The Peter Mitchell Churchill Fellowship to explore Canadian and USA based approaches empowering women, children and communities to overcome intergenerational trauma.

I understand that the Churchill Trust may publish this Report, either in hard copy or on the internet or both, and consent to such publication.

I indemnify the Churchill Trust against any loss, costs or damages it may suffer arising out of any claim or proceedings made against the Trust in respect of or arising out of the publication of any Report submitted to the Trust and which the Trust places on a website for access over the internet.

I also warrant that my Final Report is original and does not infringe the copyright of any person, or contain anything which is, or the incorporation of which into the Final Report is, actionable for defamation, a breach of any privacy law or obligation, breach of confidence, contempt of court, passing-off or contravention of any other private right or of any law.

Signed: Jane Pedersen
Dated: 22/10/2017

Keywords: Trauma, Trauma-informed, Intergenerational, Empowerment, Health, Wellbeing
Contents

Introduction ........................................................................................................................................................... 2
Executive Summary .................................................................................................................................................. 3
Itinerary Table – Visits and Meetings May – August 2017 ............................................................................. 4
Navigating the Report ......................................................................................................................................... 11
The Context .......................................................................................................................................................... 13
Definitions and Discussion - What is Trauma and How Do We Address it? ......................................................... 16
Trauma and Trauma Response .......................................................................................................................... 17
Definitions – What is Trauma ........................................................................................................................... 19
What’s Wrong with ‘Trauma’? ........................................................................................................................... 20
The Clinical Model of Care and Support ........................................................................................................ 21
An Aboriginal Experience of the Clinical System .............................................................................................. 23
Defining Aboriginal Health and Wellbeing ....................................................................................................... 23
Another Type of Care and Recovery Model ...................................................................................................... 25
Changing the National Narrative Trauma Exists and It Can Be Stopped .......................................................... 26
Empowerment ..................................................................................................................................................... 28
Building Trust ...................................................................................................................................................... 32
Why We Are Using the Term Trauma ............................................................................................................... 34
The Evidence ....................................................................................................................................................... 36
Trauma and Its Damaging Impacts .................................................................................................................... 36
Trauma 101 – Getting Rid of Blame and Shame ............................................................................................... 37
Science and Healing ........................................................................................................................................... 42
Adverse Childhood Experiences (ACEs) ............................................................................................................ 47
The Trauma Informed Care Project (TIC) ........................................................................................................ 54
The Science of Poverty ....................................................................................................................................... 57
Understanding the Costs of Trauma .................................................................................................................. 60
Breaking the Cycle .............................................................................................................................................. 61
Adverse Community Effects ............................................................................................................................. 64
Community is the Solution .................................................................................................................................. 65
Indigenous Values of Health and Wellbeing ..................................................................................................... 67
Developing Acceptance and Moving Forward .................................................................................................. 69
Articulating Health and Wellbeing in Achieving Good Health and Wellbeing ................................................. 71
Indigenous Practices as Evidenced Tools for Recovery .................................................................................... 74
Models and Approaches .................................................................................................................................... 75
The Principles of a Trauma-Informed Model .................................................................................................... 79
Bibliography by Section

Recommendations

Starting this work on the ground in the Fitzroy Valley

Measurement and Evaluation

Starting this work on the ground in the Fitzroy Valley

Accountability Down, Not Up!

Community Holds the Solutions

Putting Research and Development at the Heart of Social Design

The Challenge

It is All a Continuum

Innovation

Changing Systems – What Does It Take to Transform?

Evidence, Theory, Practice and Action

Embodying Principles in Our Working Practices

Embedding Self-Reflection

Developing Core Competencies and Skills

Putting Core Competencies into Action

Helping People Process, Respond and Work Through Their Own Triggers

Nurturing Practices

Empowerment

Integrating Practices into the Operational Structure

Methodologies that Change the Brain, and How We Engage

Collaborative Problem Solving (CPS)

Trust, Encouragement and Empowerment Approaches

A Blended Approach

The Community Approach – Putting Principles Straight into Practice

Research & Development for Trauma and Healing Work

Measurement and Evaluation

Starting this work on the ground in the Fitzroy Valley

Recommendations

Bibliography by Section
**Introduction**

I set out across North America to explore what it really means to break cycles of intergenerational trauma, and use methods of empowerment to do this. This investigation was propelled into action by my work at Marninwarntikura Women’s Resource Centre in Fitzroy Crossing, in the Kimberley region of far North-Western Australia. I thank Marninwarntikura’s leadership, board, the talented and committed staff, and the Fitzroy Valley community members engaged in the organisation for supporting this work. The findings of this report are designed to guide Marninwarntikura on its trauma informed and healing journey.

Critical to this explorative research, and at the heart of Marninwarntikura’s work, is the knowledge that Indigenous resilience and societal practices of health and wellbeing are fundamental to breaking the contemporary cycle of intergenerational trauma. A central focus of this report is how those who have experienced the devastation of colonisation and its ongoing effects, are changing the narrative of trauma from a deficit-base to a strength-base. Indigenous organisations are finding the solutions to combat trauma on-the-ground, by developing the skills and expertise around lived experience and deep local knowledges of healing.

This report documents my travels across Canadian city-scapes, into the Inuit territory of Nunavut, beyond the Arctic circle, and down into the mid-west of the USA and the desert state of Arizona. It analyses and reviews this journey across eight distinct sections.

I was impressed and overwhelmed by how people, organisations and institutes are becoming trauma informed and responsive, and grounding their work in the evidence, commitment and passion that positive change can happen for everyone.

Thank you to all of those I met with who made me believe in hope, and the emergence of a bright and better future. I haven’t been able to mention everyone in this report, but everyone’s words and advice were invaluable. Everything in this report is informed by the work of all those I met with, whether names, organisations and/or programs are mentioned explicitly. Trauma is devastating and life-threatening, but the reality is it is not permanent. In pushing our working practices to be better, in innovating to create the right interventions, together, we can transform people’s lives, society and our systems.

