact with women who are clients (including attendance at self-help groups) and conduct themselves accordingly.

- If staff members attend the same self-help group as women who are clients, clear guidelines for these encounters have been established for both staff and women, and these guidelines are adhered to.
- All staff members have conveyed to women the nature and extent of their interactions with them and have described boundary issues for both parties, including after the clinical contact is completed.

GUIDELINE #15

The limits of confidentiality and the organization's record keeping policies have been clearly communicated.

Suggested indicators:

- All staff members provide to women a clear statement about occasions when information will be released without the woman's consent.
- All staff members describe to women the information that will be gathered and allow women the opportunity to ask questions and withdraw consent.
- All staff members describe to women where files will be kept and for how long.

GUIDELINES for CHOICE and CONTROL PRACTICES

GUIDELINE #16

Service provision has been developed in ways that support various measures of progress.

Suggested indicators:

- Treatment goals and processes are not limited to abstinence.
- A range of options are provided for counselling/service provision opportunities.
- Lapse/relapse is seen as an opportunity for learning and for identifying triggers and alternate coping mechanisms.

GUIDELINE #17

Female staff are available in all areas of service provision.

Suggested indicators:

- Female staff are available for all clinical, program delivery, and residential support positions, in both daytime and nighttime activities.
- Only female staff conduct bed checks.
- Female clinical staff are available for individual counselling work.
- Female clinical staff facilitate women-only groups or women-focused sessions.
- Female clinical staff facilitate or co-facilitate mixed groups.

GUIDELINE #18

Clinical staff members have developed mechanisms to obtain input from women who have experienced trauma.

Suggested indicators:

- Feedback from women who have experienced trauma is elicited through informal feedback, formal evaluations, focus groups, and/or participation on an Advisory Committee, with options for anonymity.

GUIDELINE #19

Clinical staff members ensure that women can request changes to processes, policies, and procedures.

Suggested indicators:

- Feedback obtained through various means informs programming and general service provision.

GUIDELINES for RELATIONAL and COLLABORATIVE APPROACHES

GUIDELINE #20

Clinical staff members have an opportunity to nurture therapeutic relationships.

Suggested indicators:

- The organization supports taking the time necessary to develop a trusting relationship with women who have experienced trauma.

GUIDELINE #21

Collaboration between clinical staff and women is emphasized.

Suggested indicators:

- Women are offered choices in their service experience.
- Women in precontemplation and contemplation about their substance use are supported until ready to move to the preparation and action stages.
- Women are offered the opportunity to participate actively in, and contribute to the identification of, their needs in treatment planning.

GUIDELINE #22

Flexibility in setting and process is encouraged.

Suggested indicators:

- Normal routines, procedures, and physical surroundings accommodate women whose verbal and non-verbal feedback indicates they are uncomfortable with the current situation.

GUIDELINES for STRENGTHS-BASED EMPOWERMENT MODALITIES

GUIDELINE #23

A full range of empowerment skills are included in counselling/service provision.

Suggested indicators:

- Clinicians and other staff understand and act on the range of skills necessary to empower women who have experienced trauma.

GUIDELINE #24

Feedback from women is incorporated in the empowerment process.

Suggested indicators:

- Feedback from women who have experienced trauma is elicited through informal feedback, formal evaluations, focus groups, and/or participation on an Advisory Committee.

GUIDELINE #25

A balance is struck between addressing substance use goals and reducing trauma responses.

Suggested indicators:

- Small steps to changing substance use are encouraged in order to minimize the potential for trauma responses.

GUIDELINE #26

Empowerment language is incorporated into all aspects of programming.

Suggested indicators:

- An environmental scan results in the removal of all posters, brochures, or other written materials that contain punitive or overly directive messaging.
- Handouts, manuals, and other written materials have been updated to include empowerment language.
- Program policies, including lapse/relapse policies, do not include punitive consequences.
- Programming focuses on learning and incremental change, and does not support punitive responses when women lapse or relapse.

Disclosure: when trauma-informed practices require trauma-specific skills

While trauma-informed services do not necessarily include trauma-specific programming, women may experience trauma responses, or may begin to disclose their trauma experiences at any stage of interaction with a substance use service provider. Everyone who works in substance use service organizations needs to be conscious of triggers that can induce trauma responses and attend to these responses through the use of appropriate strategies.

When either trauma responses or disclosure of the trauma experience occur, trauma-informed practices in these situations are rooted in:

- increasing safety through the development of self-management skills (such as grounding and containment) for current distress
- facilitating the learning of coping strategies, healing, and empowerment
- supporting women to reduce harm that may arise from the unintended consequences of coping strategies
- framing the woman's coping responses to trauma as ways to survive, and exploring alternative ways to cope as part of the recovery process
- ensuring follow-up, follow through, and support which are critical to ensuring safety and trustworthiness—if a woman discloses, do not drop the subject, but follow through with support and follow up in subsequent interactions
- responding to disclosure with belief and validation that will inform practical issues related to care
- helping women contain difficult emotions before focusing on other issues that she has identified
- providing 'warm' referrals to trauma-specific services.

Skills Check for Trauma-Informed Service Providers

Although trauma-informed service providers do not engage in trauma-specific programming, they **do** need to have the skills to respond appropriately to trauma responses (such as dissociation or increased anxiety) or to disclosure of trauma experiences. This would mean that, at a minimum, trauma-informed substance use service providers have a basic knowledge of how to react to trauma responses, including grounding and safety techniques. See **Dealing With Triggers** which follows.

Ideally, the range of community services available to substance use services will include a trauma-specific program.

A trauma-specific program can either make linkages for on-going support (for the woman) or suggest practice strategies (for the service provider). If there is no trauma-specific program in the community, then look for creative ideas to provide support, such as video conferencing in remote areas or online workshops and training. If possible, bring someone in for workshops for staff training. This would be an opportunity to provide community training by collaborating with other gender-specific services in the area. In any case, never decide to attempt trauma-specific counselling without proper training—this can inadvertently cause more harm than good.

Dealing with triggers

A trigger is a stimulus, event or even use of language that can cause or 'set off' a memory or flashback.

The trigger transports a woman to recall or relive an earlier trauma. This can be a conscious or unconscious memory. Since trauma-responses vary from one woman to another, some triggers may not be predictable or avoidable.

It is inevitable that a woman will encounter triggers in all kinds of settings.

Examples are seeing someone who reminds her of a traumatic experience, or being touched unexpectedly on the bus or in a store. Just as women in substance use recovery need to deal with triggers to use substances (for example, at a social gathering), women who have experienced trauma need to develop skills that will allow them to manage everyday triggers.

Being triggered does not necessarily lead to retraumatization.

Triggering events are especially unnerving and destabilizing. But being triggered does not necessarily lead to retraumatization—skills such as self-soothing and grounding (described below) can help women manage trauma responses, and will be especially helpful for women who have had few experiences of being cared for in kind and gentle ways. Grounding and self-soothing are also important tools that women can use to regain control of their feelings and actively bring a focus on the present situation and surroundings.

Service providers can help women to think about how they can practice healthy self-care and reduce harms from substance use, self-injury, other harmful coping strategies, or unsafe or dangerous situations or people by:

- **acknowledging her wisdom and strength**, encouraging her to continue to use these assets, and supporting her attempts to do so
- **helping her to identify positive strategies** she has used in the past to deal with trauma reactions, which can be used well again
- **reviewing with her the unhealthy strategies she might have used**, which could have been of help at one time, but also have associated risks, such as substance use, over- or under-eating, or self-injury

- working collaboratively with her to **identify and learn alternative coping strategies**, and inviting her to reflect on how she might use a new technique
- **introducing and practicing new strategies** with care and attention to a woman's comfort level in using them successfully
- **recognizing that giving up all coping strategies at once may not be realistic**—incremental change to reduce harm and build skills may be the most successful approach
- working with her to **identify current situations and relationships** that may affect her safety (e.g., crowded bars, threatening behaviours, stalking), and steps that she can take to protect herself.

“When you take away the substance and there’s nothing else to replace it, it’s too much.”

Trauma Matters focus group participant

Strategies for self-soothing

Self-soothing is an important skill that women can use to deal with stress and distress.

With thought and practice, each woman will find the ways that work best for her. Some of the strategies a service provider might suggest include:

- Carry something with you that makes you feel safe, for example a small stuffed toy, a picture of a treasured pet or friend, or a medallion from your mutual aid group.
- Make a cup of a favourite tea. Sip it slowly and savour the smell and taste.
- Spend time in a peaceful, safe place.

- Take a long walk in a park, the bush, or on the land.
- Read affirmative messages.
- Take a warm bath.
- Learn and practice some simple yoga, meditation, or relaxation techniques.
- Play music – it helps release emotions.
- Watch a TV show or movie that makes you feel good.
- Go fishing or bird watching.
- Make a comfort food.
- Give yourself a manicure or pedicure.
- Call a friend or sponsor.
- Write in your journal.
- Call your therapist for support.

“Laughter is amazing, like watching comedy shows on TV. I try to do that once a day. Or watch comfort movies. Comedy takes your mind off your anxiety. And changing your self talk. It’s about changing the channel. Making it a better place in your head.”

Trauma Matters focus group participant

Grounding

Grounding is an extremely helpful skill for women who may have been triggered and are experiencing trauma reactions.

Grounding can be accomplished in many ways but this section discusses three types of grounding techniques (breathing, other physical grounding techniques, and mental/cognitive techniques).

A service provider can work with a woman to demonstrate grounding skills; start by explaining to her that:

- Grounding is a set of tools you can use at any time to help yourself cope with flashbacks, body memories, overwhelming feelings, or triggers to use substances. The goal is to help

you get out of these thoughts, feelings, or sensations and feel more stable again.

- You may not always recognize signals that you are experiencing distress or a ‘trigger’. Learn to recognize and pay attention to ways your body is telling you about your stress level; for example, your thoughts start to race, your chest gets tight, your stomach feels like a lead ball has landed there, or your heart races for no reason. You may also find that some situations or times of the day are especially distressing; for example, bed time, arguments, receiving a call from a family member or former partner, or interacting with a child welfare worker.
- Try a number of grounding strategies. Identify two that you feel comfortable with.
- It can be helpful to write these on a small card you carry with you at all times

A service provider can support a woman to learn various grounding techniques by providing basic instruction, such as:

1. Breathing

- a) Find a comfortable place to sit and place your feet firmly on the ground.
- b) Take a deep breath in through your nostrils and then slowly release the breath through your mouth.
- c) It can help to count slowly as you take your breath in and release it.
- d) Continue this slow breathing until you feel calmer.

2. Physical ways to get grounded

- a) Run water over your hand.
- b) Touch the chair you are sitting on, feel it underneath you and notice how it feels, try to describe the feeling – is it soft or hard, made of wood, etc.

- c) Listen for sounds around you and name them out loud.
- d) Clench your hands into a tight fist and then release them. Or sit with your hands in your lap, your thumbs and forefingers touching.
- e) Stamp your feet on the ground.
Take a drink of cold water and notice the cold sensation in your mouth and down into your stomach. Imagine the water bringing healing all through your body.
- f) Wash your face with a cold cloth.

3. Mental ways to get grounded

- a) Open your eyes and look all around, name all the things that you see, for example: I am in the living room, the walls are yellow, the chairs have polka dots, and so on.
- b) Count slowly to 20 and backwards back to one—if you know another language use it.
- c) Say all the letters of the alphabet slowly and carefully.
- d) Remind yourself that you are safe now, by saying “I am in a safe place right now, today is _____, and this is not the past.”
- e) Tell yourself something positive that happened today.

Self-care

Traumatic experiences and subsequent responses and adaptations can erode a woman’s ability to care for herself in healthy and life-giving ways.

Assisting women to nurture and care for themselves is an important step towards recovery and health. Some women may not have had many experiences of self-care, and may not recognize that *everyone* needs to engage in activities that give them pleasure, provide relief from stress, and bring joy to their lives

Service providers can help women to identify healthy strategies, and to develop clear and concrete achievable plans for themselves.

Because substance use is often strongly associated with relief from stress, it is essential that self-care

strategies include alternative ways to deal with stress while supporting a woman’s goals for reducing harm or abstaining from substance use. For example, some women have found it helpful to become involved in activities such as crafts or community organizations.

Boundaries and relationships

Many women who have experienced trauma may find it difficult to set appropriate boundaries.

They may find it difficult to set boundaries for ‘closeness’ and ‘distance’ in interpersonal relationships, or to say ‘yes’ or ‘no’ appropriately. A service provider can help a women to recognize the characteristics of safe and unsafe relationships, and to develop the ability to say ‘no’ to harmful relationships and ‘yes’ to those that will support her. The counselling relationship itself should be a ‘healing connection’ – one in which women can experience safety and trust, and in which appropriate boundaries are discussed and modeled.

Universal trauma-informed screening

“Trauma screening refers to a brief, focused inquiry to determine whether [a woman] has experienced ... traumatic events.”²⁸

Universal screening for trauma is a vital step for organizations to take in order to become trauma-informed.

Universal screening ensures that all participants in the therapeutic relationship—staff *and* women—are thinking about trauma. For staff, this involves a greater consciousness about trauma because questions about it are woven into the intake and assessment process. The very act of asking about trauma creates individual and organizational awareness and assists in the process of removing stigma.²⁹

For women, asking about trauma can serve many functions; it can:

- **inform** women that service providers recognize the significance of the link between trauma and substance use and are willing to engage with women about their experiences
- **communicate** to women the understanding that substance use and trauma are linked and that recovery from both is needed
- **assist** women in their reflections about the role that trauma has played in their personal stories, especially for those who have not yet made a link between their substance use and trauma

- **enhance** women’s connection to a program, by demonstrating that staff members care enough to ask about this aspect of women’s experience
- **validate and normalize** women’s experiences, as many women report that simply learning about the effects of trauma can confirm the way they feel—even if they choose not to disclose at all. Finding out their reactions are normal can be a powerful first step leading to trauma-specific care.^{30, 31}

At the same time, it is important to recognize that not all women seeking assistance with substance use problems will have access to memories or feel safe enough to disclose painful experiences; indeed, some women may not have experienced trauma. However, asking *all* women about their experiences as part of the initial intake and assessment process will assist with:

- treatment planning
- identifying any immediate safety concerns which may require an urgent response
- planning for any linkages which are required
- creating openness for later disclosure if the woman initially does not talk about traumatic experiences.

Organizational responsibilities

Before undertaking any trauma-informed screening, organizations have a responsibility to ensure that all staff are trained in clinically appropriate ways to ask questions and that they have a clear understanding of the nature and intent of the screening process.

Before staff offer trauma-informed screening, substance use service providers need to ensure that:

- they provide all staff and volunteers with **training and education** about the prevalence of trauma in women seeking help for substance use issues
- trauma-informed screening is woven into assessment and intake processes in a **paced, sensitive, non-intrusive** way and is seen as an invitation to identify issues, rather than being a ‘diagnostic’ process
- staff have a clear understanding that **not every woman will disclose**, nor should every woman have to—staff must understand that women always have the right to say “I don’t wish to answer that question” and staff must inform all women of their right not to answer
- they provide staff members with the skills to ask screening questions in clinically competent ways that are **culturally sensitive** to the diverse populations they serve
- screening for trauma is **embedded** in out-reach, intake, assessment, and clinical services
- they provide a **safe environment** for women.

Clinical steps

Prepare the woman for the screening process.

Explain that many of the women who come for help with their substance use concerns may have also experienced trauma and that questions about trauma will be included in the screening process. Then, make sure to:

- **Explain** that the questions may be emotional and difficult, that she always has the option not to answer any of the questions, and that she will not be denied service because she chose not to answer.

- **Ask** her permission to proceed.
- **Reassure** women—let each woman know that service provision is trauma-informed and that she is safe should she choose at any time to disclose.

Sample Conversation Opener

“In our experience, many women who have substance use problems have also experienced some kind of trauma, such as childhood sexual abuse or violence in adult relationships. We support women to understand the links between trauma and substance use. However, if this has happened to you, we do not expect you to tell us right away, or at any time, unless you are comfortable doing so. I do want you to know that, if you have experienced trauma, you can talk about it safely with our staff when you are ready to.”

- **Use direct and straight forward language** to avoid confusion, while at the same time phrasing questions in a gentle way to avoid retraumatization (for example, ask “have you had any experiences, either as a child or an adult, that contribute to your use of substances?”).
- **Be sensitive** to individual needs and contextual issues including culturally-specific dynamics. For example, consider the possibility that women who are immigrants or refugees may have experienced violence, rape or torture while making their transition to Canada and that they may be concerned about their status in Canada if they disclose this. Aboriginal women have varying experiences of the historical individual and cultural transmission of trauma and its effects.

- **Ask** if she is currently in any danger (for example, ask “are you afraid that some one may hurt you now?”) and if needed, help her develop a plan for her immediate safety.
- **Remain sensitive** to verbal and non-verbal signals that the questions are too stimulating or overwhelming emotionally—provide support to ground and stabilize the woman whenever this occurs.
- **Use clinical sensitivity** to defer further questions until she feels better able to continue or she agrees to further discussion on another occasion.
- **Check in** with the woman periodically and ask if it is okay to continue, especially if there are signs of distress—if in doubt, ask her.
- **Keep in mind** that negative responses to screening questions do not necessarily mean that a woman has not experienced trauma—she may need additional experience with the organization and staff to feel safe to trust others with painful disclosures.
- **Use great caution** at this stage to avoid over-disclosure of traumatic events—it may be necessary to explain that at this point, the focus is on early identification and that disclosing too much information will not be helpful because it can trigger intense feelings before a woman has the tools to deal with them.
- **Provide clear information** about the services available for her at the organization and/or any linkages that will support her recovery.

“Rather than relying on a formal diagnosis of trauma, the assessment process should assume trauma. This moves the nature of the questions from ‘do you have’, probing for symptoms, to ‘what helps you with...’ focusing on coping and strengths.” ³²

Sample trauma-informed screening questions

Make a general statement about the relationship between substance use and trauma.

- “Some women notice a connection between their substance use and experiences of trauma. Some examples of traumatic experiences might be emotional, physical, and sexual abuse, neglect, natural disaster, loss of culture, or loss of custody of a child.”

Remind the woman that she has a right not to answer the questions.

- “If these questions make you feel uncomfortable in any way, you don’t have to answer. If you don’t want to answer, you can say ‘I don’t want to answer that question.’ You always have that choice. You don’t have to give a false answer, you just don’t have to answer at all and you can tell us so. We will listen.”

Then ask:

- “Have you had similar experiences to the ones mentioned above that you think are important for us to know about?”
- “Are you currently being affected by these experiences?” (Provide examples such as flashbacks, nightmares, losing time, reactions to sudden noises, or feeling easily startled.)

- “How often does this happen to you?”
- “What do you find helpful in dealing with these experiences?”
- “Are you still in contact with the person(s) who harmed you? What helps you cope with that?”
- “Are you grieving the loss of someone or something? If you feel comfortable doing so, can you tell us about this?”

(Adapted from The Jean Tweed Centre)

A Final Word About Trauma Screening

Asking a woman if she has experienced a traumatic event is not the same as discussing it in detail. Closed questions allow women to respond with either a ‘yes’ or ‘no’ and help contain the screening process.

Trauma-informed screening minimizes the amount of information collected and ensures that women do not feel pressure to disclose information before they are ready to.

Service providers need to ensure that women feel secure, and that they have adequate supports and skills, to manage disclosure of trauma experiences.

Mothering and family relationships: impacts of trauma and emerging practices

“The strengths and needs of pregnant and [mothering] women with [concurrent] disorders and trauma have been largely overlooked. This is particularly ironic considering the desire to keep or be reunited with their children is one of the strongest motivations for seeking assistance.”³²

Substance-involved women who have experienced trauma may also be mothers, or be pregnant. Many have needs related to their mothering role when they seek help with their substance use concerns. For these women, concerns about their children and their role as mothers can play a critical part in their recovery and be a powerful catalyst for change.

Hard data on substance use, mothering, and pregnancy are somewhat limited because many mothers fear negative or punitive consequences if they disclose their substance use concerns;³³ however, research indicates that up to 70% of women who attend substance use programs have children.³⁴

Although there are sensitive and caring mother-centered programs in Canada, “there are vast gaps in the availability and accessibility of these services, depending on the required level of care, parenting status, and the severity of health and social problems.”³⁵

“For single moms, it is really difficult to get daycare to get the support you need. It’s the children who suffer because moms are not able to get help.”