Finally, I would like to acknowledge the wonderful work of the Churchill Fellowship Memorial Trust for awarding me and many other Australians this life changing and enhancing experience, and I thank Peter Mitchell and his family for making my travels possible. It has been a trip of a lifetime.
Executive Summary

Name: Jane Pedersen, Address: PO Box 43, Fitzroy Crossing, 6765, Western Australia, Organisation and Position: Marninwarntikura Women’s Resource Centre, Strategic Projects Manager, Telephone: 08 9191 5284

Project Description: Exploring Canadian and USA based approaches empowering women, children and communities to overcome intergenerational trauma.

Overview and Recommendations:

The Churchill Fellowship explorative travels and the ongoing learnings during the writing of this report follows extensive inquiry and work into trauma-informed and healing practices at Marninwarntikura Women’s Resource Centre. Marninwarntikura is renowned for its Indigenous women’s leadership in intervening on the oversupply and overconsumption of alcohol and resulting harms. Since community driven alcohol restrictions were put into effect in 2007, Marninwarntikura has focused on the strategic development of societal restoration of Indigenous health and wellbeing in addressing complex harms resulting from trauma. Recently, as part of this strategic approach, Marninwarntikura has committed to a journey of becoming trauma and healing informed.

My travels reflect the need for community based work, the social service sector and policy makers to grasp the breadth and depth of intergenerational trauma, and what it means to create effective and sustainable community interventions that can break the cycle of intergenerational trauma. I visited several Canadian and USA urban based organisations working within a framework of trauma-informed principles and practices, harm reduction approaches and women and children centred designed work and organisational strategy. Many of these organisations were working with substance using and substance involved women. The report highlights the need to take a holistic approach to addressing trauma, and relating harms, and the need to focus on strengths to develop effective healing approaches to work.

Although, many of the places visited were women focused, they appreciated women’s lives as being within context and intimately connected to children, men, families and communities. The report rarely makes a gendered distinction in the trauma-informed and recovery approaches to work highlighted throughout. However, it is important to remain aware of the intersecting nature of gender, race, economic status and class with the prevalence of traumatic experiences. Everyone needs healing, but women and those from minority backgrounds experience a far higher prevalence of violence and sexual assault than men and others from mainstream society.

This report covers 8 central sections based on the extensive findings from my visit to Canada and the USA. It begins by providing the evidence of trauma and its undeniable impact on the brain, biology and society resulting in perpetuating cycles of trauma and disadvantage. The following sections present a range of practices and approaches to engender hope that transforming trauma is possible and real. The report recommends that community organisations should commit to serious investment in research and development to form effective trauma and healing models of work. In doing this theory can be translated into immediate and context appropriate practices.