Trauma Matters focus group participant

About the women

Data collected by Breaking The Cycle (a Toronto program for substance-involved pregnant or mothering women and their children) indicates that:

- 65% of their clients report sexual abuse
- 81% report physical abuse
- 84% report emotional abuse.³⁶

Women who have received services at Breaking The Cycle reported high rates of substance use in their families of origin and high levels of substance use by their partners. Almost 50% of the women said their partners were abusive. In addition, women reported that they have experienced a wide range of psychological and emotional problems such as depression, anxiety, flashbacks, and self-harm, responses associated with abuse and trauma.³⁷

While it is clear that the effect of substance use varies significantly from family to family, Breaking The Cycle found that substance-involved women who have experienced trauma have difficulties providing stable, nurturing home environments for their children.³⁸ Other researchers found that overall higher levels of trauma exposure were linked with decreased mothering satisfaction, reports of child neglect, use of physical punishment, and a history of protective service reports.³⁹

Impacts of trauma on mothering

Past or present experiences of trauma affect women’s ability to regulate emotions, maintain physical and mental health, engage in relationships, parent effectively, and maintain family stability. Trauma can also affect a woman’s ability to keep her children safe, work effectively with child welfare staff, and engage in her own or her children’s mental health treatment.

Traumatic experiences can:

- compromise a mother's ability to appraise danger, resulting in:
 - difficulty making appropriate judgments about her own and her child's safety,
 - overprotection, or conversely,
 - failing to notice situations that could be dangerous for the child
- result in trauma reminders or triggers (sights, sounds, situations, or feelings that remind them of the traumatic event) to which women may have extreme reactions (for example, children's behaviour can remind mothers of their own past trauma experiences, some times triggering inappropriate or unhelpful behaviours toward their children—in order to avoid or manage trauma reminders, women may disengage, making it even more difficult to relate to their children)
- make it challenging for women to form and maintain secure and trusting relationships, including those with their children (for example, a mother may personalize her child's negative behaviour or have negative feelings about mothering, leading to ineffective or inappropriate discipline)
- negatively affect a woman's feelings and behaviour toward service providers, in particular when she experiences or re-experiences a loss of control
- lead to poor self-esteem and a negative view of herself as a mother
- impair decision-making, problem-solving, or planning
- make women more vulnerable to other life stressors, such as poverty and inadequate social support, all of which can increase vulnerability to trauma reactions.

The WELL Project, a service in Massachusetts that provides integrated services for substance-involved women who have experienced trauma, noted several needs and issues among the mothers it serves:

- initial denial of the existence of problems as an attempt to manage the situation and protect their children
- a need to seek out safety which can limit attention paid to their children
- limited physical and/or emotional availability
- difficulties with trust
- diminished capacity to empathize with their children
- decreased intimacy with their children
- lack of positive mothering role models
- loss of self-image as a capable and effective mother
- triggering of trauma memories by a child or a child's behaviour.⁴⁰

The mothering role of substance-involved women can be a significant motivation to seek and enter substance use services.

*"In spite of the challenges facing [substance-involved] women, they nevertheless view parenting as the central purpose and defining role of their lives. For them, motherhood is both a major source of identity and self worth, and a source of shame and guilt."*⁴¹

Impacts of trauma on children

Research has shown that problematic substance use can affect a woman's ability to provide stable, nurturing environments for children; when this is compounded by other challenging life circumstances (such as trauma), children are at greater risk for:⁴²

- impaired physical growth, development and health
- poor cognitive functioning and school performance
- emotional and behavioural problems
- psychiatric disorders
- developing substance use problems. ⁴³

The WELL Project found that children can be affected by their mother's trauma and substance use in a number of ways, such as:

- lacking clarity about what is expected of them, related to inconsistent behaviour on the part of the mother
- erratic behaviour, understood to be a 'testing' of the mother and perhaps a way to gain a sense of limits
- feelings of grief due to the multiple losses they experience because of moves, and lost contact with peers, family, and siblings
- a weakened relationship with their mother
- taking on parental responsibilities such as cooking, cleaning or caring for siblings or the parents themselves
- problems such as sleep disturbance, difficulty with eating, and mental health issues. ⁴⁴

Barriers for pregnant and mothering women

Women who are mothering or pregnant face significant barriers to the substance use services they need. In Ontario, the Early Childhood Development Addiction Initiative (ECDAI) was developed to increase the capacity of substance use services to help pregnant and mothering women. This initiative gathered information about access to services. ⁴⁵ A 2008 report on the EDCAI identified several barriers to services:

- stigma
- child custody concerns
- lack of resources
- lack of awareness on the part of service providers
- lack of expertise and resources on the part of substance use programs
- attitudes of service providers
- long wait times.

"It's difficult to get services if you have children. I have four children that I didn't want to traumatize by putting them into the CAS system just so I could get help ... There needs to be a program to include children and to re-affirm to children they are okay. To be able to get tools with a trauma focus and to help kids through it as well."

Trauma Matters focus group participant

Addressing barriers and relationships with child welfare services

Ontario programs for mothering and pregnant women have developed several strategies to help address the barriers that women face. These strategies can be used more broadly, in all programs where mothering and pregnant women receive services. They include:

- strong outreach components to actively engage women
- timely, individualized services
- ongoing support to assist women with their substance use
- relationships with community resources and a strong referral network to help women access the full range of services available to them and their children. ⁴⁶

In particular, the ECDAI programs identified strategies to encourage collaborative working relationships with child welfare agencies. These strategies help women to become well informed and be supported throughout their involvement with child welfare agencies by:

- providing training for both child protection workers and substance use service providers
- developing joint protocols for collaboration between the two sectors
- creating opportunities for cross-sectoral knowledge exchange
- suggesting other initiatives such as regular meetings with key managers from child welfare organizations, developing mutual consent forms accepted by both partners and by women, developing joint service plans, and organizing integrated case management meetings.

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

ECDAI project participant

The final report for the Ontario ECDAI concluded that these strategies are highly effective, because they lead to:

- better health and relationships for women and their children
- improvements in substance use management
- significant, measureable improvements in nutrition, housing, finances, life functioning, mental health, and social support networks.

Framework for Practice

The following principles are consistent with trauma-informed practices and should be used by substance use services for all women, including those who are pregnant and mothering. Services should strive to:

- be woman/mother-centred, and use evidence-based gender specific practices
- focus on both the mother and child
- use harm reduction approaches
- engage and collaborate with women as experts on their own lives, and work collaboratively with service providers toward paced, achievable change
- be specific and clear about the goals and expectations for the women and their families, especially as these relate to child welfare involvement
- utilize motivational interviewing strategies. ⁴⁷

Integrated services to support pregnant and mothering women

Although historically the approach of substance use services has been to provide service to women on their own, the inclusion of children in an integrated approach to services is gaining attention and respect.

“The attitude that recovery must come first and that women need their own space to recover and cannot concentrate on their recovery with children present reflects a lack of understanding of access issues, of maternal and child health issues, and of the fact that true recovery for a mother usually works only when it includes her children.”⁴⁸

The curriculum for Nurturing Families Affected by Substance Abuse, Mental Illness and Trauma was recognized by the Center for Substance Abuse Prevention as a model program for best practices in strengthening families. That curriculum, which has been used by the WELL Project, is based on the relational development principles of authenticity, mutuality, and empathy. The curriculum includes three modules:

- one-on-one mentoring and intensive skills building
- nurturing families affected by substance use, mental illness and trauma group
- mother/child skill-building activities.

The conclusions reached by the WELL Project about challenges and lessons learned can contribute to trauma-informed practices with substance-involved women who are pregnant or mothering and who have experienced trauma. They concluded that:

- it is critical to provide a nurturing atmosphere for mothers
- the connection between mothering and recovery is strong and multifaceted
- the intervention maintain a focus on mothering
- awareness of ‘triggering’ material must be kept front-of-mind
- logistical issues must be addressed (e.g., timing, transportation, and childcare)
- support for group facilitators/other program staff is essential
- facilitators should be role models for women
- evaluation is essential.⁴⁹

Emerging issue: substance use, trauma, and interpersonal relationships

Researchers have found that many of the problems experienced by women as a result of trauma (including individual stress responses, isolation, poor relationship quality, and reduced intimacy) are also reported by their partners and family members.⁵⁰

Although evidence supports the helpfulness of couples and family therapy for substance-involved women, the helpfulness of those modalities for women who have experienced trauma is less clear. The guidelines developed by the International Society for Traumatic Stress Studies (ISTSS) state that evidence of the effectiveness of couple/family therapies with women who have experienced trauma is limited. It is also unclear when those types of therapies should be used or how they should be combined with other service approaches.⁵¹

When couples or family therapy is provided, it often takes place as part of a trauma-specific service. Sessions focus initially on education about trauma and trauma reactions. Subsequent sessions may provide skills training to improve communication and problem solving, and identifying coping and mutual support needs. Interventions also provide opportunities for couples or families to process the impact of the trauma on their lives. Individual counselling is often provided concurrently or prior to the couples or family therapy.⁵²

- ³⁶ Leslie, 2011
- ³⁷ Ibid.
- ³⁸ Ibid.
- ³⁹ Cohen, 2008
- ⁴⁰ Jablonski & Moses, 2002
- ⁴¹ Skinner & O'Grady, 2005
- ⁴² Niccols et al, 2012
- ⁴³ Ibid.
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- ⁴⁵ Jean Tweed Centre, 2008
- ⁴⁶ Ibid.
- ⁴⁷ Poole & Urquhart, 2010
- ⁴⁸ Finkelstein, 1994
- ⁴⁹ Jablonski & Moses, 2002
- ⁵⁰ Nelson & Wampler, 2000
- ⁵¹ ISTSS
- ⁵² Ibid.

Endnotes

See Appendix B for full reference information

- ¹ Harris & Fallot, 2001
- ² Clinic Community Health Centre, 2008
- ³ Hopper, Bassuk & Olivet, 2010
- ⁴ Clinic Community Health Centre, 2008
- ⁵ Harris & Fallot, 2001
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- ⁸ Poole, 2012
- ⁹ Ontario Ministry of Health and Long Term Care, 2005
- ¹⁰ Poole, 2012
- ¹¹ MacKenzie, Cuff, and Poole, in press
- ¹² Clinic Community Health Centre, 2008
- ¹³ Poole, 2012
- ¹⁴ Hopper, Bassuk & Olivet, 2010
- ¹⁵ Ibid.
- ¹⁶ Moses, Reed, Mazelis & D'Ambrosio, 2003
- ¹⁷ Fallot & Harris, 2009
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- ¹⁹ Ibid.
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- ²⁴ Poole, 2012
- ²⁵ Moses, Reed, Mazelis & D'Ambrosio, 2003
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- ²⁸ Fallot & Harris, 2001
- ²⁹ Ibid.
- ³⁰ Gose & Jennings, 2007
- ³¹ Stenius & Veysey, 2005
- ³² Skinner & O'Grady, 2005
- ³³ Poole & Urquhart, 2010
- ³⁴ Niccols et al., 2012
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Section 7:

The Therapeutic Relationship

Goal of Section 7

To discuss the therapeutic relationship in trauma-informed practices, the risks of vicarious trauma, and strategies that can help to mitigate those risks

“Recovery cannot occur in isolation. It can take place only within the context of relationships characterized by belief in persuasion rather than coercion, ideas rather than force, and mutuality rather than authoritarian control — precisely the beliefs that were shattered by the original traumatic experiences”¹

Trauma-informed practice and the therapeutic relationship

The therapeutic relationship is important in particular when working with women who have experienced trauma because – at a core level – trauma violates the sense of self and ability to trust others.

The relational model of women’s development was first pioneered by Jean Baker Miller and the Stone Center at Wellesley College, Massachusetts. Their ground-breaking work profoundly changed the way that we understand women’s growth and helped to inform the practice of clinicians who work with women.

The relational model emphasizes women’s growth through connection.

It asserts that women develop a sense of self and self-worth when their actions arise from and lead back to connections with others.

Relationships foster growth by empowering - not with power *over* others but with power that is used *with* others.

The relational model identifies two key qualities of relationships that foster growth:

- **Mutuality**—each person in a relationship can reveal her or his feelings and perceptions and can be moved by the feelings and perceptions of the other.
- **Empathy**—each person can appreciate the experience of the other’s feelings and perceptions without losing connection with her own experience.

“The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon empowerment of [women who have experienced trauma] and the creation of new connections.”²

The therapeutic relationship is unique among relationships.

The counsellor and the client “come to a sense of shared purpose, a working together which implies commitment and emotional investment in the relationship as an arena for growth and change.”³

The therapeutic relationship offers respect, information, connection, and hope.

This type of relationship helps to develop safety and trust, the essential building blocks of healing human connections. Safe relationships are consistent, predictable, nonviolent, non-shaming, and non-blaming.⁴

"[In our trauma-informed service] relationships between staff are collaborative. People are 'allowed' to be who they are. Relationships between service provider and participant are collaborative."

Substance Use Service Provider—Ontario 2012

The first principle is empowerment – acknowledging that a woman is in charge of and in control of her recovery.

The counsellor's role is to become a woman's ally; she assumes a stance of solidarity with a woman.⁵ The counsellor uses her knowledge, skill, and experience to assist a woman in her recovery; she helps her to comprehend the nature and meaning of her trauma responses through insight and empathic connection.

"What's really rich is when a woman can see the connection between her trauma and her substance use...she gets why she made the choices she did...You can see understanding where there used to be shame."

Substance Use Service Provider—Ontario 2012

Both the counsellor and the woman acknowledge the unequal nature of the therapeutic relationship.

The inequality of that relationship can be amplified when working with women who have been especially marginalized, isolated and/or disempowered in our society.

*"Staff must be aware of the inherent power imbalance in the helper-helped relationship and do their best to flatten the hierarchy. Interpersonal violence involves a perpetrator and a victim. The trauma of this 'power over' experience for the victim is best healed in a very different type of relationship, one that is collaborative and empowering."*⁶

A therapeutic relationship is empowering when women are equal partners and have an equal voice.

Counsellors need to create an environment where women can experience mutuality and empathy in their relationships with organization staff, as well as with other clients. In that environment:

- exchanges between staff and clients are mutual rather than authoritarian, and limits are clear and respectful, rather than blaming
- counselling staff work *together* with a woman to help her confront and resolve her issues, rather than using aggressive confrontational techniques that may place shame and blame on her
- counsellors use strengths-based and anti-oppression approaches to help a woman identify and build on her assets
- the counsellor is committed to honouring and respecting a woman's decisions for her own life.⁷

“The clinician looks for the seeds of health and strength, even in the woman’s symptoms. For example, the clinician portrays a woman’s relational difficulties as efforts to connect, rather than as failures to separate or disconnect...”⁸

The table below illustrates a few of the differences in the characteristics of the client-counsellor relationship in trauma-informed approaches and in more traditional approaches:⁹

Trauma-Informed Approaches	Traditional Approaches
The relationship between the client and the service provider is collaborative	The relationship between the client and the service provider is hierarchical
Both the client and the service provider are assumed to have valid and valuable knowledge bases	The service provider is presumed to have a superior knowledge base
The client is an active planner and participant in services	The client is seen as a passive recipient of services
The client’s safety must be guaranteed and trust must be developed over time	The client’s safety and trust are taken for granted

The positive impacts of the therapeutic relationship

Important aspects of the therapeutic relationship have been identified in the literature.

In one study, women named five factors that helped them to recover from their experiences of trauma¹⁰, which included:

- 1) the therapeutic alliance itself
- 2) counsellors who were aware of the power imbalance and did not abuse it—they explained what they were doing, and why, and involved women in the decision making
- 3) watching the counsellors talk about, enforce, and sometimes modify boundaries, which helped women learn how to do this in their own lives
- 4) counsellors who explained how the development of boundaries enhanced the women’s own well-being
- 5) counsellors who believed in the women and expressed hope in their recovery journey .

The RICH Acronym

Saakvitne and colleagues¹¹ have suggested that counsellors use the simple acronym **RICH** to remember the four most important things to offer to women:

Respect
Information
Connection
Hope

Forging the therapeutic alliance

A woman's experience of trauma can have powerful effects on the therapeutic relationship. Trauma can affect a woman's ability to enter into a trusting relationship; it can also have an indirect but powerful impact on a counsellor. As a result, it may be difficult to forge a working alliance between the woman and the counsellor.¹²

Many counsellors may struggle with the ways in which trauma reactions manifest in the counselling relationship. It is not unusual for women to have frequent crises; some women harm themselves in various ways, or threaten suicide. Difficulty forming a therapeutic alliance may manifest in missed appointments, or in aggressive or inappropriate actions. Working with a woman to overcome these issues can be difficult. These challenges make it particularly important for counsellors who use trauma-informed practices to have a basic understanding of transference and countertransference, and to be as knowledgeable as possible about their own issues and areas of emotional vulnerability. This is especially important for counsellors who have themselves experienced trauma.

What is transference?

Transference generally refers to feelings and issues from the past that women transfer or project onto the counsellor in the current relationship.

Women bring the everyday responses and distortions of life into their relationships with their counsellor. When a woman makes a traumatic transference, it can include feelings, thoughts, hopes and fears that have grown out of her experiences of trauma. She may perceive the counsellor as threatening or abandoning in the same ways that the perpetrator of the trauma was. Conversely, she may idealize the counsellor, seeing her as the warm and loving parent or protector she always wanted.¹³

A woman's feelings about herself may also affect the therapeutic relationship.

Women who have experienced trauma may have enormous shame and low self-esteem, and may feel responsible and guilt-ridden about their experiences. As a result, some women may attempt to avoid trauma-related issues or respond to a counsellor in ways that replicate past relationships. Counsellors must be aware of and prepared for possible trauma-related responses, and must avoid replicating relational patterns that echo the past, even if a woman expects them and acts in ways to encourage them.¹⁴

What is countertransference?

Countertransference refers to a range of reactions and responses that a counsellor may have toward a woman.

Countertransference is based on the counsellor's own background and personal issues, and can include the counsellor's response to a woman's transference reactions. Counter-transference occurs in all therapeutic relationships and can be a useful tool if a counsellor is self-aware. However, if the counsellor projects onto a woman her own unresolved feelings or issues that may be stirred up in the course of working with the woman, an unhealthy countertransference occurs.

"We have to assume that we are going to be affected by the work ... we need to expect it and work with it."

Substance Use Service Provider—Ontario 2012

The effectiveness of services will be diminished if the counsellor is unaware of her countertransference.

For example:

- The counsellor can lose her objectivity and become overwhelmed, angry, or bereft when hearing a woman's story—these reactions create a risk that a counsellor may push a woman to deal with issues before she is ready or to satisfy the counsellor's own emotional needs
- Conversely, there is also a risk that the counsellor may slow or divert the therapeutic process—again, out of her own emotional needs.

It is very important to let the woman determine when and at what pace to work on the issues, especially when dealing with trauma.¹⁵

All counsellors need effective clinical supervision and consultation to help them recognize and deal with transference and countertransference.

"Countertransference explains why counsellors need to do their own therapy."

Clinical Supervisor, Substance Use Service Provider—
Ontario 2012

Vicarious trauma

The term *vicarious trauma* is used to describe the experience of counsellors who work with women who have experienced trauma.¹⁶

Substance use service providers are indirectly exposed to trauma when they work with women. As a result, many experience vicarious trauma, even if they have no personal experience of it themselves.¹⁷

Counsellors who experience vicarious trauma are at risk of becoming over-invested or under-invested in their work with a woman.¹⁸ For example:

- In an attempt to avoid and distance herself from the issues raised by the trauma, the counsellor may under-invest by unintentionally—even unconsciously—dismissing, negating, or minimizing a woman's experience of trauma
- The counsellor may over-invest by becoming extremely involved with a woman, going beyond the appropriate boundaries of the relationship
- The counsellor may have rescue fantasies or feel inappropriate anger directed at a woman's former counsellors, her parents, or her significant others.

The therapeutic relationship can cease to be beneficial if it becomes overly personal, with a resulting loss of the objectivity that is necessary in a professional relationship.

"I found myself thinking about her life at odd times—in line at the grocery store, waiting at a traffic light—it was like she was haunting my thoughts."

Substance Use Service Provider—Ontario 2012

Vicarious trauma can result from the accumulated impact of working with women who have experienced trauma.

Systemic vicarious trauma can result from the repeated experience of being unable to assist women with the resources and linkages that they need. A counsellor can be at particular risk if she does not get adequate support or supervision, does not closely monitor her reactions to women, and does not maintain a healthy personal lifestyle.¹⁹

"I felt more and more powerless and weary. I started to wonder if I could really help her, or anyone."