The seven recommendations which conclude the report are designed as a trauma-informed and healing implementation plan to be used by Indigenous and community-based organisations. The primary intention is for these recommendations to be used by Marninwarntikura as it produces a body of evidenced work to break cycles of intergenerational trauma, and ground its programs and development strategies in empowerment based community-driven approaches.
<table>
<thead>
<tr>
<th>Organisation/Association</th>
<th>Contact(s) and Position</th>
<th>Programs</th>
<th>Practices/Model/Approach Philosophy drawn on etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Child Manitoba</td>
<td>Rob Santos Assistant Minister of the department</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Child Manitoba</td>
<td>Lisa Murdock</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Steve Feldgaier Manager</td>
<td>Triple P</td>
<td>Engaging ethno-cultural communities and child welfare</td>
</tr>
<tr>
<td></td>
<td>Louanne Beaucage Community Engagement</td>
<td>Triple P</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Leanne Boyd, Director of Policy Development, Research and Evaluation</td>
<td></td>
<td>Roots of Empathy amongst many other school programs designed for generational change</td>
</tr>
<tr>
<td>Klinic Community Health Centre</td>
<td>Mary Jo and Cheryl Mathews</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Klinic Community Health Centre</td>
<td>Nicole Chammartin Executive director</td>
<td>Managers all programs of klinic</td>
<td>Processes of reconciliation and healing Principles of psychological safety and harm reduction</td>
</tr>
<tr>
<td>Klinic Community Health Centre</td>
<td>Workshop Sheona Campbell</td>
<td>Councillors at Klinic</td>
<td>Trauma informed care – they run a number of different workshops and trainings</td>
</tr>
<tr>
<td>Manitoba Youth Centre</td>
<td>Teresa Brown Assistant Superintendent of programs FASD interdepartmental committee member in justice</td>
<td>Justice FASD programing Youth Justice – starfish and the FASD youth program</td>
<td>This is me book – developing voices “they take their book where it needs to go”. Social enterprise – the empower project – for women who have FASD – unique and being trialled</td>
</tr>
<tr>
<td>Healthy Child Manitoba</td>
<td>Leanne Boyd Director of policy development research and evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Central Women’s Resource centre</td>
<td>Denise MacDonald Lorie (Executive Director) and Lisa (Community Engagement Director)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hollow water Circle Healing Program</td>
<td>Robyn Hall</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organisation</td>
<td>Contact(s)</td>
<td>Programs</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>------------</td>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>National Collaborating Centre for Aboriginal Health (NCCAH)</td>
<td>Roberta Stout Lorena Fontaine</td>
<td>Intergenerational storytelling</td>
<td>Talking circles between mothers and daughters, telling stories about residential schools and sharing feelings and experiences</td>
</tr>
<tr>
<td>Hollow water Circle Healing Program</td>
<td>Burma Bushie</td>
<td></td>
<td>Community designed justice reinvestment program</td>
</tr>
<tr>
<td>Healthy Child Manitoba</td>
<td>Holly Gammon and Kathy Andrew FASD Network</td>
<td>Looking after each other planning committee</td>
<td>Elders Gathering – community engagement De-stigmatizing language of FASD Dignity and Respect</td>
</tr>
<tr>
<td>Ka Ni Kanichihk</td>
<td>Leslie Spillet – executive director Dodie Jordaan Angie Hutchinson</td>
<td>Key features of programs – child care shared with the women’s resource centre. Creative partnership that are explained in what they are both looking at achieving</td>
<td>Mentorship programs Healing Indigenous empowerment Circle of courage</td>
</tr>
<tr>
<td>Southeast Resource Development Council Corp.</td>
<td>Louis Young</td>
<td>Indian Residential school cultural support programs manager</td>
<td></td>
</tr>
<tr>
<td>Aboriginal Health and Wellness centre of Winnipeg</td>
<td>Noella Gentas</td>
<td>Insight mentoring program</td>
<td></td>
</tr>
<tr>
<td>Boldness Project</td>
<td>Diane Roussin Kara Boles</td>
<td></td>
<td>Social innovation Prototyping and creating new models</td>
</tr>
<tr>
<td>Ottawa Organisation/Association</td>
<td>Contact(s) And position</td>
<td>Programs Practices/Model/Approach Philosophy drawn on etc.</td>
<td></td>
</tr>
<tr>
<td>Triple P Canada</td>
<td>Debbie Easton – Country Manager. Catherine Lee – trainer and</td>
<td></td>
<td>Two eyed seeing Mikm’aw Elder – Albert Marshall – also see national collaborating centre for Aboriginal health</td>
</tr>
<tr>
<td>Organisation/Association</td>
<td>Contact(s) And position</td>
<td>Programs</td>
<td>Practices/Model/Approach. Philosophy drawn on etc.</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------------------</td>
<td>----------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>The Gate House</td>
<td>Arthur Lockhart, Maria Barcelos, Melanie Panitch</td>
<td>Trauma informed and specific care, Transforming trauma conference and hub</td>
<td></td>
</tr>
<tr>
<td>The Caring Society</td>
<td>Marc St. Denis, Poster We can’t make the same mistake twice film</td>
<td>Reconciliation in Canada, ﬁlm</td>
<td>Human rights tribunal – case against discriminating against children living on reserve. Principles to guide reconciliation – truth telling, relating, restoring, acknowledging outside of our court activities, the Caring Society is focused on the grassroots. We believe that governments respond to change, and so we support that positive change at the community level.</td>
</tr>
<tr>
<td>Pauktuutit Inuit Women of Canada</td>
<td>Rose Mary Cooper</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wabano</td>
<td>Danielle and Jessica – events coordinators</td>
<td>Holistic operating environment, Positivity of believing in generational change.</td>
<td></td>
</tr>
<tr>
<td>Tungasuvvingt Inuit</td>
<td>Jason LeBlanc, Executive Director, Cindi Rye, Director of Programs, Rhonda Huneault, Manager of Family Well Being Program, Jennisha Wilson, Manager of our Exiting Prostitution and Local Poverty Reduction Program, Paani Zizman, Executive Assistant</td>
<td>Anti-oppression models and training, De-privleging</td>
<td></td>
</tr>
<tr>
<td>Homewood Health</td>
<td>Julie Martin</td>
<td>Sanctuary Model</td>
<td></td>
</tr>
<tr>
<td>-----------------</td>
<td>-------------</td>
<td>-----------------</td>
<td></td>
</tr>
<tr>
<td>Jean Tweed Centre</td>
<td>Sonali Sagare and colleague</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distinguished Visiting Professor – Ryerson University</td>
<td>Eric Young</td>
<td>Social Innovation Social change Behavioural change</td>
<td></td>
</tr>
<tr>
<td>Wraparound interagency meeting</td>
<td>Louise Latourelle and heads of wraparound agencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wraparound Northumberland</td>
<td>Jane Ashmore and team</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Des Moines, Iowa**
Organisation/Association | Contact(s) and position | Programs | Practices/Model/Approach. Philosophy drawn on etc. |
<p>| Trudy Townsend | Across sectors and institutions | The Sanctuary model All of service provider (community) implementation Oregon |
| Orchard Place: 7th Annual Psychological Trauma &amp; Juvenile Justice: Impact on Mind, Body, Behaviour and Community | Gladys N. Alvarez – forwarded contacts and presenters from previous conferences | Two days of training led by Bruce Perry and Stuart Ablon |
| Meeting those from the Trauma informed care project stakeholders | Gladys N. Alvarez Dr. Cathy Beck-Cross, Social work program Fresh Start Women’s Correctional Facility Tamra Jurgemeyer, Program Director, at Young Women’s Resource Center Julie Fugenschuh, Executive Director of Project Iowa | Lunch meeting at Blank Children’s Hospital with some TIC Project Stakeholder’s hosted by 1:30pm Chaney Yeast and Lana Herteen. Other attendees are Denise Swartz (MIHF), Lisa Cushatt (Central Iowa ACEs), Steve Quirk (YESS), Andrea Vitzthum (Polk County Attorney’s Office), Judge Seidlin |</p>
<table>
<thead>
<tr>
<th>Organisation/Association</th>
<th>Contact(s) and position</th>
<th>Programs</th>
<th>Practices/Model/Approach Philosophy drawn on etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orchard Place</td>
<td>Gladys N. Alvarez</td>
<td>Trauma informed care implementation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Amber Rand</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Anne Starr</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nicole Beaman</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vancouver</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rooming In – the need for attachment. Michael Krausz – trauma informed practice for substance using women. TIP guide from the British Columbia Centre for excellence Nordic Model</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sheway</td>
<td>Danna Clifford</td>
<td></td>
<td>Rooming In – the need for attachment. Michael Krausz – trauma informed practice for substance using women. TIP guide from the British Columbia Centre for excellence Nordic Model</td>
</tr>
<tr>
<td>The Mothering Project</td>
<td>Tammy Rowan</td>
<td></td>
<td>Connected me to the FASD trauma informed co-creating evidence group.</td>
</tr>
<tr>
<td>(Manito Ikwe Kagikwe)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Collaborating</td>
<td>Donna Atkinson</td>
<td></td>
<td>Social determinants of health Two eyed seeing Integration of health practices Contextualisation</td>
</tr>
<tr>
<td>Centre for Aboriginal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health (NCCAH)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National evaluation</td>
<td>Carol Marie</td>
<td></td>
<td>Trauma informed practice Harm reduction Gendered understanding of structural inequality</td>
</tr>
<tr>
<td>study on FASD prevention</td>
<td>(Nancy Poole and Co)</td>
<td>Birth weights/substance abuse (see docs)</td>
<td></td>
</tr>
<tr>
<td>programs</td>
<td>10 organisations</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>present including</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mothering Project,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Breaking the Cycle,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Herway and Sheway</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National evaluation</td>
<td>Carol Marie</td>
<td></td>
<td>Trauma informed practice Harm reduction Gendered understanding of structural inequality</td>
</tr>
<tr>
<td>study on FASD prevention</td>
<td>(Nancy Poole and Co)</td>
<td>Birth weights/substance abuse (see docs)</td>
<td></td>
</tr>
<tr>
<td>programs</td>
<td>10 organisations</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>present including</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mothering Project,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Breaking the Cycle,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Herway and Sheway</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HerWay Home Program</td>
<td>Amanda Seymour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coordinator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In with Forward Grounded</td>
<td>Sarah Schulman</td>
<td>Research and development collective</td>
<td>A number of different practices and behavioural and organisational change models to create innovation in the social service sector. ‘Ground up’ research Adopting from start-ups and companies known for innovation – google 20% of their time, investing in your own project Shifting stuck social outcomes Overcoming structural barriers to meaningful social reform</td>
</tr>
<tr>
<td>Grounded space</td>
<td>Social Impact coordinator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Author of, Globalisation of Addiction</td>
<td>Bruce K Alexander</td>
<td>Psychologist</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>------------------</td>
<td>--------------</td>
<td></td>
</tr>
<tr>
<td>Author of, In the Realm of Hungry Ghosts amongst many other books on childhood trauma</td>
<td>Gabor Mate</td>
<td>Physician</td>
<td></td>
</tr>
<tr>
<td>City of Vancouver</td>
<td>Chris Van Veen</td>
<td>Urban health planner</td>
<td></td>
</tr>
<tr>
<td>City of Vancouver</td>
<td>West central Aboriginal Harm Reduction society</td>
<td>Presentation</td>
<td></td>
</tr>
<tr>
<td>Assante Centre</td>
<td>Alyson Pooley Executive Director</td>
<td>FASD clinic – assessment and treatment plans</td>
<td></td>
</tr>
<tr>
<td>Fir Square</td>
<td>Head Nurse and trainees</td>
<td>Vancouver Women’s hospital for substance involved women and children</td>
<td></td>
</tr>
<tr>
<td>Rankin Inlet, Nunavut Organisation/Association</td>
<td>Contact(s) And position</td>
<td>Programs</td>
<td></td>
</tr>
<tr>
<td>Acting Executive Director Pulaarvik Kablu Friendship Centre</td>
<td>Sam Tutanuak</td>
<td>A number of community based programs including a counselling program</td>
<td></td>
</tr>
<tr>
<td>Healing Facility</td>
<td>Noel Kaludjakand Uja Karetak</td>
<td>Inuit Councillors and men’s on-country programming</td>
<td></td>
</tr>
<tr>
<td>Spousal abuse counselling program</td>
<td>Mary Fredland</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Focusing on research and development
Competition overrides collaboration.
Inside-out approaches to change

Discussion on Vancouver harm reduction strategy
Releasing current research on Aboriginal peoples experience with the western medical system

Attended an elders gathering at a Cabin on the land run by two of the organisations councillors – Hannah, an elder, and Kathryn Misheralak

Sources funds for all wellness
Participatory driven and led programing and projects.
<table>
<thead>
<tr>
<th>Location</th>
<th>Contact</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ilisaqsivik society</td>
<td>Terry Garchinski co-facilitator</td>
<td>Organic development – reflective of programing Decolonising Addressing power differentials Ground up development of programs and priorities Practice to action not theory based Non-hierarchical and non-paternalistic formation of an organisation Referring to local expertise – Safe space for healing</td>
</tr>
<tr>
<td>Arctic College</td>
<td>Shari Fox Gearheard</td>
<td>Met with the many program participants. Sat in on ‘our life’s journey’ course for four days</td>
</tr>
<tr>
<td>Tulsa, Oklahoma Various organisations</td>
<td>Bobbie Bigby</td>
<td>A number of different programs Gave me a great sense of cultural resurgence, concepts of sovereignty and nation building. They have very good health systems and other hard physical infrastructure but have found it difficult to find the investment to build and practice own societal values</td>
</tr>
<tr>
<td>Tucson, Arizona Native Nations Institute at the University of Arizona</td>
<td>Stephen Cornell</td>
<td>Cultural Match Based at the University reflecting on travel and researching report/resource</td>
</tr>
</tbody>
</table>
Navigating the Report
This report is designed primarily for community based organisations, Indigenous organisations and those working across a range of programs and departments in the social service sector. This work takes a different perspective than other trauma-informed implementation guides in that it does not focus on a specific area of service delivery, health, or clinical practice. In essence, this report is for everyone and takes a universal position for the need to transform working practices, organisational structures and systems. It is useful for anyone interested in understanding the nature of intergenerational trauma, and what can be done to practically address trauma.

Effective trauma informed strategies involve multiple stakeholders, organisations and practitioners from a range of disciplines and community groups. This means that it is necessary to drive a strategy of shared evidence and working practices across sectors and silos to appreciate that trauma is contextual and that restoring health and wellbeing for individuals and community is holistic.

This report is not directly addressed to policy makers or funders. However, it is a responsibility of everyone working in the context of trauma to communicate the importance of this work to funding bodies and policy makers, to enable the work on the ground to be the best it can be.

A note on terms
Throughout this report, service provision, community organisations and community based work is used interchangeably to discuss the groups of people and practitioners delivering services and projects on the ground.

Service users, community members, clients, those accessing support workers, and those engaging with organisations from the community, are used interchangeably to refer to the groups of people who tend to be the recipients of work.

Indigenous people and Aboriginal people are also used interchangeably to refer to the many first nations people I met with and contributed to an understanding of healing and holistic health and wellbeing, which is described throughout the report.

A note to organisations exploring and implementing trauma informed work
Much of this work is communicating a foundational understanding of trauma, and effective working practices. Each section is designed to introduce topics and approaches to work and encourage organisational discussion and investigation. The information presented is by no means exhaustive. Some readers may have good knowledge of what is presented, others might have familiarity with some of the sections and not others. This report is designed to create a consistent knowledge platform for an entire organisation to launch themselves from on their journey to implementing trauma informed and responsive practices.