Substance Use Service Provider—Ontario 2012

Signs of vicarious trauma

Meichenbaum has developed a summary of the most common signs of vicarious trauma, which can be used as a self-check list by counsellors and other staff.²⁰ The list includes:

Feelings

- feeling overwhelmed, emotionally exhausted lingering feelings of anger, rage, and sadness about women's experiences of trauma
- feeling apathetic, depressed, loss of pleasure, overly involved emotionally
- feeling isolated, alienated, distant, detached, rejected by colleagues
- feeling a heightened sense of vulnerability and personal threats

Cognitions

- being preoccupied with thoughts of clients outside of work
- over-identification with the woman
- loss of hope, pessimism, cynicism, nihilism

- questioning competence and self-worth, and experiencing low job satisfaction
- challenges to basic beliefs of safety, trust, esteem, intimacy, and control

Behaviour

- distancing, numbing, detachment
- experiencing trauma responses similar to those seen in women (intrusive imagery, somatic symptoms)
- impacts on personal relationships and ability to experience intimacy
- high overall general distress level
- overextending self and assimilating a client's traumatic material
- difficulty maintaining professional boundaries with the woman

Steps organizations can take to reduce the risk of vicarious trauma

The organizational environment can play a significant role in either reducing or increasing the risks and impacts of vicarious trauma.

Organizations can take important steps to reduce risks by acknowledging the potential impacts of working with trauma on staff, particularly when staff have themselves experienced trauma. Each organization can support the well-being of its staff by creating an environment in which there are appropriate resources.

"I know that if I'm having a really rough day, I can tell them. I cannot give them all the gory details but I know that if I went and sat down in the office and just said, 'I need a break,' that would be fine and I'd be welcomed."

Substance Use Service Provider—Ontario

At the most basic level, this means there is organizational recognition that:

- vicarious trauma is a normal reaction to an abnormal situation
- ongoing positive support is needed—by each individual and by the staff group as a whole.

Clinical and program staff can be expected to function well and to provide effective service *only* if their organization's leadership gives them the appropriate support.

Such support includes recognition for and appreciation of the role of staff, and the stresses entailed in their work. As well as showing appreciation for counsellors' work, it is important to value staff from diverse backgrounds.²¹

Organizations that refuse to accept the severity and pervasiveness of traumatic experience among the women they serve can increase the risks and impacts of vicarious trauma by failing to provide the supports that staff require.²² They may also find themselves dealing with the consequences, such as repeated or extensive sick leaves or staff departures necessitating expensive and time-consuming recruitment and training.

"We know that we are supported as workers, supported emotionally, and we know that we're not taken for granted either. We're appreciated."

Substance Use Service Provider—Ontario

Some of the specific strategies that an organization can and should use to support clinical and program staff include:²³

- imparting to staff a vision that communicates the value of their work
- asking job candidates about their experience with, and strategies for, self-care during hiring interviews

- providing ongoing training to increase understanding and expertise in relevant areas, including training on the potential risks and impacts of vicarious trauma
- raising awareness of the importance of self-care and provide social support within the organization, as well as other resources to support self-care
- providing ongoing supervision with a clinical supervisor who is knowledgeable about, and skilled in, both trauma and substance use issues
- providing resources and setting policies that enable staff to access supervision and debriefing (formal and informal), especially after an incident or difficult interaction
- if an appropriately skilled clinical supervisor is not on staff, providing funding to staff for clinical supervision outside the organization
- supporting staff members in their efforts to keep caseloads at manageable levels and to stay within the boundaries and limits of their roles
- limiting excessive work hours, encouraging time away from work for vacation and scheduled days off, and ensuring that staff take time off when they are unwell
- recognizing and rewarding the work of the staff on a regular basis
- encouraging staff to share their ideas on improving the program, and incorporating those ideas, as appropriate
- developing a supportive organizational culture and team environment that includes supervisors as well as direct service and other staff
- building in time for direct service staff to talk to each other to give and receive support, and implementing in-house peer support sessions for staff, as appropriate
- ensuring that the organization's policies address staff safety.

See **Section 9** for guidelines that address workplace practices.

Steps that staff can take to reduce the risk of vicarious trauma

Counsellors must find a balance between care giving and self-care.

Integral to that balance is recognition of the impacts of their work; a self-care plan; strong connections with their own spirituality, family, friends, and community colleagues; and a supportive organizational culture. ²⁴

The ABC Model

Pearlman and Saakvitne suggest that counsellors use an **'ABC model'** as part of their self-care strategies: ²⁵

Awareness—attunement to one's needs, limits, emotions, and resources

Balance—balancing the multiple aspects of self & one's activities

Connection—to oneself, to others, and to something larger

- Plan time for self-care activities such as time-outs, support, or opportunities to debrief
- Deliberately set aside time in personal lives to rest and relax, keep personal and professional time as separate as possible, and take regular vacations. ²⁷

Meichenbaum emphasizes the importance of using cognitive strategies to counter the impact of vicarious trauma in the following points: ²⁸

- Recognize that you are not alone in experiencing vicarious trauma and job stress
- Validate and normalize your reactions
- Listen for the 'stories' (narratives) you tell yourself and others
- Set realistic expectations for yourself and your clients—recognize your limitations and the fact that therapists will make mistakes
- Remind yourself that you cannot take responsibility for a woman's healing, but you can act as a 'midwife' on a woman's journey toward healing—remind yourself that there are some things (like traumatic grief) that you can't fix.

Some steps that staff can take to enhance self-care include trying to:

- Set clear boundaries—research indicates that counsellors who develop and maintain secure boundaries have the lowest levels of compassion fatigue
- Keep a manageable caseload ²⁶
- As much as possible, don't work in isolation—working as part of a treatment team can be a natural way to obtain support and reduce stress
- Develop and use a support network—sharing experiences with a colleague can give a counsellor crucial support and perspective
- Get regular support and guidance through clinical supervision

Questions for Self-Reflection

Kohlenberg ²⁹ challenges clinical staff to ask themselves the following questions:

- What are my own issues and how do they play out in my therapeutic work?
- How do I find the balance between caring too much and caring too little?
- How do I handle the situation when what is in the best interest of the woman clashes with what is in my own best interest?
- How can I keep growing as a therapist and as a person while working with women?

More Questions for Self-Reflection

Meichenbaum suggests questions that staff can use for self-assessment of vicarious trauma, including: ³⁰

- How am I doing? What do I need? What would I like to change?
- What is hardest about this work?
- What worries me most about my work?
- How have I changed since I began this work? What changes, if any, do I see in myself that I do not like?
- Am I experiencing any signs of vicarious trauma?
- What am I doing and what have I done to address vicarious trauma?
- What is my sense of personal accomplishment in my work? What work barriers get in the way of my having more satisfaction? How can these barriers be addressed?
- What am I going to do to take care of myself?
- How can I keep going as a person while working with women who have experienced trauma?
- How can I use my social supports more effectively?
- Is there anything about my work experience or other stressful events in my life that I have not told anyone that is 'unspeakable'?
- What is the possible ongoing impact, toll, emotional price of not sharing and working through these feelings? How will sharing these feelings help?

Research shows that the most influential resource is a group of peers that we can talk to about trauma-related work. ³¹ Clinical supervision, team meetings and chances to debrief are all valuable in helping counsellors stay connected.

"Our clients change us forever; to honour them and ourselves, we must practice self-care." ³²

Endnotes

See Appendix B for full reference information

- 1 Herman, 1992
- 2 Ibid.
- 3 Miller, Jordan, Kaplan, Stiver, & Surrey, 1991
- 4 Saakvitne, Gamble, Pearlman & Lev, 2000, cited in McEvoy & Ziegler, 2006
- 5 Herman, 1992
- 6 Miller & Stiver, 1997, cited in Elliott, Bjelajac, Merkoﬀ, Fallot, & Reed, 2005
- 7 Herman, 1992
- 8 Covington, 2002
- 9 Adapted from Fallot, 2008
- 10 Barrett, 2004, cited in: McEvoy, & Ziegler, 2006
- 11 Saakvitne, Gamble, Pearlman & Lev, 2000, cited in McEvoy & Ziegler, 2006
- 12 Herman, 1992
- 13 Substance Abuse and Mental Health Services Administration (SAMHSA), 2000
- 14 Ibid.
- 15 Ibid.
- 16 The terms vicarious trauma, secondary traumatic stress, and compassion fatigue are often used interchangeably; however, there are differences in their definitions.
- 17 Bride, Hatcher & Humble, 2009
- 18 Pearlman & Saakvitne, 1995, cited in Substance Abuse and Mental Health Services Administration (SAMHSA), 2000
- 19 Substance Abuse and Mental Health Services Administration (SAMHSA), 2000
- 20 Meichenbaum, no date
- 21 Rothrauff, Abraham, Bride & Roman, 2011
- 22 Bloom, 2003
- 23 The strategies identified here have been drawn from the finding and recommendations of several experts, including: Bride, Hatcher & Humble, 2009; Fahy, 2007 ; MacEwan, 2007; and Bell, Kulkarni & Dalton, 2003
- 24 MacEwan, 2007
- 25 Substance Abuse and Mental Health Services Administration (SAMHSA), 2000
- 26 Ibid.
- 27 Ibid.
- 28 Meichenbaum, no date
- 29 Kohlenberg et al., 2006
- 30 Meichenbaum, no date
- 31 Sexton, 1999
- 32 Srdanovic, 2007

Section 8:

Supporting Staff Competencies

Goal of Section 8

To describe how organizations can build staff competencies needed for trauma-informed practices

Baseline competencies for staff in substance use services

The Canadian Network of Substance Abuse and Allied Professionals (CNSAAP) has developed a framework of competencies for workers who deliver substance use services in Canada. The framework defines ‘competencies’ as specific, measurable skills and/or knowledge needed to effectively perform a particular function or role. Two types of competencies are defined:

Technical Competencies

Core knowledge and skills specific to the substance use field—the ‘what’ of a job, usually learned in an educational environment or on the job

Behavioural Competencies

Abilities, attitudes and values required to perform effectively—the ‘how’ of performing a job, typically learned and developed through life experiences

All of the competencies identified by the CNSAAP framework are foundational to delivery of substance use services, and all are needed by staff who delivery trauma-informed substance use services.

Detailed information about the CSNAAP framework and the national consultation process through which it was developed can be found at:

www.cnsaap.ca/Eng/DevelopingTheWorkforce/Competencies

Competencies required for trauma-informed practices

The United States Substance Abuse and Mental Health Services Administration (SAMHSA) has identified additional knowledge and skills needed by direct service staff who are working within a trauma-informed practices framework. ¹ Highlights of those findings include the following:

Staff should have knowledge about:

- the incidence and impacts of violence and abuse experienced by women
- the nature of trauma, and its impacts on women’s development, behaviour, coping mechanisms, relationships, and self-care
- the nature of trauma memories and triggers;
- the interrelationships of trauma, substance use, and mental health issues
- the range of responses to traumatic life experiences, including coping strategies that can mimic ‘symptoms’ of mental health disorders
- the principles and elements of trauma-informed practices, and how they differ from trauma-specific services
- how women with ‘lived experience’ can contribute to a greater understanding of trauma-informed systems, services, and processes
- specialized services that may be available (e.g. for trauma-specific services, mental health issues, intimate partner violence, refugees and victims of torture, and other issues).

Staff should have the skills needed to:

- utilize trauma-informed practices in their direct service roles
- respond with sensitivity and cultural competence to women of varied ages, ethnicity, race, class, faith, ability, and sexual orientation
- assist women in understanding the connections between experiences of trauma and the development of problematic substance use and/or mental health issues
- recognize trauma-related behaviours and respond appropriately
- promote safety, and help women to develop and implement safety plans
- create and contribute to a safe service environment that encourages connection, empowerment, and mutuality
- recognize potential behaviours (*e.g. actions, tone of voice*), and/or situations (*e.g. drug testing, aggressive confrontation*) that can trigger or retraumatize women
- identify their own capacity to serve women who have experienced trauma—this includes being skilled at knowing when to ‘do no harm’ by linking the woman to clinicians or services with more highly developed skills and training
- help women to connect with trauma-specific, or other specialized services, when needed.

Experienced staff in Ontario substance use services may already have some or all of the skills and knowledge identified by SAMHSA. However, many will require additional education to develop full competencies.

In some cases, using a ‘trauma-informed lens’ may require new thinking. For example, the theoretical and/or clinical training of some workers may interfere with their ability to see the interplay between trauma and problematic substance use.

Some training and clinical approaches have taught workers to believe that substance use issues must ‘take precedence’ over acknowledging trauma. This can cause workers to ignore or downplay the impacts of trauma.

Competencies to support inclusive services

In addition to the trauma-related competencies identified by SAMHSA, staff should have a sound knowledge of anti-oppression and culturally competent approaches ². Some of the markers of these approaches include: ³

Knowledge and skills

- Staff understand that culture is complex and multi-faceted; the women for whom they provide services may be affected by a variety of intersecting cultural influences.
- Staff are aware of the institutional, social, and political systems that marginalize women, and the barriers that can prevent women from accessing needed services and supports—especially women who are not from ‘mainstream’ cultural groups.
- Staff understand how values and assumptions of counselling practices and theories can contribute to marginalization and oppression.
- Staff are aware of alternative methods of helping that may be more effective when working with women who are not from ‘mainstream’ cultural groups.
- Staff are able to modify and adapt conventional communication (verbal and non-verbal) and counselling methods to accommodate cultural diversity.

Self-knowledge and attitudes

- Staff are aware of their own values, beliefs, attitudes, feelings and biases, and of how they are likely to affect their clinical or direct service work.

- Staff have genuine respect for, and interest in, the cultural diversity of the women they serve.
- Staff are aware of their limitations. They seek supervision, consultation, and education to expand their knowledge of diverse cultures and enhance their ability to work with women from cultures different from their own.
- Staff are comfortable linking a woman with additional or alternate resources when appropriate.

Building a trauma-informed staff

Organizations should ensure that the required knowledge and skills are reflected in job descriptions and recruitment strategies, and are supported by training and clinical supervision.⁴

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“Organizational strategies to promote a trauma-informed approach also included changes to our hiring practices. We began screening resumé and formulating interview questions to explore candidates’ attitudes toward, and experience in working with [women who have experienced trauma].”⁵

Case Example — Staff Development at Iris Addiction Recovery for Women⁶

Iris has taken the following steps to develop staff competencies needed to provide trauma-informed services:

- Education and training is provided.
- The interview process includes questions about awareness of trauma and self-care strategies.
- Clinical supervision is provided by a skilled, knowledgeable clinical supervisor.
- An external researcher, who has a strong background in trauma and vicarious trauma, ‘checks in’ with staff periodically to provide support and input.
- Staff are encouraged to debrief—informally, as well as formally.
- Ideas about how staff can maintain balance and wellness have been collected, shared, and pursued.
- Features (such as a staff room) have been provided at little cost, and with great impact.

Education and training to support staff competencies

All staff contribute to the overall atmosphere of safety and comfort that a woman experiences when she accesses services.

Whether at the front desk, in the finance area, or attending to the maintenance of the physical space, all staff may interact with women who are seeking or receiving services. Simple and ordinary interactions can have a significant impact—a greeting or tone of voice; a smile or frown; a look.

Since the behaviour of all staff can impact women, all should have education and training that will enable them to respond appropriately.

Training will help to generate an organization-wide understanding and respect for coping mechanisms and strengths of women who have experienced trauma. It will also help to sensitize staff to trauma-related dynamics, and to identify and reduce trauma triggers in the service environment.

“All staff need to be trauma-informed, not just counsellors; it can be as simple as letting women know when loud noises are about to happen, like a fire drill.”

Substance Use Service Provider—Ontario 2012

Three basic components of staff development must be addressed to successfully implement trauma-informed practices: staff values and attitudes, knowledge, and skills.

Staff values and attitudes have been extensively discussed in these Guidelines. Knowledge is often developed through formal education and training or structured information sessions (in person or on line).

“Training on trauma for non-trauma providers was the first and most important step in making services more trauma-informed”.

Substance Use Service Provider—Ontario 2012

Knowledge is also generated through learning from other staff (in team meetings and debriefing or in mutual support sessions) and reading. Skills building can happen in many ways—for example, through training, practice, supervision and mentoring.

Becoming trauma-informed is a process, not a one-time event.

Within any organization, programs—and the staff who deliver them—may be at differing stages of readiness to change. New practices take time to be fully understood and integrated. New staff need orientation and training. Consequently, ongoing education and training is needed to reinforce learning, as well as to provide knowledge and skills to all staff. ⁶

Women with ‘lived experience’ of trauma and substance use should be significantly involved in helping to build staff knowledge and skills.

They may contribute to or assist with staff orientation, training and curriculum development and delivery. The input of women (clients and staff) with ‘lived experience’ should be a part of all staff training in trauma issues. ⁷

Baseline, organization-wide training for all staff should include:

- the nature and impacts of trauma
- the prevalence of experiences of trauma among substance-involved women
- the interconnections between trauma and substance use.

All staff should have knowledge about how to reduce risks of retraumatization.

Basic training should provide information about potential trauma triggers in organizational and clinical practices, and how staff can best respond when triggers occur.

Additional education and training will be needed by direct service staff.

Clinical and program staff need opportunities to develop a comprehensive knowledge of trauma-informed clinical practices, and the skills to integrate those practices into their service and program delivery roles.⁸

Training and education should be delivered in inter-organizational and inter-disciplinary sessions, whenever possible.⁹

Organizations that have implemented trauma-informed practices report that cross training can have several important benefits. Bringing together staff from multiple organizations or disciplines can support partnering and referrals, and can generate more effective approaches to services. When staff learn together and from each other, they can network, learn about each other's programs and services, understand differing job roles, approaches, and philosophies, and create a foundation for collaboration across services and sectors.

Clinical infrastructures to support competencies

Education and training are fundamental—but not in themselves sufficient—to support trauma-informed practices. In programs that have implemented trauma-informed practices, competent clinical supervision has been found to be extremely important.¹⁰

As well as providing critical support for effective performance of job roles and responsibilities, clinical supervision will help staff to develop competencies.

GUIDELINES for STAFF DEVELOPMENT ¹¹

GUIDELINE #27

The organization ensures that a) job descriptions reflect the competencies of trauma-informed practices, in line with job roles, and b) clearly communicates those requirements to staff.

Suggested indicators:

- Job descriptions clearly indicate requirements for education, knowledge, and expertise in trauma-informed practices, and each staff member has a copy of her/his job description.
- Performance is regularly monitored and evaluated against the fulfillment of these requirements.
- The organization supports both existing and new staff in obtaining the education and training needed to develop and maintain the required competencies.
- Organizational expectations for staff to attend education and training are clearly communicated.

GUIDELINE #28

The organization's policies and practices support recruitment and hiring of staff who have competencies in trauma-informed practices.

Suggested indicators:

- Recruitment processes and procedures, interview questions, ranking scales, and job requirements incorporate knowledge of and skills in trauma-informed practices, as key job requirements.

GUIDELINES for STAFF EDUCATION and TRAINING

GUIDELINE #29

The organization provides education and basic training to all staff about trauma, and how trauma-informed practices will be used in their work.

Suggested indicators:

- The organization provides education and training to ensure that all staff have basic knowledge about trauma and its impacts, including the connections between trauma and substance use.
- Basic education and training provides all staff with an understanding of the importance of safety and trustworthiness in the organizational environment (e.g., triggers, trauma responses, boundaries, confidentiality, sexual harassment).

GUIDELINE #30

The organization provides in-depth training for direct service staff about trauma, and how trauma-informed practices will be used in their work.

Suggested indicators:

- The organization provides in-depth training that enables direct services staff (clinicians and program staff) to establish a sound understanding of how trauma-informed practices should be used in developing new programs and services, and modifying those that already exist.
- Direct services staff receive training that enables them to identify trauma reactions and help women to manage them, including the necessary skills and techniques (e.g., grounding).

GUIDELINE #31

The organization provides ongoing education and training to all staff about trauma-informed practices, as is appropriate for their job roles and responsibilities.

Suggested indicators:

- The organization provides education and training to reinforce learning and extend the scope and depth of staff knowledge and skills.
- Appropriate education and training are provided to new staff.
- The organization evaluates the effectiveness of the education and training it has provided annually, and elicits feedback from staff and from women with ‘lived experience’ as part of that evaluation.
- The organization plans future education and training based on evaluation results, and seeks input on those plans from staff and women with ‘lived experience’.

GUIDELINE #32

The organization partners with other service providers and community stakeholders to provide shared training sessions in trauma-informed practices for staff from a variety of organizations and/or disciplines.

Suggested indicators:

- Opportunities for inter-organizational and interdisciplinary training are developed or identified through existing organizational partnerships.
- Organizations participate in networks and planning tables within their local community, and seek opportunities for joint education and training in trauma initiatives in those groups.
- Organizations work with Local Health Integration Networks to identify system-level education and training needs and opportunities.