No organisation or group of stakeholders can implement all the practices and methodologies in this report. It is important to consider what is useful to your organisation and how you can gradually implement new approaches to work. This report is here for you to dip in and out of as you decide how you want to take on this work.

For an organisation to commit to being trauma informed and responsive, means that they have to be ready to change work practices and possibly organisational structures and strategies. In working out whether you are ready for this commitment take the time to explore and investigate the approaches and practices presented throughout this report. Everything you do should be fit for context.
A Note on Methodology

I met with over 60 people in a range of different organisations and settings. Each meeting took place around a semi-structured interview where a series of questions were asked about trauma informed, responsive and empowerment practices. In many instances, I sat in on programs being delivered to see firsthand the work being done.

The information and analysis presented throughout this report is drawn from all the conversations, meetings and observations made throughout my explorative travels. There are a number of TIP and THINK boxes to give the reader ideas and thoughts that they can take directly to their own working practice. Again, all of these recommendations have come directly from the learnings during the trip.

Some of the writing has been drawn directly from the Marninwarntikura healing blog, which I wrote as I travelled, and can be found here,

The Context

Knowing the context, we live and work within helps us understand why we are doing our work and how to make it better. As this report will explore, knowing our context is the foundation to breaking the cycle of intergenerational trauma. Trauma informed practice and socially innovative programs deal with root causes of issues to address and overcome problems. Without an understanding of context, finding the root to problems is impossible.

This report provides concepts and ideas for further exploration, and context is the first to be investigated. Although, I do not go into a deep exploration of the context for each place I visited, it is important for anyone working in the social service sector to make sure you know your context. In the ‘Applying Practices’ section, I review what it means to be a trauma-informed individual or staff member of a trauma-informed organisation. A primary skill to develop is empathy. At the heart of empathy is being able to appreciate people’s contextual reality, with acceptance and without judgement. This means understanding a person and their geographical location’s history; how that history effects the current environment, society and socio-economic status; an appreciation of current cultural practices, and peoples lived reality. Lived reality is what people experience daily.

The best way to get an appreciation for the context you work in is by talking to the community and asking them about their history and what their lives are like.

Australia, Canada and the United States of America

The context of this report is the history and contemporary political and societal affairs of these three western nations. Although, not always explicitly mentioned, backgrounding this report are the Indigenous peoples of these three nations. In Australia, Indigenous people belong to hundreds of distinct language groups, known collectively as Aboriginal and Torres Strait Islander people. In Canada, there are three distinct Indigenous peoples – the Inuit, Metis and First Nations. The First Nation people belong to distinct tribes and languages spread across territories in North America. In the USA Indigenous people are known as Native Americans, or American Indians, there are hundreds of distinct tribes and languages. Native Americans also include the Inuit people of Alaska known as Native Alaskans in the USA.

The Historical Context

Canada’s and the USA’s history and Indigenous intergenerational disadvantage is similar to Australia’s. The often-violent history of colonisation and first contact with Indigenous peoples across Canada, the US and Australia happened at different times and in different, mainly deeply disturbing and painful ways. First contact across the continents are varied, complex and dynamic. However, there are universal modes and operations of colonisation. These are methods which were designed to annihilate and/or assimilate Indigenous peoples into western society so their land could be taken and resources extracted to fuel the western settlements and their economies.

Much of this history of colonisation remains unresolved and for many unknown. It does not feature in length or depth in mainstream education. In this sense, dominant Western society is largely unaware of this global intergenerational trauma. As western economies and social systems continue to ignore or deny people’s history, intergenerational trauma remains unresolved. The contextual reality of today is the result, a perpetuation of disadvantage and inequality. This theme is explored in the section on Intergenerational trauma.

As I travelled and witnessed this global context, I saw how so many marginalised Indigenous communities with similar socio-economic context - inadequate housing, inflated prices of food, a
lack of mobility due to prohibitive transport costs, an education system that does not reflect the richness of Indigenous knowledge but privileges western teachings of language, histories and values, mass incarceration, a welfare system that leaves people vulnerable and trapped...the list goes on. This system manifests a range of harms which leads to further trauma.

Australia, Canada and the USA are not detached linear histories of nation building. Each country is not dealing with isolated issues of infrastructural inequality, deprivation, issues of low employment and addictions. Together these nations are part of a global system of ongoing oppression and subjugation of Indigenous people and others living in vulnerable contexts within western nation states.

The reason we see similar average life outcomes for Indigenous people in Australia as we do in Canada and the United States is not a quirk of the environments or the peoples. Indigenous people’s living in these nation states, as in other parts of the globe, experienced a similar overwhelming transformative and shocking assault by Western powers post the historical period of the enlightenment. The consequences of this history are reviewed and described in detail in the social norms and behaviours we see in societies that have been colonised today has left a legacy of entrenched structural violence and inequality. This is the historical and political context that must be understood by anyone attempting to grapple with the phenomena of intergenerational trauma.

**Changing the Context**

In Australia, over the course of 2017 there have been a series of debates and discussions about recognising Indigenous history, society and people today. While I was in Canada, Australia marked the events of Sorry Day, marking the apology from the Australian nation to Indigenous people for the systematic removal of Indigenous children from their parents known as the Stolen Generations; the release of the Aboriginal and Torres Strait Islander Healing Foundations report, ‘Bringing Them Home 20 years on: an action plan for healing’; the ‘Uluru Statement From The Heart’, a call from Australia’s Aboriginal leadership to recognise Indigenous Australian’s in the constitution and to ensure there are Indigenous voices present in the Government of the nation.

A section of the statement reads,

*“These dimensions of our crisis tell plainly the structural nature of our problem. This is the torment of our powerlessness. We seek constitutional reforms to empower our people and take a rightful place in our own country. When we have power over our destiny our children will flourish. They will walk in two worlds and their culture will be a gift to their country...In 1967 we were counted, in 2017 we seek to be heard”.*

The Uluru statement and ongoing discussions around constitutional recognition go to the heart of what justice looks like in the face of overwhelming injustice, and the deep and meaningful processes required to rectify past wrongs with present rights. Ultimately, they emphasise the necessity of constitutional and governmental structural reform as a means to break a cycle of national injustice and resulting traumas.