GUIDELINES for BUILDING CLINICAL INFRASTRUCTURE

GUIDELINE #33

The organization ensures that all direct service staff have regular, confidential clinical supervision from a qualified clinical supervisor.

Suggested indicators:

- A qualified clinical supervisor (i.e. one who has thorough knowledge of trauma, substance use, and the interconnections between them, and who is skilled in providing trauma-related services, as well as clinical supervision) is employed by the organization, either as a full or part time staff member or on a contract basis.
- Regular clinical supervision sessions and consultation are available to all direct services staff—weekly supervision sessions are recommended; at a minimum, sessions should be provided bimonthly and consultation should be provided as needed.
- Clinical supervision is provided in sessions that are separate from administrative supervision (even if both are provided by the same person).
- Clinical supervision is confidential and provides a safe place for staff to process issues and concerns.
- Clinical supervision assists direct service staff in dealing with issues of transference, countertransference, burnout, and vicarious trauma.

GUIDELINE #34

The organization provides and facilitates opportunities for staff to work in teams, and to support each other in team meetings and in ad hoc sessions as needed.

Suggested indicators:

- The organization provides a structure in which regular team meetings are held, and in which staff have a forum to seek support and/or input, to exchange newly-acquired information and knowledge, and to enhance skills.
- The organization ensures that staff are able to take time-outs when needed to debrief, to seek support or input from other staff, or to recharge.
- Staff who work alone or in isolation (e.g. on shift, outreach locations, or in satellite offices) have resources that they can call upon for emotional or practical support, or professional consultation, when needed.
- The organization provides a safe environment and a positive atmosphere in which staff can discuss uncertainties or mistakes and use them as opportunities for learning.
- The organization encourages and facilitates a culture of openness—staff embrace change, and do not feel threatened by new practices or new learning—organization leaders model this attitude and behaviour.
- The organization encourages staff to hear feedback from women, including feedback that is critical or negative, without feeling threatened.

Endnotes

See Appendix B for full reference information

¹ Substance Abuse and Mental Health Services Administration (SAMHSA), 2011

² The concept of 'culture' as used in this document is defined in a broadly inclusive way, encompassing age; language; ethno-cultural and racial identification; immigrant /refugee status; sexual orientation; ability challenges; literacy challenges; homelessness/marginal or under-housing; street involvement; poverty; and isolated circumstances.

³ BC Association of Specialized Victim Assistance & Counselling Programs, 2007

⁴ Jennings, 2008

⁵ Bloomenfeld & Rasmussen, 2011, in Poole & Greaves, 2012

⁶ Interview with Kathryn Irwin-Seguin, Executive Director of Iris Addiction Recovery for Women

⁷ Jennings, 2008

⁸ Ibid.

⁹ Ibid.

¹⁰ Ibid.

¹¹ Guidelines have been adapted from Fallot & Harris, 2009

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Section 9:

Trauma-Informed Organizational Practices

Goal of Section 9

To describe how organizational culture, policy, and procedures are transformed by trauma-informed practices

“[In a trauma-informed environment] women who access services are viewed differently, staff respond differently, and the day-to-day delivery of services is conducted differently. Without such a shift in the culture of an organization or service system, even the most ‘evidence based’ treatment approaches may be compromised.”¹

How do trauma-informed practices change the organizational culture?

Trauma-informed practices are not limited to clinical or service areas.

The organizational environment in which services are delivered must draw upon and be shaped by an understanding of trauma and its impacts. For many organizations, this may require a significant ‘culture shift’.

The culture of an organization reflects what it considers important, how it understands its staff and the women it serves, and how it puts those understandings into practice.

The core principles of trauma-informed practices must become part of the organization’s basic values—as such, they should be reflected in *every* contact with women and among staff, in the physical setting, and the organization’s structure, culture, and practices.²

Organizational support for trauma-informed practices

Changing the way that organizations respond to women who have experienced trauma requires time, work, and commitment.

Studies of programs that have implemented trauma-informed practices show that changes at the organizational level often precede and support those at the service level. However, changes may also occur in cycles that involve the evolution of both organizational and clinical practices:³

“As all staff were trained in the impact trauma can have on a woman’s life, our services became trauma-informed—a switch to focusing on ‘what happened to her’ as opposed to focusing on working with her to change her behaviour.”

Substance Use Service Provider—Ontario 2012

It is important to build ‘buy-in’ across the organization.

Experts suggest that it is helpful for an organization to undertake a change process that begins with education. A clear commitment needs to be articulated and demonstrated by the organization’s senior leadership.

Throughout the process, that commitment should be maintained and strengthened through leadership, support, and ongoing training and educational opportunities.

Building on a sound foundation

Organizations that implement trauma-informed practices should already be using the gender-appropriate practices set out in *Best Practices in Action: Guidelines and Criteria for Women's Substance Abuse Treatment Services*. Released by the Ontario Ministry of Health and Long Term Care in 2005, this document provides information about:

- the policy and contextual background of evidence-informed practices in services for substance-involved women
- patterns of women's substance use and concurrent, related, or contextual issues
- guidelines for gender-appropriate approaches for:
 - operational policies and structure
 - addressing barriers to services
 - treatment planning
 - clinical practices
 - population-specific strategies
 - monitoring/evaluating progress.

Organizations can find additional information about gender-appropriate practices in *Best Practices in Treatment and Rehabilitation for Women with Substance Abuse Problems* (published by Health Canada in 2001).

Lessons from other trauma-informed services

Jennings,⁴ Moses,⁵ and Fallot and Harris,⁶ among others, have identified several critical steps taken by organizations that have implemented trauma-informed practice:

Understanding that trauma is a central issue

- Trauma must be understood as a *primary* issue—it cannot be viewed as an ‘add-on’ to a woman's substance use and mental health issues.

Making a commitment to trauma-informed practices across the organization

- Energy for change requires leadership, direction, and action from the top. A formal expression of the organization's commitment is needed to ensure that trauma-informed practices become embedded in the system. The commitment should be stated in the organization's mission statement or program philosophy and objectives; priority should be given to staff support, education, and training.

Learning from women with ‘lived experience’

- The active involvement of women with ‘lived experience’ is integral to trauma-informed practices. They can contribute unique perspectives about service practices that are helpful or harmful. Whether as volunteers or committee members, their feedback can help to ensure that service planning, delivery, policy making, and evaluation are trauma-informed.

Training

- It is critical that training be provided to all staff, including direct service staff, administration, and management, and to the Board of Directors and other volunteers. Staff who are not involved in direct services need, at a minimum, basic knowledge about trauma, its impacts, and appropriate responses. Direct service staff need more extensive knowledge and skills training.

Developing staff competencies

- A trauma-informed workforce should be developed through hiring practices and staff orientation, training and support. Job descriptions should reflect appropriate competencies and performance standards.

Clinical supervision and consultation

- It can take time, learning, and support for staff to recognize the many ways in which trauma is manifested and to integrate the appropriate service responses. Direct service staff require on-going and regular (weekly or biweekly; individual and/or group format) support, consultation, and supervision from a clinical supervisor who has expertise in trauma-informed practices. Clinical supervision plays a critical role in enabling staff to deliver services effectively and encouraging staff who may be at risk of burnout or vicarious trauma to practice appropriate self-care.

Assessing the current state

- Organizational leaders, staff, and women with ‘lived experience’ need to work together and contribute to a thorough review of the organization’s policies and procedures (as well as its array of services), using a trauma-informed lens. The review needs to look at how a woman who has experienced trauma may be impacted by her contact with the organization—the goal is to ensure that the principles of trauma-informed practices pervade every aspect of a woman’s experience with the organization.

Leadership and ‘champions’

- Many organizations have developed a team or work group to conduct the review and identify needed changes. The team should have representation from direct service and administrative or support staff, management or supervisory staff, and women with ‘lived experience’.

In some organizations, staff who have specific expertise in trauma-informed practices have played pivotal roles as ‘trauma-champions’, providing needed expertise.

Attending to safety in the physical setting

- Since women who have experienced trauma often feel unsafe—and may actually be in danger—trauma-informed practices take precautions to attend to women’s physical (as well as emotional) safety in the service environment. The organization needs to identify issues in physical settings that may engender safety concerns, or that may trigger trauma-based reactions. For example, feelings of powerlessness and terror can be awakened in environments that are restrictive, crowded, noisy and/or chaotic.

“When walking into a trauma-informed environment, you notice and you feel something ... You are greeted and welcomed, you see people walking at a regular, calm pace.

“You are told what is going to happen—when and where. People take time to ask if you have any questions, ask what can they do, and then they listen.

“You feel that you have control over what you say—information is not pulled out of you. People ask before closing a door, and lights are not turned out.

“You aren’t told ‘trust me, I’ve been doing this for years and know what’s best’—instead, you are told ‘trust is earned and develops over time’.”

Substance Use Service Provider—Ontario 2012

Using trauma-informed practices with staff

The work environment in which services are provided has a profound impact on the experiences of people who are accessing services, as well as on the staff who deliver services. Trauma-informed practices should be reflected in an organization's relationships with staff, and the policies and procedures that shape the workplace environment.

Case Example — Transforming Services at the Jean Tweed Centre

Steps taken to implement trauma-informed approaches and trauma-specific services were:

Stage 1—Identifying the issue

80% of women were identified as having a trauma-related experience; once identified, the issue was addressed through:

- **education**—of staff and funders
- **proposal development**—receiving funding for a clinical supervisor and trauma counsellor
- **program evaluation**—resulting in changes to any approaches that were found to contribute to instability and retraumatization.

Step 2—Shifting to trauma-informed practices

A trauma-informed approach to screening was implemented and staff increased their knowledge of trauma-informed practices.

Step 3—Building capacity

Staff received in-depth training in the practice of mindfulness and in the Seeking Safety model; Seeking Safety groups were offered to all women and a dedicated trauma counsellor provided individual counselling for women and consultation/education for staff.

Step 4—Continuing braided support

Trauma and substance use are integrated as new programs are developed through:

- ongoing **staff education**
- support for a **concurrent and staged approach** that combines trauma-informed with trauma-specific services
- **clinical and peer supervision** that builds reflexive practice for all staff
- **evaluation**—continuing to listen to the experiences of women as they move through their journey, building on clinical wisdom and incorporating evidence-informed practice.

GUIDELINES for TRAUMA-INFORMED ORGANIZATIONAL POLICIES and PROCEDURES

GUIDELINE #35

The organization integrates knowledge and skills about trauma in all its programs, services, and organizational structures.

Suggested indicators:

- The organization recognizes the centrality of trauma in a formal, explicit manner (e.g., in the mission statement, vision statement, strategic plan, and/or objectives).
- Leadership communicates a clear commitment to trauma-informed practices across the organization, and supports the implementation of those practices.
- The organization has a process for continuous monitoring, evaluation, and improvement of trauma-informed practices, including regular reviews in which feedback is received from staff at all levels as well as from women with 'lived experience'. Protocols are developed for acting on issues identified in those reviews.

GUIDELINE #36

The organization's policies and practices ensure that women with 'lived experience' are involved in developing and evaluating trauma-informed practices.

Suggested indicators:

- Women with 'lived experience' actively contribute to the organization's planning, implementation, and evaluation of trauma-informed practices (e.g., via input from an Advisory Committee, volunteers, and staff with 'lived experience'), including women who can help to identify barriers to service access.
- Feedback about the quality of trauma-informed practices is regularly elicited from women with 'lived experience', and used to inform organizational practices.

GUIDELINE #37

The organization understands the diversity of the community it serves.

Suggested indicators:

- The organization develops formal and informal relationships with culturally specific services and groups in the community to enhance its knowledge and understanding of the community it serves.
- The organization reviews data (e.g. census and survey data, health care system reports) to ensure a good understanding of its community.

GUIDELINE #38

The organization's decision making is informed by diverse points of view from within and beyond the organization.⁷

Suggested indicators:

- The organization systematically and consistently involves women, family members, and community members, including those who can speak to the needs of specific cultural groups, in developing

organizational practices that support cultural competence.

- The organization has regular processes (both formal and informal) for eliciting feedback from women, family members, and community members about its service environment, modalities, and the cultural competence of its staff.
- The organization has developed linkages with community groups and other community services that can enhance its knowledge of and effectiveness in providing services for a range of diverse populations.

GUIDELINE #39

The organization creates a physically and emotionally safe environment for women and staff.

Suggested indicators:

- The physical environment is accessible and welcoming to women from a variety of cultural backgrounds (see **Section 5**).
- The organization identifies dimensions to assess the physical and emotional safety of the service environment (see **Section 6**).
- The organization identifies possible triggers that may elicit trauma responses (see **Section 4** and **Section 6**).
- Female staff are readily available to work with a woman at all phases of her engagement with services.
- Organizational policies and procedures ensure that female staff are available to work with women in clinical, program delivery, and residential support positions, in both daytime and night time functions.
- Functions specific to residential services (night monitoring, housekeeping needs, bed checks) are carried out by female staff.
- The organization has a process for regular review of environmental safety, and that process includes input about potential safety issues and triggers from both staff and women with ‘lived experience’.

GUIDELINE #40

The organization implements protocols for universal trauma screening.

Suggested indicators:

- The organization ensures that screening for trauma is embedded within outreach, intake, assessment, and clinical services (see **Section 6**).
- Staff members involved with those services have the required knowledge and skills to ask screening questions in clinically competent and culturally sensitive ways.

GUIDELINE #41

The organization has trauma-informed policies and procedures for helping women to manage trauma responses.

Suggested indicators:

- Staff work with women to identify strategies that can help to manage trauma/crisis responses, such as discussing potential grounding strategies (see **Section 6**).
- The organization demonstrates respect for women’s preferred actions and strategies when responding to trauma-based reactions and/or crises.
- The organization has a protocol in place to document and review incidents in which trauma responses have been triggered, and utilizes reviews to maximize learning and improvements in practices.

GUIDELINE #42

Organizational policies and procedures respect the privacy and confidentiality rights and needs of women who have experienced trauma.

Suggested indicators:

- The organization has a clearly written, easily accessible statement of the rights and responsibilities of women and staff (see **Section 6**).
- The organization provides protection for the privacy of both women and staff members.
- Policies regarding privacy, confidentiality and access to information are clear, are provided in writing to women, and are verbally communicated to and discussed with them.
- Organizational guidelines and policies, and staff training, ensure that documentation respects a woman's privacy (see **Section 6**).

GUIDELINES for USING TRAUMA-INFORMED PRACTICES WITH STAFF

GUIDELINE #43

The organization creates a physically and emotionally safe environment for women and staff.

Suggested indicators:

- The program attends to the safety needs of all staff, including support and administrative staff as well as those who provide direct services.
- The organization seeks input from staff about the conditions that support and contribute to, or undermine, their safety, and addresses those conditions.
- Staff have adequate space and privacy, and assistance can be readily contacted, if needed.
- The organization has mechanisms to assess staff safety on an on-going basis, and to make improvements when required.

GUIDELINE #44

The organization ensures that work roles, practices, and boundaries are clear and consistent for all staff.

Suggested indicators:

- The organization's mission, goals, and objectives are clear to staff, and are consistent with trauma-informed practices.
- Managers and supervisors understand the nature of trauma-informed practices in its programs and services, and the potential emotional impacts (burnout, vicarious trauma, compassion fatigue).
- Organizational policies and practices encourage staff to maintain appropriate professional boundaries and exercise appropriate self-care.
- Direct service staff receive regular support from a qualified clinical supervisor, and clinical supervision is conducted through a separate session or process from administrative supervision.
- The organization maximizes transparency and honesty by providing staff with clear communication about program plans, and information about changes.
- Job roles and expectations are clear, consistent and fair for all staff, including support staff.
- The organization has mechanisms to ensure that clear, consistent work roles and boundaries are maintained, and to make improvements wherever possible.

GUIDELINE #45

The organization provides opportunities for staff choice and control.

Suggested indicators:

- Staff have appropriate autonomy within the boundaries of their job duties and responsibilities.
- Staff have opportunities to provide meaningful input into factors that affect their work whenever possible (e.g., workload, hours of work, training needs, programs and services provided by the organization, the physical environment).

GUIDELINE #46

The organization maximizes collaboration and sharing of power among staff, supervisors, administrators, and managers (as well as with clients).

Suggested indicators:

- The organization seeks feedback and ideas from all staff, and encourages participation in both planning and action when implementing changes.
- Formal and structured mechanisms are in place to elicit input from staff members.
- It is made clear to staff that their input is valued and considered, even if their ideas are not always implemented as suggested.
- The organization seeks to improve collaboration and power-sharing among its staff.

GUIDELINE #47

The organization prioritizes staff empowerment and skill-building.

Suggested indicators:

- The strengths and skills of staff are recognized and utilized to the fullest extent possible in their job roles.
- Staff are offered development and training opportunities to build on their skills and abilities.
- Staff receive regular and ongoing training in areas related to trauma, including the impact of workplace stressors.
- Feedback from supervisors is affirming, encouraging, and constructive, even when providing a critique.
- The organization seeks opportunities to support professional development and provide the resources required for job performance.

GUIDELINE #48

The organization takes actions to reduce the impact of vicarious trauma.

Suggested indicators:

- The organization (in consultation with staff) identifies the characteristics of its culture that can either mitigate the risks of vicarious trauma or exacerbate them.
- The organization provides support and resources to staff who have experienced vicarious trauma.
- The organization trains staff in good self-care.
- Organizational policies, expectations, scheduling, and infrastructure promote staff well-being and good self-care.

Endnotes

See Appendix B for full reference information

¹ Jennings, 2008

² Fallot & Harris, 2009

³ Moses, Reed, Mazelis & D'Ambrosio, 2003

⁴ Jennings, 2008

⁵ Moses, Reed, Mazelis & D'Ambrosio, 2003

⁶ Fallot & Harris, 2009

⁷ Guidelines have been adapted from Fallot & Harris, 2009

Section 10:

Linkages With Other Services and Sectors

Goal of Section 10

To identify strategies for collaboration and partnerships that will support coordinated, trauma-informed responses to women's needs across services and sectors

The benefits of collaboration and partnership

Health Canada's National Treatment Strategy highlights the importance of coordination among services:

*"Historically, there has been little integration or effective communication within and between the systems and jurisdictions that provide services and supports to people with substance use problems. As a result, people face considerable gaps in service and barriers to accessing the help they need. People who may have significant health problems, at a time of great personal strain, must navigate a complex and ever-changing labyrinth of services and supports."*¹

Collaboration among service providers is a key component of trauma-informed services.²

Few organizations have the resources to offer *all* the services that clients need under one roof.

Many of the health and social services needed by women who have experienced trauma function as parallel programs with their own sources of funding and leadership. Differences among programs (e.g., differing eligibility requirements, hours of operation, and locations) can create barriers for many women. Those who are already facing multiple challenges must navigate a complicated recovery path to access support from multiple service providers. Without linkages among needed services, the continuity and consistency of a woman's care can be undermined. Service planning may be disjointed and women may experience significant service gaps, and/or receive services that are contradictory and counter-productive.³

Creative linkages can supplement and complement programs, building on their strengths and compensating for gaps.

Before linkages can be developed, it is necessary to know what resources exist in the community. To forge successful working relationships with other organizations, service providers need to understand and be sensitive to the requirements and cultures of potential partners. In Ontario, many communities have service provider groups and networks (e.g. LHIN planning groups, networks) which provide a natural platform for linkages and collaboration.

When service providers work together, they can significantly improve the quality of care that a woman receives.

Collaboration can result in more effective services across the continuum of care. It can facilitate seamless referrals or shared-care, and can reduce the need for a woman to re-tell her story repeatedly. It can also help staff to broaden their knowledge and skills.

Collaboration can also help to use organizational and system resources more effectively.

The benefits of approaches that are integrated among sectors and disciplines (e.g. crisis intervention, substance use and mental health services, trauma-specific services, parenting supports, housing, and healthcare) have been identified in the *Women, Co-occurring Disorders, and Violence Study*.⁴

Collaboration and partnership strengthen trauma-informed responses

Linkages with allied services are especially important in trauma-informed practices, given the array of impacts that trauma can have on a person.

For example, a woman who needs help with trauma and substance use issues may also need access to ancillary services such as income security, housing, parenting and children's services, primary health care services, mental health services, and culture-specific services.

Collaboration and partnerships between substance use service providers and other sector services have become common practice.

Service providers have been very creative in developing an array of strategies to work together across sectors—strategies that respond to community needs and use the assets and resources of the community most effectively.

Collaboration occurs in a system context.