Unlike Australia, there are treaties in Canada and the USA. However, in both countries Indigenous people grapple with similar issues of being disenfranchised and marginalised and a history of treaties being formed and broken time again. The Inuit people of Canada never formed treaties with the nation, however in 1999 they became the first Indigenous population to form a self-governing territory called Nunavut, which I visited toward the end of my trip. The Native Americans I met spoke of self-government and sovereignty. For some Native American groups, self-government has enabled
them to build large enterprises to finance cultural centres, health care and schools. This is explored briefly in the section on evidence.

When I was in Ottawa I was told by Indigenous advocacy groups that there are nation to nation dialogues, between the First Peoples and the Canadian government, and there are Inuit to Crown conversations. There are funded advocacy bodies representing the political rights of Indigenous people. I was told there are multiple avenues for negotiation with the government. It was explained to me that these avenues for discussion open doors on possibilities for change, and this means there is hope for a different future.

**Taking a different approach, the time is now**

“Nothing is more powerful than an idea whose time has come”

*Victor Hugo*

Canada and the USA are becoming internationally recognised for setting in motion a movement to embed trauma informed models/approaches to enable recovery from ongoing societal-wide trauma. This practice, explored extensively throughout this report is enabling a range of community based organisations, the social service sector and policy makers to understand and respond to the context of intergenerational trauma.

It is clear that a movement is growing to understand the huge effects of trauma. Over the last 20 years pockets of the clinical and health professions have been responding to the evidence that trauma is real and can be overcome. A body of trauma informed working practices has emerged that can be applied beyond clinical disciplines. Five years ago, trauma remained a niche discussion, now practices to confront and overcome trauma are entering the mainstream. It is being appreciated that community development and the social services sector need this applied approach to reflect the enormously challenging and complex nature of the work on the ground.

This report on trauma and our ability to overcome and heal from it, comes at an interesting and disturbing time in international politics, and western history. As our work, predominantly in the social service sector, attempts to become informed and responsive to trauma, we cannot ignore the local, national and international context we operate within. As the report highlights our interventions need to be specific to place, but the cause and impact of trauma knows no bounds.

As the report reveals, the emerging brain science of neuroplasticity, is giving hope that positive societal change is very possible. It tells us that applying the right amount of stress, at the edge of chaos, might be all we need to transform the way we work, live, build and connect into vibrant and resilient communities.

Momentum is gaining to use trauma informed and empowerment practices across multiple working environments to learn how to make large scale impact, create innovative interventions and restore societal health and wellbeing. These practices are a guide for better ways of working and interacting in all our lives. These practices appreciate people’s unique context and our universal humanity.

These are practices designed to bring about necessary wide scale change. The current global context demands that the only time for this change is now.
Definitions and Discussion - What is Trauma and How Do We Address it?

Having a philosophical approach to work is the backbone to why our organisations, the service sector, welfare structures and other institutions, do what they do. When we are able to understand the enormity of trauma and the field we work within we can approach our work with renewed meaning and vigor.

Having a shared knowledge platform is a fundamental element of trauma informed practice. Developing this platform requires a gathering of information that helps to define the platform, and our working approaches.

This section explores the definitions of trauma and discusses how our systems have incorporated rejected, or entrenched trauma within people’s lives. The information presented is designed to be the platform that we launch ourselves from in considering what working practices we should implement; working practices designed to empower and intervene to break the transmission of intergenerational trauma.

Understanding Trauma

Trauma is a difficult concept to understand. Societal trauma is the primary cause of an overwhelming raft of societal, economic and health issues which our social service sector and welfare systems are responding to today.

At first this correlation can seem like too much of a catch-all abstract relationship to be addressed seriously by public policy, community development organisations and health prevention research. This is understandable because of the multilayered non-linear nature of the experience and ongoing effects of large-scale trauma, which sits at odds with the cause and effect, reductionist philosophical basis of the government and non-government service sector.

This section explores the many different forms and definitions of trauma and how they can enhance our understanding of the transmission of trauma and inform the development of approaches to break the cycle of intergenerational trauma. Further it looks at some of the key terms around countering trauma. These terms include holistic approaches and empowerment. Understanding empowerment was a primary focus of this work. I devote a lot to explaining it and exploring processes of empowerment.

All of the following definitions are based on explanations given by a range of practitioners and researchers working within what can be understood as trauma-informed or empowerment-based practice organisations, frameworks and strategies.

Before exploring the complexity of trauma here is a simple straightforward definition that we can launch ourselves from.

Many of the definitions found throughout this section draw on the information from three trauma informed practice guides, given to me by the respective organisations I visited in Canada. They are, 

*The Klinic Community Health Care, Trauma Informed Toolkit (2013)*


*The Jean Tweed Centre, Trauma Matters (March 3013),*
Trauma and Trauma Response

A trauma is a dangerous and often life-threatening event which happens unexpectedly. It can also be a series of impacting behaviours, feelings and sensations such as colonisation and ongoing policies of discrimination, living in poverty, or being continuously verbally abused and threatened. In all instances, it triggers a rapid increase in stress, and associated surges in hormones such as cortisol, which are too severe for the body and brain to cope with rationally and functionally.

(Center for Substance Abuse Treatment (US). Trauma-Informed Care in Behavioral Health Services. 2014)

Developmental trauma

If unresolved these experiences can be cumulative and additive. They can develop into a series of stressors and anxieties which result in a range of negative feelings, emotions and harmful behaviours that lead to poor life outcomes.

Toxic stress

The sensations brought on by trauma can be locked into parts of our memory which are not associated with a time or place, but with feelings, such as terror, hopelessness, powerlessness and extreme anxiety. A person can be triggered into a trauma response without warning, often due to encountering and dealing with everyday stressors. Examples include having to pay a late bill, dealing with a disagreement at work, etc. A person living with toxic stress is in a constant state of hyperarousal that can be easily triggered by these normal stressors.

Trauma is different for everyone

Each individual experiences trauma and developmental responses to trauma differently. When working with people who have trauma in their lives, what matters is not the severity of the trauma, but the severity of the resulting feelings. No one should be judged for how they respond and adapt to traumatic feelings.

Colonial trauma and traumas of oppression

For Indigenous societies and other marginalised minority societies and those that live in socio-economic disadvantage, trauma is often massive and cumulative and has happened as a result of national and international policies and historical forces. This means it has occurred frequently in the past, often sanctioned by the State without being addressed, continues to happen in the present, and will have lasting harmful effects in the future. If it remains unresolved it can lead to a cycle of re-traumatisation. This re-traumatisation is intergenerational trauma which will be explored in the following section.

(Aguiar, W. & Halseth, R. 2015)

As a consequence of this large historical and political narrative of trauma, people experience other harmful issues that compound and entrench trauma, such as:

- Physical and emotional violence
- Abuse of alcohol and other drugs
- Child sexual abuse
- Domestic and family violence
- Fetal Alcohol Spectrum Disorders
- Missing and murdered family members
- Poverty
- Removal of children from parents

Every organisation I visited was addressing these complex and interrelated issues. All those I spoke to understand these issues as occurring because of the traumas defined above. Every organisation was grappling with what it takes to break the cycle of physical and psychological abuse and oppression in order to stop the occurrence of the secondary harms that are deepening and entrenching the cycle of trauma.
Definitions – What is Trauma

When I asked people how they understood intergenerational trauma, and how they were addressing it, they would look at me blankly. I soon realised it was because trauma is pervasive. It is everywhere and has occurred for so many reasons that often our work is immersed in trauma.

Many of the definitions below come from resources that I was given and demonstrate that trauma is immense and ongoing and cannot be considered as a past event. This list is by no means exhaustive. The sheer number of definitions is an indication of how difficult it is to get a handle on trauma.

A first step to breaking the cycle, as I was told by many practitioners, is understanding. Having the understanding means that we never impose a single solution on an environment where people are living with trauma and complex harms. It is important as practitioners to have a good sense of the complexity of trauma so we can embrace that complexity in our working models in order to effectively respond to and overcome the enormity of trauma.

The following definitions are useful to know when working in a cross-cultural context and/or in an Indigenous organisation or community to appreciate the many layers and cycles of trauma that are occurring simultaneously.

**Complex Post Traumatic Stress Disorder** - is the long-term effect of severe, prolonged or repeated trauma. It often includes a socio-historical understanding of trauma within the context in which it occurs. Still, this has been criticised by Bryant-Davis and others for not taking into account racism, oppression, violence and the many intersecting social and political dynamics that lead to the occurrence of trauma.

(ibid, p8)

**Chronic trauma** – results in anxiety, depression, grief addictions and self-destructive behaviours

**Poly-victimization** – being exposed to many forms of violence either as a child or ongoing across a lifetime. The outcome is often a complex trauma diagnosis due to abuse and profound neglect. “For instance, a child who has been physically assaulted in the past year is five times as likely to also have been sexually assaulted or maltreated during this time”.

(Pinderhughes H, Davis R, Williams M, 2015: 10)

**Cumulative trauma** – earlier forms of oppression and injustice are built on by systems that continue to replicate the same structures. The ongoing trauma resulting from the original injustices has never been addressed. Past traumas reappear in contemporary forms.

(Aguiar, W. & Halseth, R. 2015)

**Collective trauma** – happens to a large group of individuals, a community or society and can be transmitted across communities and generations. War, colonisation, genocide, slavery and natural disasters can cause collective trauma.

(ibid)

**Cultural trauma** – is a, “collective feeling that a cultural group or community have been subjected to a horrendous event that leaves indelible marks upon their group consciousness, marking their memories forever and changing their future identity in fundamental and irrevocable ways.”

(Pinderhughes H, Davis R, Williams M, 2015: 11)

**Community trauma** – breakdown in trust amongst community members, social isolation with small and destructive/ dysfunctional family groups, and deteriorated unsafe public spaces. It is a destruction of societal infrastructure that leads to a degradation of the social, physical and economic
contributing to poor health outcomes for large numbers of the community.
(ibid:5)

Historical trauma – Dr Maria Yellow Horse Braveheart defines it as “cumulative...collective and compounding emotional and psychic wounding both over the life span and across generations, including the lifespan...involves the constellation of features identified in the literature on PTSD” (Braveheart, 1998: 288). In her research she discusses the genocidal impact of colonisation on Indigenous societies and the loss of huge swathes of the population, including healers, teachers and warriors. Massive amounts of knowledge was lost in the colonial conflict and this perpetuates grief and loss for generations to come.
(Braveheart, 1998)

Political trauma – felt through political oppression, discriminatory and prejudicial state and federal policies that isolate and marginalise cultural and ethnic groups, further excluding and blocking them from mainstream opportunities. It creates a sense of disenfranchisement, political helplessness, lack of self-determination, and exclusion from civic governance structures. (Gullette, 2008)

Historical and contemporary trauma – trauma experienced in the past is unresolved and has caused trauma in the present. Individual trauma in the present is intimately tied to communal trauma experienced in the past and continuing into the present.
(Braveheart, 1998)

Race base traumatic stress - “Bryant-Davis (2007) ...describes it as an “emotional injury motivated by hate or fear of a person or group of people as a result of their race” (Aguiar, W. & Halseth, R. 2015: 9). While ‘race-based traumatic stress’ is similar to other types of trauma, it is unique in that it provides a “more precise description of the psychological consequences of interpersonal and institutional traumas motivated by the devaluing of one’s race” (Bryant-Davis, 2007, cited in ibid:8). She states that race-based violations can add to, and in some cases multiply, the impact of other stressors such as living with violence, abuse, and disadvantage.
(Bryant-Davis, T, 2005).

Colonial trauma response - Evans-Campbell and Walters (2006) explore the interactions of historical trauma and current traumas, which they term the ‘Colonial Trauma Response.’ They argue that contemporary traumas such as ongoing racism and discrimination are stresses that perpetuate colonialism, and are just another example of injustices experienced by Aboriginal peoples through the generations. These stresses build on previously existing trauma and are intimately connected to the Colonial Trauma Response” (Cited in ibid:8-9) (Evans-Campbell, et al, 2006

What’s Wrong with ‘Trauma’?
Some issues with the term

Clearly, there is no single phrase that can conceptualise the impact of trauma on Indigenous societies, although ‘massive and overwhelming’ is being frequently used by Indigenous research institutes and community groups seeking to understand the social determinants of health as being underpinned by trauma continuing from one generation to the next. It also encompasses many of the definitions presented above.