Collaboration must be supported by government policies, planning groups, and system structures that emphasize system perspectives. See **Section 11 Trauma-Informed Practices at the System Level**.

Examples of collaboration and partnership

The following examples profile three successful collaboration strategies that are currently being used in Ontario:

Example 1 — The Ontario Woman Abuse Screening Project

The Ontario Woman Abuse Screening Project is a collaboration of over 150 organizations and programs in the mental health, addiction, woman abuse, sexual assault, child protection and allied sectors, as well as women with lived experience, in twelve Ontario regions.

The initiative has helped groups of service providers in communities across Ontario to promote awareness of effective practices in working with women who have experienced trauma, problematic substance use, and mental health issues. Groups of service providers work together in each community to develop and deliver cross-training to their staff, share knowledge, and create linkages.

The project is working toward making 'every door the right door', so that women can connect with the services they need, and service providers have a better understanding of the interrelationship of woman abuse, sexual assault, trauma, mental health, problematic substance use and child protection issues.

Example 2 — Toronto Drug Treatment Court Program

Women who are involved with the Toronto Drug Treatment Court Program, led by the Centre for Addiction and Mental Health (CAMH), have experienced the added impact of multiple arrests and incarcerations and the stigma of being ‘criminalized’.

To meet their needs, the Program has developed a partnership with Woman’s Own Withdrawal Management Centre and with housing providers that have mandates to serve women. A committed group of representatives from women and children-serving organizations hold membership on the Women and Children Sub-Committee of the Program’s Community Advisory Council.

The program is actively developing a women’s stream that provides women-only primary therapists, female peer support workers and women-only early recovery groups.

Example 3 — The Jean Tweed Centre

The Jean Tweed Centre has built collaborative working relationships with child protection agencies and other service providers in the Toronto area. The collaboration has generated cross-training and consultation opportunities, and has informed the development and ongoing implementation of practice guidelines between substance use services and Toronto child welfare agencies.

The collaboration has also helped child welfare agencies gain a greater understanding of how trauma-informed practices and harm reduction approaches can be used to provide tailored supports for mothers with substance use, mental health, and trauma-related concerns.

GUIDELINES for DEVELOPING CROSS-SECTOR LINKAGES

GUIDELINE #49

The organization cultivates collaborative and partnering relationships with providers of allied services (e.g., mental health, other health care, services that have expertise in working with specific populations, child welfare agencies, parenting organizations, violence against women services, social services agencies, housing providers, shelters).

Suggested indicators:

- The organization seeks input from women with ‘lived experience’ about women’s needs for ancillary services, and how it can help to facilitate access and connections with those services.
- The organization works with other community service providers to create mechanisms for service coordination and collaboration (e.g., LHIN planning groups, local networks).
- The organization seeks opportunities to make services more accessible and culturally competent (e.g., through outreach, co-facilitated programs/services, co-location of services).
- The organization’s agreements to collaborate and partner with allied service providers reflect the principles for trauma-informed practices.
- The organization regularly evaluates its success in developing linkages, and collaborative/partnering relationships.

Endnotes

See Appendix B for full reference information

¹ National Treatment Strategy Working Group, 2008

² Poole, 2011

³ Center for Substance Abuse Treatment, 1997

⁴ The Women, Co-occurring Disorders, and Violence Study, available online at <http://www.nationaltraumaconsortium.org/documents/CreatingTraumaServices.pdf>

Section 11:

System Level Trauma-Informed Practices

Goal of Section 11

To identify the system-level benefits of trauma-informed practices, and the strategies and supports needed to support them at the system level

Ontario's service system

The province of Ontario is large, its population is diverse, and its communities vary significantly in size, character, and resources (from large urban centres to small cities or towns, and rural, remote, or isolated communities). Ontario, like many jurisdictions, is taking steps to strengthen its system approach to health care. Across the province, there is considerable variability among substance use services with respect to program models and requirements; organizational structures and cultures; philosophies; and resource bases. As a result, women may encounter significant differences in how their needs are addressed from one community or service to another.

Some organizations provide specialized, women-only, gender-specific services, while others have developed gender-specific program components for women within mixed gender programs. In some parts of the province, gender-specific services are unavailable or not readily available; however women can access services in 'co-ed' settings and in programs designed for both women and men. For some women, being in a 'co-ed' facility or receiving services from male staff (e.g., counsellors, night staff) reduces safety and is retraumatizing.¹

For others, mixed gender programming does not provide opportunities to address women's critical recovery issues and concerns.

In remote and isolated areas, both women and men can encounter challenges in accessing services. Significant and long-standing issues include: insufficient resources; restricted training opportunities; and limited numbers of personnel who have specialized knowledge and skills in the areas of women's services, substance use, and trauma.

There is also considerable variation among services for women (and men) who have concurrent substance use and mental health issues. In some areas of the province, mergers of substance use services and mental health services have created opportunities for integrated or coordinated services. Many of the substance use service providers that have not merged with mental health organizations are actively working to be 'CD capable'² and to create linkages with mental health organizations.

Notwithstanding the variations in Ontario's system, substance use services are unified in their shared commitments to evidence-based practices.

This commitment is supported by government direction. Several system-wide tools have been developed by the Ontario Ministry of Health and Long Term Care and by sector groups and associations to support consistent services, for example:

- provincial service definitions
- assessment and treatment planning tools
- provincial guidelines for women's services
- sector standards for withdrawal management and other service types
- data systems that support management of information about service availability (Connex) and utilization (through Datis).

Like other system-wide tools, these guidelines for trauma-informed practices can and should be used across the entire substance use service system.

Some service providers may encounter challenges in implementing all of the guidelines. Reconsidering organizational and clinical practices through a ‘trauma-informed lens’ requires an investment of time and resources.

These Guidelines are intended to help organizations implement trauma-informed practices immediately and, where barriers are identified, to help organizations overcome them. Where barriers prevent full implementation, service providers should be creative in finding solutions that will support the fullest possible achievement of each guideline. In these situations, they may find it helpful to document the difficulties they encounter.

Evidence of positive impacts

Evidence demonstrates that trauma-informed approaches can generate numerous benefits:

- **Trauma-informed, integrated services are cost-effective**—because trauma-informed integrated services have improved outcomes, but do not cost more than standard programming, they are judged to be cost-effective.³
- **Trauma-informed practices can lead to a decrease in the use of crisis-based services**—some studies have found decreases in the use of intensive services such as hospitalization and crisis intervention following the implementation of trauma-informed care.⁴

Service providers report positive outcomes in their organizations.

These include:

- greater collaboration with [women who have experienced trauma]

- a greater sense of self-efficacy among clients
- enhanced staff skills
- more collaboration within and outside their agencies
- improved staff morale
- fewer negative events
- more effective services.

The findings of the Women, Co-Occurring Disorders and Violence Study have also demonstrated multiple benefits of trauma-informed care.

These benefits include:

- When integrated models that were trauma-informed and financially accessible were provided, women with complex co-existing problems experienced reductions in trauma symptoms, drug use severity, and mental health symptoms.
- Integrated counselling in a trauma-informed policy and service context was found to be more effective than ‘services as usual’.
- The quality of the work improved when consumers, providers, and system planners were included in all aspects of the policy design, implementation, and evaluation of services.
- The costs of providing such integrated care were not higher than providing ‘service as usual’.⁵

Trauma-informed practices in the broader system of care

Women who have substance use problems may seek help from a variety of primary health or acute care services.

Since all types of health services may be entry points for substance-involved women, all should be trauma-informed. Poole and Urquhart emphasize that the entire system needs to “move toward a holistic, instead of a closed or narrow understanding of the intersections (of trauma and substance use).”⁶

“Every health care service should be sensitive to the impacts of trauma. Substance-involved women should be able to access such services regardless of which “door” they enter or whether they ever find their way to a trauma-specific treatment program.”⁷

A system of care in which there is wide-spread use of trauma-informed practices can improve the quality of services. For example:

- A woman’s care can be coordinated across a range of services, and each member of her care team shares a commitment to trauma-informed practices
- All members of the team, including the woman, are clear about what services will be provided, by whom, and in what way—she does not receive contradictory information, advice, or services.
- She has continuity of care and support during wait times for specific services.
- Information is shared (with informed consent) when needed, so she has no need to repeat her story over and over again—her team understands information, tools, and processes used in different services and develops complementary approaches where possible.

Commitment to system-level change

Health care and other sector services operate in the context of policy and planning at local, regional, and provincial system levels.

Implementation of trauma-informed practices across substance use services, and in a broad range of health and social services, will require leadership, clarity, and commitment from those responsible for system development, management, and oversight.

Experts recommend a system-wide commitment to trauma-informed practices that is supported by:⁸

- policy and/or position statements that identify trauma as a priority health issue, and ongoing, high-visibility leadership among policy makers, system planners, and funders
- a clear commitment to the use of trauma-informed practices in government-funded service systems
- support for training (in trauma-informed practices) that engages multiple service systems (substance use, mental health, other health care, criminal justice, social services), and promotes coordination among those systems
- participation of women with lived experience in system planning, oversight, and evaluation, including strategies to improve access and accountability for services
- resource allocation strategies and funding criteria that target the development of a trauma-informed service system, including implementation of evidence-based and promising practices
- dissemination of clinical practice guidelines that reflect evidence-based practices
- policies, standards, quality improvement tools, and contracting mechanisms that respect client preferences, privacy, and rights, and that help to reduce or eliminate potentially retraumatizing practices
- collection of data that can inform ongoing planning and quality improvement processes, including:
 - the prevalence and impacts of trauma
 - client needs, utilization of trauma-informed and trauma-specific services, and satisfaction

- measures to assess the effectiveness and impacts of trauma-informed and trauma-specific services
- evaluation and research activities to determine effectiveness of system change on trauma-informed practices.

Endnotes

See Appendix B for full reference information

¹ This was reported by women who participated in focus groups held for this project; see **Section 3**.

² The term 'CD capable' refers to substance use services that have developed the capacity to assist people who have both substance use and mental health problems. The term 'CD capable' does not necessarily indicate trauma-informed practices.

³ Domino et al., 2005

⁴ Community Connections, 2002

⁵ Poole & Urquhart, 2009

⁶ Ibid.

⁷ Rosenberg, 2011

⁸ Blanch, 2007

Section 12:

Introduction to Trauma-Specific Services

Goal of Section 12

To provide basic information about the types of programming used to deliver trauma-specific services, the staff knowledge and expertise required, and assessment processes for those services

This section provides basic information about specialized trauma-specific services.

It is not intended to offer the level of detail or the specific guidelines found in this document in respect to trauma-informed practices, which should be implemented across the entire substance use services system. Not all substance use service providers will implement more specialized trauma-specific services.

The purpose of this section is to help organizations that are considering whether to develop trauma-specific services.

To make that decision, organizations will need to engage in considerable research, assessment of current capacities, evaluation of potential models and approaches, planning, and development and training activities. The introductory information in this section includes:

- goals, and clinical approaches and models used, to provide trauma-specific services
- specialized skills and knowledge required to deliver trauma-specific services
- models and approaches used in trauma-specific services.

Appendix C provides examples of trauma-specific models and approaches, for those who are interested in further reading and exploration.

“Practitioners assume that when a trauma has occurred, it changes the rules of the game. [A woman who has experienced trauma] constructs a sense of self, a sense of others and a belief about the world that incorporates, and is in many cases based on, the horrific event or events. This then informs other life choices and guides the development of particular coping strategies. The impact of trauma is thus felt throughout [a woman’s] life in areas of functioning that may seem quite far removed from the trauma, as well as in areas that are more obviously connected to the trauma.”¹

What are trauma-specific services?

Trauma-specific services are interventions that are designed to facilitate recovery from both problematic substance use *and* traumatic life experiences in an integrated manner.

In providing trauma-specific services, substance use service providers must ensure that:

- services respect a woman’s rights and needs to be informed, connected and hopeful about her own journey
- the interrelationship between trauma and trauma responses such as problematic substance use, eating disorders, depression, anxiety, and self-harm are understood and acknowledged
- each woman has given informed consent to participate in trauma-specific services
- the service provider works in a collaborative way with each woman, significant others in her life, and other human service organizations, in a way that will empower her.

What organizational groundwork is needed?

Before an organization can consider developing *trauma-specific* services, the following key elements must be in place:

1. The organization has **implemented** the trauma-informed practices that have been laid out in these Guidelines. See **Appendix A** for a list of all guidelines.
2. Staff who will deliver trauma-specific services have **specialized knowledge and skills**. See **Section 8** for more information about staff competencies and workforce development.
3. Counsellors and other direct service staff have regular, frequent, and ready access to **clinical supervision and consultation** from a clinical supervisor who has a thorough knowledge of both trauma-specific interventions, substance use services, and related areas of concern such as mental health, eating disorders, or self-harm.
4. The organization has researched **evidence-informed trauma-specific models** and approaches and has identified those that best match the needs of clients and the goals, capacities, and culture of the organization.
5. The organization has assessed its capacity to implement and support the preferred model(s) or approach(es), and has identified the steps it will need to take to **overcome gaps and barriers**. Should an organization not have the capacity or resources to implement *trauma-specific* services, it may consider developing a partnership with another organization that has significant expertise in this area.
6. The organization has enlisted the input of staff and of **women with ‘lived experience’** to develop a plan for implementing the preferred model or approach.

Staff competencies

Universally accepted best practices have not yet been established for the specialized knowledge and skills required to deliver trauma-specific service.

However, the International Society for Traumatic Stress Studies has developed an initial document to discuss best practice parameters; that document can be found at www.istss.org. Additional work done by Weine et al ² has identified core curriculum elements to be used in training counsellors who will work with women who have experienced trauma.

Counsellors who will provide trauma-specific services should have the following essential skills and knowledge:

1. In addition to a solid grounding in counselling skills and approaches, counsellors require knowledge of the many possible **types of traumatic events** and the potential emotional, behavioural, cognitive, and somatic responses to those events.
2. Counsellors must have the skills required to **assist women to manage** a wide range of trauma responses (e.g., grounding strategies).
3. A thorough understanding of problems related to substance use, the recovery process and the **interrelationship** with experiences of trauma is essential.
4. Counsellors require the ability to conduct assessments in a **paced and sensitive** way.
5. They must be able to help women with **safety planning**, including making plans for themselves and, when needed, for the care and safety of their children.
6. Counsellors must be able to work within a **strengths-based** framework, which acknowledges and builds upon women’s strengths and assets.

7. Counsellors must be able to draw upon an **array of therapeutic interventions** to utilize those that best support a woman, and recognize that while certain approaches (such as cognitive behavioural strategies) are well suited for many clients, they may not be suitable or helpful for every woman.
8. If the organization offers group services, the counsellor will have the ability to **facilitate trauma-specific groups**.
9. Because responses to trauma may be shaped by culture, ethnicity, sexual orientation, class/social status, and many other influences, counsellors must be **sensitive and responsive** to these factors in forming a working alliance with women.

“Helpers must also appreciate that the crisis of trauma and its resultant suffering may result not only in damage and demoralization, but for some, result in increases in resilience, personal meaning-making and transformation, and post-traumatic growth.”³

Working with women who have experienced trauma makes unique emotional and coping demands on counsellors.

Counsellors will need to be committed to self-care, and should have the skills to deal with the impacts of the stress that can result from this work. In addition, they will require a commitment to active participation in clinical supervision and an ongoing examination of the transference and countertransference issues that may emerge.

Workforce development

Hiring qualified staff may present challenges for some organizations.

Although Courtois and Gold advocate for the inclusion and integration of basic information about trauma to be addressed through academic training, beginning at the undergraduate level, this rarely occurs.⁴ Few professional training programs for counsellors include training about trauma and the integrated treatment of trauma and problematic substance use despite the prevalence of trauma among women who have substance use problems.

There is little specific training about integrated practices to address trauma and substance use in formal education programs.

As a result, counsellors who want to provide trauma-specific services must seek out specialized courses, workshops, and other training opportunities to acquire the necessary skills and expertise. When hiring qualified counsellors, an organization may need to assess how well a candidate’s training, skills, and academic qualifications meet their requirements.

Education and training is recognized as a key component of trauma-specific care

Organizations that have adopted trauma-informed practices have committed themselves to providing the training needed for all staff to be trauma-informed, and have provided specialized training and supervision for staff who provide trauma-specific services.⁵

See **Section 8** for more information about staff competencies and workforce development.

What factors affect responses to trauma?

Responses to trauma can vary considerably from person to person; they are “influenced by a complex matrix of biological, social, temperamental, and experiential issues.”⁶

Research is being conducted to understand the complexity of responses to traumatic experiences.

An individual’s experience of a traumatic event and the ability to recover can be influenced by an array of risk factors and protective factors, including:

- biology, physiology and genetics
- temperament
- age and developmental level
- attachment history
- prior life events, including other experiences of trauma and adaptations to them
- contextual and situational factors such as culture
- the availability of support following the event.

Responses to trauma can also be affected by factors such as the type, severity, duration, and complexity of traumatic experiences, including the following:

- trauma that takes place in private and is hidden or secret (e.g. physical and/or sexual abuse), especially when it involves young vulnerable children
- trauma that results from the betrayal of trust by a person in a position of trust and authority
- abuse or other trauma that is repeated, prolonged, and/or chronic
- the lack of support or validation following disclosure of abuse, especially when the woman who has experienced trauma is shamed, blamed, or isolated.⁷

What is Post Traumatic Stress Disorder (PTSD)?

Many women who have experienced a traumatic event or events develop post traumatic distress reactions and may be diagnosed with Post Traumatic Stress Disorder (PTSD). Najavits uses plain language to explain the meaning this way:

post = after;
traumatic = trauma;
stress = anxiety;
disorder = reaction⁸

Najavits also provides a brief checklist for women to help them to identify PTSD.⁹ She also makes the link between trauma and substance use and notes that PTSD is one of the most common diagnoses seen among women seeking support for their problems with substance use.

What is complex trauma?

The concept of ‘complex trauma’ initially grew out of an increased understanding of the long term impacts of child abuse.

However, in the last several years, clinicians and researchers have recognized complex trauma relative to the long term impacts of trauma experienced by adults, as well as children. Women may experience complex trauma in family or other intimate relationships, as well as in catastrophic situations, such as ongoing armed conflict and combat, prisoner of war experiences, and the displacement of populations through ‘ethnic cleansing’, refugee experiences, and through human trafficking and prostitution.¹⁰

Courtois identifies stressors that are frequently associated with complex trauma:¹¹

- abuse or other traumatizing experiences that are repetitive, prolonged, or cumulative
- interpersonal experiences of trauma that involve direct harm, exploitation, and maltreatment including neglect, abandonment,

and/or antipathy by primary caregivers or other ostensibly responsible adults

- traumatic events that occur at developmentally vulnerable times in the woman's life, especially in early childhood or adolescence, but can also occur later in life and in conditions of vulnerability (such as disability, disempowerment, dependency, age, and infirmity).

The experiences associated with complex trauma tend to be chronic rather than acute (occurring once or rarely) and often increase in severity over time.

The betrayal of trust associated with such abuse can lead to great difficulty in emotional development, personal identity, and relationships with others. When complex trauma is rooted in childhood experience, the consequences are often particularly severe because a child is physically and psychologically immature.

A fulsome discussion of the current theories and research into complex trauma and diagnostic criteria is not within the scope of this document. The reader is encouraged to learn more from additional authoritative sources, such as Courtois, C.A. and Ford, J.D. (Eds.) (2009) *Treating Traumatic Stress Disorders: An evidenced-based guide*. New York: The Guilford Press, or van der Kolk, Bessel A. (2001) "The Assessment and Treatment of Complex PTSD." Chapter 7 in *Traumatic Stress*. Yehuda, Rachel, Ed. American Psychiatric Press.

When a woman is viewed exclusively through the lens of a diagnosis and without considering the impacts of trauma, there is a risk that medications will be prescribed inappropriately.

Nonetheless, some women benefit enormously from medications to address problems such as sleep problems, depression, anxiety, or self-destructive feelings or thoughts. According to Van der Kolk, the beneficial purposes of medications are:

- reduction of frequency and/or severity of intrusive symptom
- reduction in the tendency to interpret incoming stimuli as recurrences of the trauma
- reduction in conditioned hyperarousal to stimuli reminiscent of the trauma, as well as in generalized hyperarousal
- reduction in avoidance behaviour
- improvement in depressed mood and numbing
- reduction in psychotic or dissociative symptoms
- reduction of impulsive aggression against self and others.¹³

*"For so long I didn't know what was going on. So many diagnoses. I never felt I fit those categories, but this feels right."*¹²

How are trauma-specific services provided?

Trauma-specific services are provided based on a three phase recovery model:

- Phase 1 – Safety and Stabilization
- Phase 2 – Remembrance and Mourning
- Phase 3 – Reconnection

Trauma-specific services can be delivered in phases that are aligned with the model.

All three phases of services can be delivered in a group, individual counselling, or a combination of those modalities. Many women find that group work helps them to recognize that they are not alone and provides a safe place in which to build trust. It is not unusual for women to prefer to process memories of traumatic experiences in individual counselling. Many women find that the combination of individual and group work is the most beneficial.

Group work goals

The goals of groups in each phase vary according to the focus of work; however, the following are common to all three phases of trauma-specific group work: ¹⁴

- promote safety
- enhance self-care
- contextualize women's experiences especially as they relate to substance use and the inter-relationship with trauma
- enhance self-efficacy
- validate women's experience
- promote sharing of expertise
- provide opportunities to connect with and learn from other women
- decrease shame
- increase mutual support
- demonstrate and create sensitivity to cultural perspectives.

Group work opportunities and responsibilities

During all three phases of group work, counsellors collaborate with women to pursue the following opportunities:

- build safety, trust and group cohesion
- attend to recovery from substance use and trauma
- attend to other health or mental health needs which may affect a woman's participation
- develop cognitive, emotional, and behavioural skills and strategies to promote safety and increase distress tolerance and affect regulation
- identify risks to safety and plan strategies to address risks (people, places and things)
- identify, name, and express feelings
- enhance interpersonal relationships through the dynamics of the group
- use cognitive-behavioural strategies to address persistent self-critical thoughts and beliefs, and distressed mood
- use relaxation and stress management strategies to cope with tension and stress
- increase awareness of how feelings and thoughts are experienced bodily
- use strategies such as mindfulness and relaxation to promote the development of self-awareness and attention to the impact of thoughts and mood on body and behaviour
- develop and practice effective self-care plans
- examine the impact of trauma on family and other relationships
- increase awareness of how other issues such as problems with eating, shopping, or gambling may be a substitute for substance use, or avoidance of difficult feelings or memories
- increase supports and develop plans to cope with triggers to use substances or engage in other high risk or self-harming behaviours
- create meaning and hope.

Pacing in trauma-specific services

Pacing is critical to safety.

Counsellors who are providing trauma-specific services must maintain awareness of the trauma reactions that an individual woman is experiencing and her ability to manage those reactions, and adjust the pacing of group and individual work accordingly. For example, it will be important to know whether a woman experiences intrusive memories, nightmares, or dissociative episodes. Is she able to find ways to deal with intense emotions or triggers to use substances?

Since the impacts of trauma are often complex and far reaching, a woman's trauma reactions may not be obvious or easy to identify.

The counsellor must have great sensitivity to the many ways in which trauma has affected her inner world and defenses.

The phases of trauma recovery

Although the model conceives of recovery work occurring in phases, it is important to realize that few women make their way through recovery from trauma in a linear way.

Judith Herman, one of the early proponents of this model for trauma recovery, cautions that the identification of phases is “an attempt to impose simplicity and order upon a process that is inherently turbulent and complex.”¹⁵

Phase One: Safety and Stabilization

The focus of therapeutic work at this phase is safety and stability.

The nature and extent of this work varies from woman to woman; identification of the assets and areas requiring skill development and knowledge require careful assessment. Cultural issues are equally significant factors to understand and appreciate, since they bring particular nuances to a woman's needs in recovery.

Phase One work involves:

- building internal and external safety
- forming a therapeutic alliance
- recognizing the interrelationship between responses and trauma
- building on strengths and developing skills for self-care
- increasing the ability to tolerate affect
- learning effective self-soothing
- developing skills to deal with self-harming behaviours such as substance use, eating too much or too little, risky sex
- increasing supportive resources and connections
- attention to present circumstances and experiences.

Establishing safety and stability requires that the counsellor explore with a woman all aspects of her life and thoroughly understand the support she may need to address fundamental concerns such as housing, food, finances, or care for her children.

Women who have experienced trauma may underestimate risks to their well-being.

A counsellor's help may be required to identify risks and access services to address basic needs. Counsellors should help each woman develop both short-term and long-term safety strategies and review those strategies regularly. Cooperation with other service providers should assist to ensure a collaborative approach in supporting women with their recovery and with associated concerns.

Women who have experienced trauma may be involved in relationships that are harmful or dangerous.

This may be either a re-enactment of the abuse or a form of self-punishment. Counsellors should help women to identify unsafe relationships and work towards safety, and freedom from abusive relationships.

Helping a woman to establish safety and stability involves addressing self-harming behaviours such as substance use, cutting or burning, eating more or less than is healthy, or risky sexual behaviour.

Recognizing how these behaviours may have served a woman—to self-soothe, to create a numbing or heightened emotional state, or reduce stress and tension—will be part of the work in Phase One. It is important to understand and name these behaviours as strategies that a woman has used to manage the impacts of trauma. The counsellor’s task will be to respectfully engage with her about how these behaviours have helped her and how they now place her at risk, and to support her to identify and develop alternative ways of dealing with overwhelming feelings or other trauma reactions.

It is essential for counsellors to be sensitive to cultural dynamics.

Specific cultural practices or beliefs may form important aspects of a woman’s worldview and shape what she will experience as safe. For example an orthodox Jewish woman may not be able to access a shelter if kosher food is not available. An Aboriginal woman whose background includes inter-generational trauma may benefit from aboriginal services to support her recovery.

One of the greatest tasks of therapy is to learn to tolerate and nurture feelings.

Women who have been traumatized often have great difficulty paying attention to inner sensations and perceptions and, when asked about these, can become overwhelmed or deny awareness of their inner experiences. Learning that it is safe to have feelings is a significant task. A woman needs to believe that she can depend on herself and that she can acquire and use skills that will keep her safe and stable.

There may be times throughout all phases of trauma recovery when overwhelming feelings or other trauma reactions return and present a threat to stability and safety.

The counsellor’s task is to collaborate with a woman to develop a service plan that fits her needs and

abilities, including her variable needs for support. If a woman wants to participate in the next phase of trauma-specific treatment, in which more direct work with painful memories and affect will take place, the counsellor should work with her to assess her emotional and cognitive capacities to manage more intensive trauma work.

“Because the tasks of the first stage of recovery are arduous and demanding, patient and therapist alike frequently try to bypass them. It is often tempting to overlook the requirement of safety and to rush headlong into the later stages of therapeutic work. Though the single most common therapeutic error is avoidance of the traumatic material, probably the second most common error is premature or precipitate engagement in exploratory work, without sufficient attention to the tasks of establishing safety and securing a therapeutic alliance.”¹⁶

Phase Two: Remembrance and Mourning

In this phase of recovery from trauma, a space is created for women to tell their stories about their experiences of trauma and begin to integrate those experiences.

The process of telling the story of her trauma experiences makes it possible for a woman to acknowledge those experiences as part of her own narrative, rather than as intrusive memories and disconnected affect. The work of this phase includes opportunities to grieve and mourn the losses, despair, and sadness related to having experienced trauma; some women begin to envision and create a future with hope. Safety remains an integral focus.

*"I started using drugs and alcohol, or anything I could get my hands on, when I was thirteen. I found it was the only way that I could deal with my mom's temper, and it took the edge off of the anger and sadness, but now I'm really messed up, and find that the memories are still there and so are the feelings I had when I was thirteen, but I'm forty-two."*¹⁷

Phase Two work involves:

- addressing the impact of traumatic experiences
- processing and integrating traumatic experiences
- grieving and mourning
- deconstructing negative beliefs
- developing alternative belief systems that are life enhancing
- addressing and working through post-traumatic responses
- understanding that they did not 'cause' the abuse, and placing responsibility for abuse where it belongs

- attending to the intense relational aspects of the therapeutic relationship
- maintaining a focus on safety and stability internally and externally.

Counsellors must never underestimate challenges that a woman can experience in retrieving memory.

Since memory is profoundly affected by traumatic experiences, a woman's stories about what happened may emerge in a disconnected, fragmented, or confusing manner. Often, experiences of trauma are not remembered as a whole story, but are stored "in mind and brain as images, sounds, smells, physical sensations, and enactments."¹⁸

The counsellor should have knowledge about how memory is affected by trauma.

The process of recovery involves coming to terms with what can be remembered and accepting that this may not be the whole story. The counsellor's task is to assist the woman to gather the fragments and ambiguities and to hold them tenderly while she works to create the whole of her experience.

Grief and loss are integral aspects of this phase of treatment as a woman faces the losses she has experienced.

For example, a woman who has experienced abuse in childhood may mourn the loss of her innocence and stability as a child; she may also find it difficult to face the reality that her parents, or others in a position of power and authority, were abusive or neglectful. Grief about her losses can be deep and profound and may lead to a time of less emotional stability which will require compassion and work to restore safety.

Traumatic experiences are a violation of the self; as such, they can affect the ability to form healthy attachments and engage in safe trusting relationships.

Difficulties with relationships and boundaries can emerge in powerful ways in many relationships, including the therapeutic relationship. Some women may have rigid boundaries that leave them unable to

connect with others in meaningful ways; others may have difficulty establishing the necessary boundaries to appropriately protect them from unsafe people and relationships.

The counsellor should help a woman to learn about healthy boundaries.

Counsellors work with her to identify characteristics of others which are exploitative or potentially abusive. Some women test the counsellor's boundaries; for example, a woman may repeatedly ask her counsellor for her home phone number and find it very difficult to understand the limits of the counselling relationship. Responding with clarity, respect, and compassion to such testing is important, as a woman is learning about new ways of being in a relationship which permits both closeness and autonomy.

Providing trauma-specific services can present many challenges to the counsellor.

Attention to the unique transference and countertransference aspects of the therapeutic relationship is required; for example, counsellors may be confounded by some questions posed by women who have experienced trauma, such as a question from a woman about whether or not the counsellor believes what she has said about her experiences of trauma.

"Safe, self-reflective disclosure of traumatic memories and associated reactions in the form of progressively elaborated and coherent autobiographical narrative is the primary task of this phase." ¹⁹

The counsellor will need to be aware of the possibility that such a question may have multiple meanings. The question may be rooted in messages from her past which minimized or denied the trauma, but it may also reflect her uncertainties about her memory or her experiences of dissociation. Counsellors must

be sensitive to the multiple possibilities which emerge out of questions such as these and manage her own reactions to a woman's experiences.

See **Section 7** for additional information about the therapeutic relationship.

Two sources of in-depth information about transference and countertransference are:

- Pearlman Laurie Anne and Saakvitne Karen W. (1995). *Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors*. New York: W.W. Norton & Company ²⁰
- Chu, James A. (1998). *Rebuilding Shattered Lives: The Responsible Treatment of Complex Post-Traumatic and Dissociative Disorders*. New York: John Wiley & Sons, Inc. "Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors" and "Rebuilding Shattered Lives: The Responsible Treatment of Complex Post-Traumatic and Dissociative Disorders." ²¹

Phase Three: Reconnection

In this phase, the woman attends to her ongoing recovery, with a particular focus on reconnection with her whole self—mind, heart and body.

This includes meaningful social reconnection and the restoration of meaning and hope. The work is present- and future-oriented and includes:

- fuller integration of the traumatic experiences, so that they no longer have the same hold over her everyday life
- a commitment to move forward with her life in ways that are meaningful for her (for example, to seek stable housing or make a commitment to a healthy diet, or work towards regaining custody of her child(ren)—other women may pursue educational or employment goals)

- evaluation of future possibilities for a life free from the hold of trauma
- confidence in her ability to be safe and make choices for her life from a place of freedom
- developing resilience to deal with unexpected life challenges
- connecting or reconnecting with spiritual beliefs and cultural groups
- the possibility of participating in her community in meaningful ways (for example, joining a parenting group or a yoga class at the local community centre)
- considering the possibility of joining with others to address social and political realities that contribute to the abuse of others.

As women move into this phase of work, they are increasingly able to move forward with their lives in integrated ways.

The goal is for the experiences of trauma to recede into the background, rather than intruding into their day-to-day experiences. Women may begin to feel more vibrant and open to new possibilities for their lives. For example, a woman may make a commitment to finding a new home which reflects her commitment to herself and the changes she is making. Others may look for employment, work towards reconnecting with their child or children, make a commitment to healthy meals, or possibly return to school in order to pursue educational or vocational goals.

Women observe that they feel empowered when they are able to make choices for their lives which are intentional and achievable.

Increasingly women will be able to reflect on themselves, their experience, and their future with hope.

Although women may encounter new challenges or struggles, they generally have confidence in their abilities to navigate these successfully.

The counsellor supports a woman's confidence in her ability to meet new challenges—at the same time, the

counsellor should reinforce the importance of seeking help and support, when needed. Some women will find it helpful to connect with the counsellor—for example, in a booster session—knowing that it is a sign of strength to recognize when help is needed.

In Phase Three, a woman may benefit from couple or family therapy.

This will assist her in restoring or building couple or family relationships. Many women also find it helpful to use expressive and art therapies in this phase of their recovery.

Group work is especially effective and helpful at this stage.

Connections to and linkages with community resources are needed to assist women address the changes they are envisioning and making. Peer led groups can be valuable as women transition to greater independence and strength.

Assessment for trauma-specific services

Linking women with a trauma-specific service requires assessment of the nature and severity of the traumatic events, the effect of these events, present responses related to the trauma, and acknowledgment of the relationship between the trauma and problems with substance use.

An assessment for trauma-specific services should build on safety and trust that is established with a service provider.

The assessment process should enable the woman and the counsellor to develop a shared understanding of the role that trauma has taken in shaping her life and an appreciation of her resources, skills, strengths and coping strategies. The assessment process also helps to identify how some trauma responses and adaptations may have hindered her development. For example, a woman who was raped repeatedly as a child may have coped with that trauma by dissociating. But at a later point

in her life, when she is safe from that assault, dissociation may interfere with her ability to be present, and may result in negative consequences.

The assessment process should be a collaboration between a service provider and a woman.

The counsellor's task includes providing information about the three phases of treatment and making it clear that safety is the essential foundation for therapeutic work to address trauma and substance use. A woman needs to understand that progress through these phases, while not a linear process, always begins with Phase One. She will also need to know that each woman's journey is unique and that there is no 'right' way to work through the ways she has been affected by trauma and substance use. It may be helpful to point out that some women find Phase One services to be the most helpful and decide against participation in Phase Two or Three services. Assure her of the commitment to developing a plan, together with her, that meets her needs and supports her.

The counsellor needs to convey clear information about trauma-specific services offered by the organization.

The counsellor will establish a clear understanding of which phase of treatment is being considered. The woman is invited to share her experiences, to the best of her ability, and work with the counsellor to identify her needs for services, as well as any other resources she may require. When collaborating with other organizations involved in the woman's life, the counsellor should ensure that she has given informed consent and is clear about the specific information that will be shared.

Assessment for Phase One services

The purpose of the Phase One assessment is to prepare women for their journey of recovery from traumatic experience.

The counsellor emphasizes that the focus of this phase is to work towards establishing safety and stabilization and that this means the emphasis will be

on self-care, safety planning, information about the link between trauma and substance use, education about the after-effects of trauma, expanding coping strategies, such as grounding techniques to deal with emotions, and support to deal with difficult situations or crises.

The counsellor should explain that Phase One work does inquire about the specifics of her trauma experiences.

The counsellor also will explain that this is necessary so that she will achieve an understanding that the trauma experiences are a part of her life, that this has adversely affected her life, and that her substance use may be interconnected with trauma. It is especially useful at the assessment phase to let women know that the counsellor and the organization understand that trauma and substance use are known to be strongly linked and a frequent experience among the women served.

*"For a [woman] to participate in trauma-specific services, [she] must be aware of a trauma history and recognize current symptoms as sequelae of that trauma."*²²

The counsellor requires sensitive and finely-tuned assessment skills to inquire about trauma while, at the same time, helping a woman to avoid over-disclosure at this phase of assessment.

The counsellor should inform a woman that since Phase One services focus on safety and stabilization, the assessment will not be eliciting information about the details of the trauma. Containment can be a challenging issue at this juncture, since many women may never have had an opportunity to be heard and believed and they may find it difficult to have limits placed on the disclosure of their traumatic experiences. The assessment is therefore an opportunity to practice containment and grounding with the woman.

Assure the woman that it is not necessary to tell her entire story in order to receive services.

The counsellor should prepare the woman for the possibility that limits may be placed on the amount of disclosure about her traumatic experience(s) during Phase One group or individual sessions. It is helpful to inform the woman that speaking about her traumatic experiences in too much detail may be emotionally difficult; until she has first developed sufficient coping skills, disclosure of details may lead to destabilization, nightmares or increased substance use. Najavits points out that “[women] in early recovery are virtually always unaware of the full impact of talking about trauma.”²³ She suggests that questions such as “Does this feel safe to keep talking about?” or “How does it feel to tell me about this?” can be ways to assess for safety and assist with containment.²⁴ She adds that the counsellor has the primary responsibility for assessing for safety.

Assessment for Phase Two and Phase Three services

When a woman is being considered for participation in Phase Two or Phase Three services, a more detailed assessment is needed. The counsellor should:

1. **Prepare** a woman for the assessment by letting her know that the purpose of the assessment is to develop a mutual understanding of her trauma experience, at the pace she is comfortable sharing this information; to identify how she has been affected by the trauma; and to learn about her strengths and coping abilities. This groundwork will support a good decision about participation in Phase Two or Phase Three services.
2. **Reassure** the woman that, although the questions may be emotional and difficult, she has the option at all times not to answer them. The goal is to support her to receive the services she needs, and for her to feel in control.
3. **Use direct and straight-forward language** to avoid confusion and assist with naming and identifying problematic experiences. This is essential because women have often been taught to normalize or minimize sexual or physical abuse. For example, a woman may have been told that the sexual abuse she experienced as a child was part of her education, or that physical abuse was needed discipline for her ‘bad behaviour’.
4. **Assess a woman’s capacity to tolerate discussion** about the nature of the trauma; explore with sensitivity what happened, how she experienced it, how it has affected her, and her relationship with the perpetrator, without going into great detail.
5. **Ask about her current triggers** or stressors that are responses to the trauma, clarify what these are, and how she manages at these times. Assist her with concrete plans when needed.
6. **Inquire about her strengths** and coping strategies and assist her to consider how well they had served her in the past and if they are still effective. Are there ways in which they may be creating difficulties for her at present?
7. **Ask about her current recovery plans** for her substance use and her degree of confidence about the success of these plans.
8. **Ask about her social supports** and whether they are safe and trustworthy relationships.
9. **Remain sensitive** to all verbal and non-verbal cues that may indicate that the questions are creating distress of any kind. When needed, offer grounding and stabilizing support to create a renewed sense of safety and comfort. If needed, defer completing the assessment to another occasion.
10. **Inquire about involvement with other health care professionals** and ask if she is willing to give permission to contact them regarding mutual support for her recovery.
11. **Provide clear information** about the services that will be available for her at the organization and collaborate with her in developing a plan for her participation and care.

Next steps to develop trauma-specific services

This section has provided a basic introduction to the components and requirements of trauma-specific services. Organizations that are interested in developing trauma-specific services should undertake research to learn more about evidence-informed models and the resources required to implement them.

Several models have been developed and shown to be helpful for the treatment of women who have experienced trauma. They require specialized training and supervision. For additional information about models and training, refer to the websites of the International Society for Traumatic Stress Studies www.istss.org or the International Society for the Study of Trauma and Dissociation www.isst-d.org. A brief description of a variety of models is provided in **Appendix C**.

Endnotes

See Appendix B for full reference information

- 1 Harris and Fallot, 2001
- 2 Weine et al., 2002
- 3 Courtois & Gold, 2009
- 4 Ibid.
- 5 Van Wyk & Bradley, 2007
- 6 McFarlane & Yehuda, 1996
- 7 Courtois, 2004
- 8 Najavits, 2001
- 9 Ibid
- 10 Courtois, 2004
- 11 Ibid
- 12 Najavits, 2001
- 13 Davidson, & van der Kolk, 1996
- 14 Najavits, 2001
- 15 Herman, 1992
- 16 Ibid
- 17 Woman with ‘lived experience’ quoted in Klinik—Trauma-Informed Toolkit, 2008
- 18 Van der Kolk & Bessel, 2009
- 19 Courtois, 2009
- 20 Pearlman & Saakvitne, 1995
- 21 Chu, 1998
- 22 Harris & Fallot, 2001
- 23 Najavits, 2001
- 24 Ibid

Appendix A:

Summary of Guidelines

This Appendix provides a consolidated list of all the guidelines in the document.

Section 6 Guidelines: Trauma-Informed Service Practices

GUIDELINES for ACKNOWLEDGEMENT PRACTICES

GUIDELINE #1

Points of first contact are examined and are found to convey a trauma-informed approach.

Suggested indicators:

- The organization's website contains trauma-informed language and indicates that all staff engage in trauma-informed practices.
- All publically available written information about the organization has been reviewed to ensure that it contains trauma-informed language and indicators of trauma-informed practices.
- Voicemail messages and all initial phone contacts with women use trauma-informed language and indicators of trauma-informed practices.

GUIDELINE #2

Non-clinical staff who have first contact with women are supported to respond appropriately.

Suggested indicators:

- Training is provided to reception and other non-clinical staff to encourage them to understand the links between substance use and trauma.
- Scripts are developed to ensure that conversations with women are trauma-informed and use trauma-informed language.
- An on-going mechanism is implemented to support non-clinical staff and allow them to practice and enhance their trauma-informed abilities.

GUIDELINE #3

Assessment procedures are adapted to incorporate trauma-informed screening.

Suggested indicators:

- Assessments have been adapted to include universal trauma-informed screening processes.

GUIDELINE #4

A self-assessment for staff is developed to identify capacity to work effectively with women who have experienced trauma.

Suggested indicators:

- Appropriate clinical staff are identified as internal referral sources in these situations.

- Clinicians, counsellors, and program staff have an opportunity to reflect on personal limitations that can interfere with their effectiveness in working with women who have experienced trauma.

GUIDELINES for SAFETY PRACTICES

GUIDELINE #5

An environmental scan of the physical space is conducted.

Suggested indicators:

- The organization's signage is welcoming, includes trauma-informed information, and indicates cultural sensitivity.
- Comfort items are provided.
- Private spaces are provided as needed and monitored for safety.

GUIDELINE #6

All service activities have been reviewed to ensure they are welcoming, clear, and consistent.

Suggested indicators:

- Appointment times are scheduled consistently.
- Information about programming is clear and all questions from women responded to promptly.

GUIDELINE #7

Early contacts with women are broader than information gathering only.

Suggested indicators:

- Women are introduced to other staff and are clear about who will be present during service provision.
- Confidentiality protocols are clearly explained and all questions from women responded to promptly.

GUIDELINE #8

Clinicians and other staff have undertaken a review of practices to ensure their emotional safety.

Suggested indicators:

- Staff convey emotional safety through trustworthiness, collaboration, choice and control, relational approaches, and empowerment modalities.

GUIDELINE #9

Clinicians and other staff ensure that safety issues are addressed at every opportunity.

Suggested indicators:

- Staff have reviewed policy and procedures and attended orientation/training sessions to ensure that safety is a topic of primary discussion.
- A statement of client safety 'rights and responsibilities' has been developed and is widely available.
- Women are asked about their safety needs and their concerns or suggestions are addressed.
- All clients are engaged in safety discussions and understanding of safety 'rights and responsibilities'.

GUIDELINE #10

Clinicians and other staff demonstrate comfort with trauma-based reactions.

Suggested indicators:

- Staff can respond to trauma-based responses with empathy and a calm, respectful demeanour.

GUIDELINE #11

Clinicians and other staff have reviewed their practices to ensure that cultural safety has been taken into account.

Suggested indicators:

- Culturally appropriate conversations and/or linkages are made.

GUIDELINES for TRUSTWORTHINESS PRACTICES

GUIDELINE #12

Each woman is provided with clear information about service provision.

Suggested indicators:

- All women receive a clear description of services and know criteria for admission, timing, and length of time commitment.
- The concept of informed consent has been fully explained.
- Staff do frequent check-ins with women to ascertain their comfort levels and ensure that they have a clear understanding of service provision.
- Staff ask women for their questions and ensure that their concerns or suggestions are addressed.

GUIDELINE #13

Clinicians and other staff act consistently in all interactions with women.

Suggested indicators:

- Goals and tasks are clarified with women.
- Commitments made to women are always kept.
- Appointment times are scheduled consistently.

GUIDELINE #14

Boundary guidelines have been established and clearly communicated.

Suggested indicators:

- All staff members understand the limits of appropriate physical contact with women who are clients, and conduct themselves accordingly.
- All staff members understand the limits of self-disclosure, and conduct themselves accordingly.
- All staff members understand the limits of their extracurricular contact with women who are clients (including attendance at self-help groups), and conduct themselves accordingly.

- If staff members attend the same self-help group as women who are clients, clear guidelines for these encounters have been established for both staff and women, and these guidelines are adhered to.
- All staff members have conveyed to women who are clients the nature and extent of their interactions with them, and have described boundary issues, including after the clinical contact is completed.

GUIDELINE #15

The limits of confidentiality and the organization's record keeping policies have been clearly communicated.

Suggested indicators:

- All staff members provide to women a clear statement about occasions when information will be released without the woman's consent.
- All staff members describe to women the information that will be gathered and allow women the opportunity to ask questions and withdraw consent.
- All staff members describe to women where files will be kept and for how long.

GUIDELINES for CHOICE AND CONTROL PRACTICES

GUIDELINE #16

Service provision has been developed in ways that support various measures of progress.

Suggested indicators:

- Treatment goals and processes are not limited to abstinence.
- A range of options are provided for counselling/service provision opportunities.
- Lapse/relapse is seen as an opportunity for learning and for identifying triggers and alternate coping mechanisms.

GUIDELINE #17

Female staff are available in all areas of service provision.

Suggested indicators:

- Female staff are available for all clinical, program delivery, and residential support positions, in both daytime and night time activities.
- Only female staff conduct bed checks.
- Female clinical staff are available for individual counselling work.
- Female clinical staff facilitate women-only groups or women-focused sessions.
- Female clinical staff facilitate or co-facilitate mixed groups.

GUIDELINE #18

Clinical staff members have developed mechanisms to obtain input from women who have experienced trauma.

Suggested indicators:

- Feedback from women who have experienced trauma is elicited via informal feedback, formal evaluations, focus groups, and/or participation on an Advisory Committee with options for anonymity.

GUIDELINE #19

Clinical staff members ensure that women can request changes to processes and procedures.

Potential indicators:

- Feedback obtained through various means is incorporated into programming and general service provision.

GUIDELINES for RELATIONAL AND COLLABORATIVE APPROACHES

GUIDELINE #20

Clinical staff members have the opportunity to nurture therapeutic relationships.

Suggested indicators:

- The organization supports taking the time necessary to develop a trusting relationship with women who have experienced trauma.

GUIDELINE #21

Collaboration between clinical staff and women is emphasized.

Suggested indicators:

- Women are offered choices in their service experience.
- Women in precontemplation and contemplation about their substance use are supported until ready to move to the preparation and action stages.
- Women are offered the opportunity to participate actively in, and contribute to the identification of, the determination of their own needs in treatment planning.

GUIDELINE #22

Flexibility in setting and process is encouraged.

Suggested indicators:

- Normal routines, procedures, and physical surroundings accommodate women whose verbal and non-verbal feedback indicates they are uncomfortable with the current situation.

GUIDELINES for STRENGTHS-BASED EMPOWERMENT MODALITIES

GUIDELINE #23

A full range of empowerment skills are included in counselling/service provision.

Suggested indicators:

- Clinicians and other staff understand and act on the range of skills necessary to empower women who have experienced trauma.

GUIDELINE #24

Feedback from women is incorporated in the empowerment process.

Suggested indicators:

- Feedback from women who have experienced trauma is elicited through informal feedback, formal evaluations, focus groups, and/or participation on an Advisory Committee.

GUIDELINE #25

A balance is struck between substance use goals and reducing trauma responses.

Suggested indicators:

- Small steps to changing substance use are encouraged, in order to minimize the potential for trauma responses.

GUIDELINE #26

Empowerment language is incorporated into all aspects of programming.

Suggested indicators:

- An environmental scan results in the removal of all posters, pamphlets, brochures, or other written materials that contain punitive or overly directive messaging.
- Handouts, manuals, and other written materials have been updated to include empowerment language.
- Program policies, including lapse/relapse policies, do not include punitive consequences.
- Programming focuses on learning and incremental change, and does not support punitive responses when women relapse.

Section 8 Guidelines: Supporting Staff Competencies GUIDELINES for STAFF DEVELOPMENT

GUIDELINE #27

The organization a) ensures that job descriptions reflect the competencies of trauma-informed practices, in line with job roles, and b) clearly communicates those requirements to staff.

Suggested indicators:

- Job descriptions clearly indicate requirements for education, knowledge, and expertise in trauma-informed practices, and each staff member has a copy of her/his job description.
- Performance is regularly monitored and evaluated against the fulfillment of these requirements.
- The organization supports both existing and new staff in obtaining the education and training needed to develop and maintain the required competencies.
- Organizational expectations for staff to attend education and training are clearly communicated.

GUIDELINE #28

The organization's policies and practices support recruitment and hiring of staff who have competencies in trauma-informed practices.

Suggested indicators:

- Recruitment processes and procedures, interview questions, ranking scales, and job requirements incorporate knowledge of and skills in trauma-informed practices, as key job requirements.

GUIDELINES for STAFF EDUCATION and TRAINING

GUIDELINE #29

The organization provides education and basic training to all staff about trauma, and how trauma-informed practices will be used in their work.

Suggested indicators:

- The organization provides education and training to ensure that all staff have basic knowledge about trauma and its impacts, including the connections between trauma and substance use.
- Basic education and training provides all staff with an understanding of the importance of safety and trustworthiness in the organizational environment (e.g., triggers, trauma responses, boundaries, confidentiality, sexual harassment).

GUIDELINE #30

The organization provides in-depth training for direct service staff about trauma, and how trauma-informed practices will be used in their work.

Suggested indicators:

- The organization provides in-depth training that enables direct services staff (clinicians and program staff) to establish a sound understanding of how trauma-informed practices should be used in developing new programs and services, and modifying those that already exist.
- Direct services staff receive training that enables them to identify trauma reactions and to help women manage them, including the necessary skills and techniques (e.g., grounding).

GUIDELINE #31

The organization provides continuing and ongoing education and training about trauma to all staff, as is appropriate for their job roles and responsibilities.

Suggested indicators:

- The organization provides education and training to reinforce learning and extend the scope and depth of staff knowledge and skills.
- Appropriate education and training are provided to new staff.
- The organization evaluates the effectiveness of the education and training it has provided annually, and elicits feedback from staff and from women with 'lived experience' as part of that evaluation.
- The organization plans future education and training based on evaluation results, and seeks input on those plans from staff and women with 'lived experience'.

GUIDELINE #32

The organization partners with other service providers and community stakeholders to provide shared training sessions in trauma-informed practices for staff from a variety of organizations and/or disciplines.

Suggested indicators:

- Opportunities for inter-organizational and inter-disciplinary training are developed or identified through existing organizational partnerships.
- Organizations participate in networks and planning tables within their local community, and seek opportunities for joint education and training in trauma initiatives in those groups.
- Organizations work with Local Health Integration Networks to identify system-level education and training needs and opportunities.

GUIDELINES for BUILDING CLINICAL INFRASTRUCTURE

GUIDELINE #33

The organization ensures that all direct service staff have regular, confidential clinical supervision from a qualified clinical supervisor.

Suggested indicators:

- A qualified clinical supervisor (i.e. one who has thorough knowledge of trauma, substance use, and the interconnections between them, and who is skilled in providing trauma-related services, as well as clinical supervision) is employed by the organization, either as a full or part time staff member or on a contract basis.
- Regular clinical supervision sessions and consultation are available to all direct services staff—weekly supervision sessions are recommended; at a minimum, sessions should be provided bimonthly and consultation should be provided as needed.
- Clinical supervision is provided in sessions that are separate from administrative supervision (even if both are provided by the same person).
- Clinical supervision is confidential and provides a safe place for staff to discuss process issues and concerns.
- Clinical supervision assists direct service staff in dealing with issues of transference, counter-transference, burnout, and vicarious trauma.

GUIDELINE #34

The organization provides and facilitates opportunities for staff to work in teams, and to support each other in team meetings and in ad hoc sessions as needed.

Suggested indicators:

- The organization provides a structure in which regular team meetings are held, and in which staff have a forum to seek support and/or input, to exchange newly-acquired information and knowledge, and to enhance skills.
- The organization ensures that staff are able to take time-outs when needed to debrief, to seek support or input from other staff, or to recharge.
- Staff who work alone (e.g. on shift, outreach locations, or in satellite offices) have resources that they can call upon for emotional or practical support, or professional consultation, when needed.
- The organization provides a safe environment and a positive atmosphere in which staff can discuss uncertainties or mistakes and use them as opportunities for learning.

- The organization encourages and facilitates a culture of openness—staff embrace change, and do not feel threatened by new practices or new learning—organization leaders model this attitude and behaviour.
- The organization encourages staff to hear feedback from women, including feedback that is critical or negative, without feeling threatened.

Section 9 Guidelines: Trauma-Informed Organizational Practices

GUIDELINES for TRAUMA-INFORMED ORGANIZATIONAL POLICIES and PROCEDURES

GUIDELINE #35

The organization integrates knowledge and skills about trauma in all its programs, services, and organizational structures.

Suggested indicators:

- The organization recognizes the centrality of trauma in a formal, explicit manner (e.g., in the mission statement, vision statement, strategic plan, and/or objectives).
- Leadership communicates a clear commitment to trauma-informed practices across the organization, and supports the implementation of those practices.
- The organization has a process for continuous monitoring, evaluation, and improvement of trauma-informed practices, including: regular reviews in which feedback is received from staff at all levels as well as from women with ‘lived experience’. Protocols are developed to act on issues identified in those reviews.

GUIDELINE #36

The organization’s policies and practices ensure that women with ‘lived experience’ are involved in developing and evaluating trauma-informed practices.

Suggested indicators:

- Women with ‘lived experience’ actively contribute to the organization’s planning, implementation, and evaluation of trauma-informed practices (e.g., via input from an Advisory Committee, volunteers, and staff with ‘lived experience’), including women who can help to identify barriers to service access.
- Feedback about the quality of trauma-informed practices is regularly elicited from women with ‘lived experience’, and used to inform organizational practices.

GUIDELINE #37

The organization understands the diversity of the community it serves.

Suggested indicators:

- The organization develops formal and informal relationships with culturally specific services and groups in the community to enhance its knowledge and understanding of the community it serves.
- The organization reviews data (e.g., census and survey data, health care system reports) to ensure a good understanding of its community.

GUIDELINE #38

The organization's decision making is informed by diverse points of view from within and beyond the organization.

Suggested indicators:

- The organization systematically and consistently involves women, family members, and community members, including those who can speak to the needs of specific cultural groups, in developing organizational practices that support cultural competence.
- The organization has formal and informal, regular methods of eliciting feedback from women, family members, and community members about its service environment, modalities, and the cultural competence of its staff.
- The organization has developed linkages with community groups and other community services that can enhance its knowledge of and effectiveness in providing services for a range of diverse populations.

GUIDELINE #39

The organization creates a physically and emotionally safe environment for women and staff.

Suggested indicators:

- The physical environment is accessible and welcoming to women from a variety of cultural backgrounds (see **Section 5**).
- The organization identifies dimensions to assess the physical and emotional safety of the service environment (e.g. the physical plant conveys a sense of community, supports client ownership of the space and program, and is reflective of cultural inclusivity (see **Section 6**).
- The organization identifies possible triggers that elicit trauma responses (see **Section 4** and **Section 6**).
- Female staff are readily available to work with a woman at all phases of her engagement with service.
- Organizational policies and procedures ensure that female staff are available to work with women in clinical, program delivery, and residential support positions, in both daytime and night time functions.
- Functions specific to residential services (night monitoring, housekeeping needs, bed checks) are carried out by female staff.
- The organization has a process for regular review of environmental safety, and that process includes input about potential safety issues and triggers from both staff and women with 'lived experience'.

GUIDELINE #40

The organization has implemented protocols for universal trauma screening.

Suggested indicators:

- The organization ensures that screening for trauma is embedded within outreach, intake, assessment and clinical services (see **Section 6**).
- Staff members involved with those services have the knowledge and skills needed to ask screening questions in clinically competent and culturally sensitive ways.

GUIDELINE #41

The organization has trauma-informed policies and procedures for helping women to manage trauma responses.

Suggested indicators:

- Staff work with women to identify strategies that may help to manage trauma or crisis responses, such as discussing grounding strategies (see **Section 6**).
- The organization demonstrates respect for women's preferred actions and strategies when responding to trauma-based reactions and/or crises.
- The organization has a protocol and process in place to document and review incidents in which trauma responses have been triggered, and utilizes reviews to maximize learning and improvements in practices.

GUIDELINE #42

Organizational policies and procedures address the privacy and confidentiality rights and needs of women who have experienced trauma.

Suggested indicators:

- The organization has a clearly written, easily accessible statement of the rights and responsibilities of women and staff (see **Section 6**).
- The program provides protection for the privacy of both women and staff members.
- Policies regarding privacy, confidentiality, and access to information are clear, are provided in writing to women, and are verbally communicated to and discussed with them.
- Organizational guidelines and policies, and staff training, ensure that documentation respects the woman's privacy (see **Section 6**).

GUIDELINES for the USING TRAUMA-INFORMED PRACTICES WITH STAFF

GUIDELINE #43

The organization creates a physically and emotionally safe for women and staff.

Suggested indicators:

- The program attends to the safety needs of all staff, including support and administrative staff, as well as those who provide direct services.
- The organization seeks input from staff about the conditions that support and contribute to or undermine their safety, and addresses those conditions.
- Staff have adequate space and privacy, and assistance can be readily contacted, if needed.
- The organization has mechanisms to assess staff safety on an on-going basis, and to make improvements wherever possible.

GUIDELINE #44

The organization ensures that work roles, practices, and boundaries are clear and consistent for all staff.

Suggested indicators:

- The organization's mission, goals, and objectives are clear to staff, and are consistent with trauma-informed practices.
- Managers and supervisors understand the nature of trauma-informed practices in its programs and services, and its potential emotional impacts (burnout, vicarious trauma, compassion fatigue).

- Organizational policies and practices encourage staff to maintain appropriate professional boundaries and exercise appropriate self-care.
- Direct service staff receive regular support from a qualified clinical supervisor, and clinical supervision is conducted through a separate session or process from administrative supervision.
- The organization maximizes transparency and honesty by providing staff with clear communication about program plans, and information about changes.
- Job roles and expectations are clear, consistent and fair for all staff positions, including support staff.
- The organization has mechanisms to ensure that clear, consistent work roles and boundaries are maintained, and to make improvements wherever possible.

GUIDELINE #45

The organization maximizes opportunities for staff choice and control.

Suggested indicators:

- Staff have appropriate autonomy within the boundaries of their job duties and responsibilities.
- Staff have opportunities to provide meaningful input into factors that affect their work whenever possible (e.g., workload, hours of work, training needs, programs and services provided by the organization, the physical environment).

GUIDELINE #46

The organization maximizes collaboration and sharing of power among staff, supervisors, administrators, and managers (as well as with clients).

Suggested indicators:

- The organization seeks feedback, and ideas from all staff, and encourages their participation in both planning and action when implementing changes.
- Formal and structured mechanisms are in place to elicit input from staff members.
- It is made clear to staff that their input is valued and considered, even if their ideas are not always implemented as suggested.
- The organization seeks to improve collaboration and power-sharing among its staff.

GUIDELINE #47

The organization prioritizes staff empowerment and skill-building.

Suggested indicators:

- The strengths and skills of staff are recognized and utilized to the fullest extent possible in their job roles.
- Staff are offered development and training opportunities to build on their skills and abilities.
- Staff receive regular and ongoing training in areas related to trauma, including the impact of workplace stressors.
- Feedback from supervisors is affirming, encouraging, and constructive, even when providing a critique.
- The organization seeks opportunities to support professional development and to provide the resources required for job performance.

GUIDELINE #48

The organization takes actions to reduce the impact of vicarious trauma.

Suggested indicators:

- The organization (in consultation with staff) identifies the characteristics of its culture that can either mitigate the risks of vicarious trauma or exacerbate them .
- The organization provides support and resources to staff who have experienced vicarious trauma.
- The organization trains staff in good self-care.
- Organizational policies, expectations, scheduling, and infrastructure promote staff well-being and good self-care.
- The organization provides appropriate supports to staff who are experiencing vicarious trauma.

Section 10 Guidelines: Linkages With Other Services and Sectors GUIDELINES for DEVELOPING LINKAGES WITH ALLIED SERVICES

GUIDELINE #49

The organization cultivates collaborative and partnering relationships with providers of allied services (e.g. mental health, other health care, services that have expertise in working with specific populations, child welfare agencies, parenting organizations, violence against women services, social services agencies, housing providers, shelters).

Suggested indicators:

- The organization seeks input from women with ‘lived experience’ about women’s needs for allied services, and how it can help to facilitate access and connections with those services.
- The organization works with other community service providers to create mechanisms for service coordination (e.g., LHIN planning groups, local networks).
- The organization seeks opportunities to make services more accessible and culturally competent (e.g., through outreach, co-facilitated programs/services, co-location of services).
- The organization’s agreements to collaborate and partner with allied service providers reflect the principles for trauma-informed practices.
- The organization regularly evaluates its success in developing linkages, and collaborative/partnering relationships.

Appendix B:

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This Appendix provides a list of source documents for the citations in the document.

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Appendix C:

Models for Trauma-Specific Services

This Appendix provides a list of information sources where evidence-based *trauma-specific* services can be found. Several models have been developed and shown to be helpful for women who have experienced trauma. They require specialized training and supervision. For additional information about models and training refer to the websites of the International Society for Traumatic Stress Studies www.istss.org or the International Society for the Study of Trauma and Dissociation www.isst-d.org.

Eye Movement Desensitization Reprocessing (EMDR)

This model was developed by Shapiroⁱ with the goal of reducing intrusive responses. It is based on the Adaptive Information Processing model, which found that traumatic memories and experiences are incompletely processed with the result that they continue to be experienced in the present as though they are still taking place. This model has been researched and found to be effective.

Cognitive and Behavioural Therapies

Many cognitive and behavioural therapies initially used to treat people dealing with anxiety and depression have been adapted for work with women who have experienced trauma. For detailed information see *Effective Treatments for PTSD*. Models described include Exposure Therapy, Trauma-Informed Cognitive Therapies, Cognitive Therapy for PTSD, Mindfulness-Based Therapies, Acceptance and Commitment Therapy (ACT), Dialectical Behavior Therapy, Trauma Resolution Integration Program, Skills training for Affective and Interpersonal Regulation/Narrative Story Telling (STAIR/NST).

Models for Working with Substance-Involved Women Who Have Experienced Trauma

A number of models have been developed and researched for working in an integrated way with individuals recovering from substance use and trauma. For detailed descriptions of the models and training see SAMHSA's National Registry of Evidence-Based Programs and Practices www.nrepp.samhsa.gov

Seeking Safety www.seekingsafety.org

A model for the concurrent treatment of trauma and substance related problems
Developed by Lisa Najavits at Harvard Medical School

Goal

- To support women to understand and 'own' both substance use and trauma and their interrelationship.
- To decrease the frequency with which each problem triggers the other.

The program includes psychoeducation, cognitive-behavioural therapy, interpersonal therapy and case management. Treatment is practical, solution focused, and structured, and includes client handouts and therapist guidelines on 25 topics.

Core concepts

- staying safe
- respecting oneself
- using coping skills
- making the present and future better than the past
- learning trust
- getting help

The program has been studied in various settings and with a variety of populations.

Trauma Recovery and Empowerment Model (TREM)

Developed by Maxine Harris, Roger Fallot and their colleagues at Community Connections in Washington D.C., TREM is a peer-informed model that emphasizes the principles of:

- empowerment
- validating women's experiences
- multicultural perspectives.

Core assumptions

- That some current dysfunctional behaviours and/or responses may have originated as legitimate coping responses to trauma.
- That women who experienced repeated trauma in childhood were deprived of the opportunity to develop certain skills necessary for adult coping.
- That traumatic events, specifically sexual and physical abuse, severed core connections to family, community and ultimately the self (including disrupting awareness of one's own feelings, thoughts and behaviours).
- That women who have been abused repeatedly feel powerless and unable to advocate for themselves.

TREM employs cognitive restructuring, skills training, psychoeducation, and peer support. It adopts a three-part focus—empowerment, education, and skills building—and includes 33 recovery topics including the interconnection of trauma and substance use problems.

The program is delivered over nine months in weekly 75 minute meetings. TREM is a group model for women, with groups consisting of 8 to 10 women with 2 to 3 co-leaders. It has not been extensively researched beyond the SAMSHA Women with Co-occurring Disorders and Violence Study.

Addictions and Trauma Recovery Integration Model (ATRIUM)

Developed by Dusty Miller and Laurie Guidry and used with women in rural areas, it was designed to assess and intervene in the somatic, spiritual, and cognitive aspects of the experience of trauma.

Core concepts

- Uses a cognitive-behavioural and relational approach
- Informed by the 12-step model
- Four basic principles of recovery:

- Recognizing and reinforcing resilience
- Achieving abstinence from addiction
- Recognizing and healing the wounds of non-protection
- Creating a sacred connection to the world coupled with a sense of social purpose
- Organized into 12 sessions each containing:
 - a didactic component
 - a process section
 - an experiential component
 - a homework assignment

ATRIUM is organized into sections representing a graded exposure to the painful layering of the participant's trauma experience. These include: information on anxiety, sexuality, self-harm, depression, anger, physical health problems, sleep difficulties and spiritual disconnection. To date, there has been no extensive study of the model's effectiveness.

Beyond Trauma: A Healing Journey for Women

Developed by Stephanie S. Covington, this program can be used alone or following Covington's "Helping Women Recover: A Program for Treating Addiction". It is comprised of eleven sessions that focus on three areas, each of which includes a number of activities:

- teaching women about trauma and abuse
- helping them to understand typical reactions
- developing coping skills

Themes

- Safety
- empowerment
- Connection
- normal reactions
- mind-body connection
- substance misuse
- woman-centered

There has been one completed study of this model.

Model for Working with Women Dealing with Child Sexual Abuse and Addictions

Developed by The Laurel Centre, Winnipeg, Manitoba [see: Journal of Substance Abuse Treatment 18 (2000)], the model represents the integration of a trauma recovery model with a feminist approach to practice and is based on the knowledge and practice experience of clinicians working at The Laurel Centre. The Centre was established in 1985 to provide services for women who have experienced sexual abuse in childhood or adolescence and have been affected by addictions.

The model uses a staged approach which recognizes that stages may recur and overlap throughout the therapeutic process.

The stages are:

Stage One—engaging and assessing

- The goal is to establish rapport and assess the fit between the woman's needs and the organization's resources
- Establishes the roles and boundaries of the therapeutic alliance
- Explores the impact of addictive behaviour and the extent to which the woman uses substances as a coping strategy

Stage Two—creating safety

- Focus is on safety
- Continues to build the therapeutic relationship
- Builds a range of coping methods

Stage Three—intense debriefing

- Processes the child sexual abuse and its context
- Addresses the multiple effects of abuse
- Links past experiences and messages with present behaviours, beliefs and responses
- Assists women to recognize their personal power
- Grieves losses associated with the abuse and the emotional loss of the addictive behaviour
- Monitors for potential relapse of addictive behaviour and support healthy skills and responses

Stage Four—integrating

- Focusses on aligning behaviour, affect and cognition (i.e. achieving congruency)
- Encourages competence in new behaviours and skills
- Assists with developing new or changed relationships
- Develops a positive future orientation with realistic expectations
- Assists with placing her experiences of abuse into the broader socio-political environment

Stage Five—moving on

- Facilitates a shift in priorities so that the abuse is no longer the central feature of her identity
- Celebrates accomplishments
- Assists with making changes in goals and lifestyle
- Strengthens social supports
- Anticipates and prepares for future difficulties
- Gradually deemphasizes the therapist's role, leading to closure

Appendix D:

Resources

This Appendix identifies sources of supplemental information that will help readers to extend their learning. The resource section is not intended to be all-inclusive—the web sites, books, and articles that have been suggested will present a starting point for further learning.

Canadian Centre on Substance Abuse www.ccsa.ca

Substance Abuse and Mental Health Services Administration: SAMHSA's National Registry of Evidence-Based Programs and Practices www.nrepp.samhsa.gov

The Canadian Network of Substance Abuse and Allied Professionals; Competencies for Canada's Substance Abuse Workforce

<http://www.cnsaap.ca/Eng/DevelopingTheWorkforce/Competencies/Pages/default.aspx#resources>

WOMEN AND SUBSTANCE USE

Coalescing on Women and Substance Use www.coalescing-vc.org

Consumer/Survivor/Recovering Women: A Guide For Partnerships In Collaboration

<http://www.wcdvs.com/pdfs/CSR%20Manual%20Final.pdf>

Haskell, L. (2003). First-stage trauma treatment: A guide for mental health professionals working with women. Toronto: Centre for Addiction and Mental Health.

National Center on Addiction and Substance Abuse at Columbia University. (2003). The Formative Years: Pathways to Substance Abuse Among Girls And Young Women Ages 8-22. New York: CASA.

Poole, N. and Greaves, L. (Eds.) (2007). Highs & Lows: Canadian Perspectives on Women and Substance Use. Toronto: Centre for Addiction and Mental Health

TRAUMA AND TRAUMA-INFORMED CARE

Briere, J. (2002). Treating Adult Survivors of Severe Childhood Abuse and Neglect: Further Development of an Integrated Model. In Myers, J.E.B., et al. (Eds.) (2002) The APSAC handbook on child maltreatment, 2nd Edition. Newbury Park, CA: Sage Publications

British Columbia Centre of Excellence for Women's Health. Trauma-informed Approaches in Addictions Treatment

<http://www.bccewh.bc.ca/publications-resources/documents/GenderingNatFrameworkTraumaInformed.pdf>

Brown, L. S. Treating Trauma: Basic Skills and Specific Treatments
www.continuingcourses.net/active/courses/course073.php

Brown, L. S. Becoming a Trauma-Aware Therapist: Definitions and Assessment
www.continuingcourses.net/active/courses/course070.php

Centre for Addiction and Mental Health (2012). Becoming Trauma Informed http://www.camh.ca/en/education/about/camh_publications/pages/becoming_trauma_informed.aspx

Centre for Addiction and Mental Health. Bridging responses: A front-line worker's guide to supporting women who have post-traumatic stress
http://www.camh.ca/Publications/Resources_for_Professionals/Bridging_responses/bridging_responses_overview.html

Chu, J. A. (1998). Rebuilding Shattered Lives: The Responsible Treatment of Complex Post-Traumatic and Dissociative Disorders. New York: John Wiley & Sons, Inc.

Coalescing on Women and Substance Use www.coalescing-vc.org

Community Connections. A Self-Assessment and Planning Protocol for Cultures of Trauma-Informed Care
<http://www.healthcare.uiowa.edu/icmh/documents/CCTICSelf-AssessmentandPlanningProtocol0709.pdf>

Community Connections: Creating Culture of Trauma-Informed Care
<http://www.communityconnectionsdc.org/web/page/673/interior.html>

Connections: Knowledge Exchange for Agencies Serving Women with Substance Use Issues
<http://www.connectionsCanada.ca/>

Covington, S. Beyond Trauma: A Healing Journey for Women www.stephaniecovington.com/books.asp

Covington, S. (2008). Women and Addiction: A Trauma-informed Approach. Journal of Psychoactive Drugs. SARC Supplement 5

Courtois, C. A. and Ford, J. D. (Eds.) (2009). Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide. New York: Guildford Press

Courtois, C. A. (2004). Complex Trauma, Complex Reactions: Assessment and Treatment. Psychotherapy: Theory, Research, Practice, Training. Vol. 41, No. 4.

Courtois, C. A. and Gold, S. N. (2009). The Need for Inclusion of Psychological Trauma in the Professional Curriculum: A Call to Action. Psychological Trauma: Theory, Research, Practice and policy. Vol. 1, No. 1

Dass-Brailsford, P. and Myrick A.C. (2010). Psychological Trauma and Substance Abuse: The Need for an Integrated Approach. Trauma, Violence, & Abuse. 11 (4)

Elliott, D.E., et al. (2005). Trauma-informed or Trauma-denied: Principles and Implementation of Trauma-informed Services for Women. *Journal of Community Psychology*. Vol. 33, No. 4

Fallot, R. D. and Harris, M. (2001). A Trauma-Informed Approach to Screening and Assessment, Chapter 2 in *New Directions for Mental Health Services*, no. 89

Fallot, R. D. and Harris, M. (2005). Integrated Trauma Services Teams for Women with Alcohol and Other Drug Problems and Co-occurring Mental Disorders. *Alcoholism Treatment Quarterly*. Vol. 22, 3-4

Foa, E. B., et al. (Eds.) (2009). *Effective Treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies*. New York: The Guildford Press

Herman, J. (1992). *Trauma and Recovery*. New York: Basic Books

Harris, M. and Fallot, R. D. (2001). Envisioning a Trauma-Informed Service System: A Vital Paradigm Shift. Chapter 1 in *New Directions for Mental Health Services*, no. 89

Hiebert-Murphy, D. and Woytkiw, L. (2000). A Model for Working with Women Dealing with Child Sexual Abuse and Addictions. *Journal of Substance Abuse Treatment*. Vol. 18

Institute for Health Recovery: Trauma Integration Services

http://www.healthrecovery.org/projects/trauma_integration/trauma_integration_services.asp

International Society for the Study of Trauma and Dissociation www.isst-d.org

International Society for Traumatic Stress Studies (ISTSS) ISTSS Treatment Guidelines for PTSD www.istss.org

Jennings, A., Articles, presentations, and links about trauma and retraumatization <http://www.theannainstitute.org/articles.html>

Jennings, A. and Ralph, R. O. (1997). In Their Own Words Trauma Survivors and Professionals They Trust Tell What Hurts, What Helps and What Is Needed for Trauma Services, Office of Trauma Services Department of Mental Health, Mental Retardation and Substance Abuse Services

Klinik Community Health Centre: Trauma-informed Toolkit www.trauma-informed.ca

Mental Health Coordinating Council. Trauma-Informed Care and Practice Conference: 2011 Presentations <http://www.mhcc.org.au/TICP/webcasts.aspx>

Miller, D. (1994). *Women who Hurt Themselves*. New York: Basic Books

Morrow, M. Violence and Trauma in the Lives of Women with Serious Mental Illness. British Columbia Centre of Excellence for Women's Health www.bccewh.bc.ca

Najavits, L. A. (2002). *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*. New York: The Guilford Press

National Trauma Consortium www.nationaltraumaconsortium.org

Pearlman, L. A. and Saakvitne, K. W. (1995). *Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors*. New York: W. W. Norton & Company

Substance Abuse and Mental Health Services Administration (SAMHSA): Definitions of trauma
www.samhsa.gov/traumajustice/traumadefinition/index.aspx

Substance Abuse and Mental Health Services Administration (SAMHSA) National Mental Health Information Center: Trauma-informed care and trauma-specific interventions
www.mentalhealth.samhsa.gov/nctic/trauma.asp

Schachter, C.L., et al. (2009). *Handbook on sensitive practice for health care practitioner: Lessons from adult survivors of childhood sexual abuse*. Ottawa: Public Health Agency of Canada

The Women, Co-occurring Disorders, and Violence Study
<http://www.nationaltraumaconsortium.org/documents/CreatingTraumaServices.pdf>

Trauma Center, the website of Dr. B. van der Kolk www.traumacenter.org

Van der Kolk, B. A., McFarlane, A. C. and Weisaeth, L. (Eds.) (1996). *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body and Society*. New York: The Guildford Press

Van der Kolk, B. A. (2001). The Assessment and Treatment of Complex PTSD. Chapter 7 in Yehuda and Rachel, (Eds.) *Traumatic Stress*. American Psychiatric Press

Women's Hospital and Health Centre Vancouver, BC., *Building Bridges: Linking Woman Abuse, Substance Use and Mental Ill Health*
<http://www.bcwomens.ca/Services/HealthServices/WomanAbuseResponse/Building+Bridges.htm>

VIOLENCE AGAINST WOMEN

Abuse Counselling & Treatment Inc. www.actabuse.com

Briere, J. and Jordan, C. E. (2004). Violence Against Women Outcome Complexity and Implications for Assessment and Treatment, *Journal of Interpersonal Violence*, Vol. 19 No. 11

Canadian Association of Sexual Assault Centres <http://www.casac.ca/english/home.htm>

Canadian Women's Health Network. Making the links: Violence, trauma and mental health
<http://www.cwhn.ca/en/node/41607>

Ending Violence Association of BC <http://www.endingviolence.org/node/459>

National Clearinghouse on Family Violence <http://www.phac-aspc.gc.ca/nc-cn>

Ontario Woman Abuse Screening Project <http://womanabusescreening.ca/en>

The Stella Project. (2005). Domestic Violence, Drugs and Alcohol Toolkit. Greater London Domestic Violence Project (GLDVP) and Greater London Alcohol and Drug Alliance (GLADA): London, UK.

POPULATION SPECIFIC APPROACHES AND CULTURAL COMPETENCE

Aboriginal Canada Portal www.aboriginalcanada.gc.ca

Aboriginal Healing Foundation www.ahf.ca

Brown, L. S. Emotional and Cultural Competence in the Trauma-Aware Therapist
www.continuingcourses.net/active/courses/course074.php

Mattar, S. (2010). Cultural Considerations in Trauma Psychology Education, Research and Training. *Traumatology*. 16 (4)

Dell, C.A. (2006). Self-Harm Among Criminalized Women. Ottawa: Canadian Centre on Substance Abuse.

Guarino K, Soares P, Konnath K. (2007). Trauma-informed organizational self-assessment for programs serving families experiencing homelessness. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration <http://www.familyhomelessness.org/media/90.pdf>

Health Canada (1996). Immigrant women and substance use: Current issues, programs and recommendations. Office of Alcohol, Drugs and Dependency Issues, Population Health Directorate: Ottawa, ON http://www.hc-sc.gc.ca/hl-vs/pubs/adp-apd/index_e.html.

Health Canada (1996). Rural Women and Substance Use: Issues and Implications for Programming. Ottawa, ON http://www.hc-sc.gc.ca/hl-vs/pubs/adp-apd/index_e.html.

Health Canada (2001). Best Practices Treatment and Rehabilitation for Women with Substance Use Problems. Canada's Drug Strategy Division Health Canada, Ottawa, ON http://www.hc-sc.gc.ca/hl-vs/pubs/adp-apd/index_e.html.

Health Canada (2002). Best Practices: Concurrent Mental Health and Substance Use Disorders. Ottawa, ON www.hc-sc.gc.ca/hl-vs/pubs/adp-apd/index_e.html

Law and Abused Immigrant Women <http://www.rosenet.ca/index.html>

National Aboriginal Circle Against Family Violence www.nacafv.ca

Native Women's Association of Canada www.nwac-hq.org

Ontario Women's Justice Network http://owjn.org/owjn_2009/legal-information/understanding-violence-against-women

Prescott L, Soares P, Konnath K, Bassuk E. (2007). A long journey home: a guide for creating trauma-informed services for homeless mothers and children. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration <http://www.familyhomelessness.org/media/89.pdf>

The Homeless Hub <http://www.homelesshub.ca/Topics/Trauma-Informed-Care-512.aspx>

FAMILY, RELATIONSHIPS, AND CHILDREN

Addictions Foundation of Manitoba. (2003). Preventing FASD: Getting 'Moms' to Help: Using the Transtheoretical Model of Change with Pregnant Women who use Substances.

Allen, S. N. and Bloom, S. L. Group and Family Treatment of Post-Traumatic Stress Disorder www.sanctuary-web.com

Brown, L. S. (2008). Weaving the Web of Support: Working with Families and Communities and Caring for Oneself in Cultural Competence in Trauma Therapy: Beyond the Flashback. Washington, DC, American Psychological Association

Copello, A. G., et al. (2005). Family interventions in the treatment of alcohol and drug problems. Drug and Alcohol Review., 24

Cohen, L. R. and Hien, D. A. (2008). The Impact of Cumulative Maternal Trauma and Diagnosis on Parenting Behavior. Child Maltreatment. Vol. 13, No. 1

DiLillo, D. and Damashek, A. (2003). Parenting Characteristics of Women Reporting a History of Childhood Sexual Abuse. Child Maltreatment. Vol. 8, No. 4

Fetal Alcohol Spectrum Disorder (FASD) Prevention: Canadian Perspectives (Public Health Agency of Canada) www.phac-aspc.gc.ca/fasd-etcaf/cp-pc-eng.php

Finkelstein, N. (1994). Treatment Issues for Alcohol and Drug-dependent Pregnant and Parenting Women. Health and Social Work. Vol. 19

Finkelstein, N. Parenting Issues for Women with Co-Occurring Mental Health and Substance Abuse Disorders who have Histories of Trauma. Coordinating Center of the SAMHSA Women, Co-occurring Disorders and

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