A resource published by the National Collaborating Centre for Aboriginal Health, which can be found on their website under Aboriginal Peoples and historic Trauma, states:
Aboriginal peoples’ experiences are rooted in multigenerational, cumulative, and chronic trauma, injustices, and oppression. The effects of trauma can reverberate through individuals, families, communities and entire populations, resulting in a legacy of physical, psychological, and economic disparities that persist across generations.

(Aguir, W. & Halseth, R. 2015:7)

The resource goes on to comment that western understanding and definitions of trauma are too narrow to fully comprehend the scale of trauma from the individual to the systemic experienced by Aboriginal people.

**Post-traumatic stress disorder (PTSD)**

PTSD is commonly defined as the result of being exposed to extreme stressors. It refers to the various ways in which traumatic events are re-experienced as symptoms. Most definitions of PTSD agree that symptoms eventually disappear in most people, but for some people symptoms persist and may be experienced even when a person is not in danger.

(Center for Substance Abuse Treatment (US). Trauma-Informed Care in Behavioral Health Services. 2014)

I have spoken to people who explained to me that this way of talking about trauma can lead to pathologising people. We tell people that they have something wrong with them but, with the right attitude and skill set, they can fix it. When trauma is medicalised it can quickly be taken out of context. The blame or burden of recovery is placed on the individual rather than on the political and socio-economic context an individual or community lives within.

For Indigenous people the idea that most people will eventually overcome trauma responses is not part of their lived reality. It shows a disregard to the entrenched cycles of trauma arising from the perpetuation of disadvantage and discrimination. That denial of lived reality can compound trauma even further, filling people with grief, loss, and a sense of hopelessness and disempowerment which can lead to further trauma of both the individual and the collective which manifests in the harms we witness such as suicide, the most devastating of all.

**The Clinical Model of Care and Support**

Given the domination of the Western medical system a diagnosis of PTSD means that there is often only a clinical option for treatment available to individuals. This option is suited to some but can be culturally inappropriate and insensitive for many. In remote locations, it is often not an available option. In urban centres where it is available it can be too costly to be accessible.

It is important to recognise in the case study below that there are structural barriers which stop people from being able to access the services they need. Exclusion from treatment programs can entrench trauma responses in society and lead to ongoing harms. This exclusion and violence inflicted on individuals by state institutions is termed structural violence; the pervasive and entrenched experience of Indigenous peoples.

**Structural Violence** –systemic ways in which social structures harm or otherwise disadvantage individuals. It is subtle, often invisible, and often there is no one specific person who can be held responsible.

(Farmer PE et al, 2006)
Case Study: who is the clinical system for?

I visited one of the best-known PTSD clinics in Canada, Homewood Health, which was using the latest trauma informed practices for recovery from the Sanctuary Model (to be reviewed later). The clinic had a high success rate but was private and incredibly expensive. It catered mainly for returned service people who had witnessed or participated in violence in war and offices from the Royal Canadian Mounted Police (RCMP). The military and RCMP budgets and expenses could afford to compensate the treatment of its workers and soldiers. When considering a holistic approach, it is important to ask if our criminal justice and defense systems were trauma informed would they need to be financing private PTSD treatment centres which due to cost are rarely available to the general public. The treatment that they receive is excellent. It was explained to me that it is implicitly understood that war is inevitable and therefore these treatment centres are inevitable. These returned service peoples have encountered and experienced atrocities and need a recovery plan to continue to live in reasonable state.

Again, when we know clinically that violence has massive effects on the psyche and body, why is this treatment not available to everyone that has sustained violence and trauma? The definitions above shed light on the post-conflict state Indigenous societies continue to live in. Yet, this type of intensive PTSD treatment is not available in Indigenous communities.

At the Klinic community health centre, in the trauma informed training, we were given a similar set of questions. We were presented with the example of some RCMP officers who tasered to death Robert Dziekanski a Polish immigrant at Vancouver international airport. The polish man had been held up in customs for a long time did not speak any English and was incredibly tiered. After a series of events where he became very agitated but did not cause any harm RCMP officers tasered him five times. He fell to the ground and died.

A number of questions were put before the group being trained. The most striking where those that challenged the systems that are currently established to respond to crisis, and not prevention.

What would have happened differently if the RCMP officers had been trained in trauma response?
What was the training of the RCMP officers to make them act swiftly with brutal authority?
Would they have been able to calm Robert down, and if so, avoid his death if they had been train in trauma informed practices?
What happened to the RCMP officer who killed Robert?
Did he need to be treated for recovery from PTSD?

These examples show that the treatment is available, but only to a few. If our systems were different, how many people would need treatment in the first instance? How many conflicts and situations of serious injury or death could we avoid as a society?

It is challenging to consider that the institutions designed to protect the public could be causing unnecessary damage and harm, particularly concerning those who come from minority backgrounds.
An Aboriginal Experience of the Clinical System

In Vancouver, I attended a presentation by The Western Aboriginal Harm Reduction Society (WAHRS) based in Vancouver’s Downtown Eastside. They have many interesting resources on Harm Reduction for Aboriginal people which can be found here on their website, http://wahrs.ca

They were delivering research they had conducted around Aboriginal people’s experience of the healthcare system. They found that Aboriginal people in the downtown eastside were experiencing multiple and overlapping forms of stigma when interacting with healthcare professionals and attending medical appointments. This included stigma related to race, socioeconomic status and substance use.

(Goodman et al, 2017)

The group used a series of Indigenous methodologies, primarily Talking Circles, to encourage Aboriginal people to share their experiences. A highlight of their key findings on page 3 of the project overview document are,

- Institutional racism – influencing clinical decisions and practices, and results in unsafe care
- Clinical perception Aboriginal patients are drug seeking – resulting in undiagnosed pain
- Aboriginal people anticipate adverse care – deters people from seeking medical attention resulting in unmet medical needs
- Clinical practice lacks an understanding of social and historical determinants of Aboriginal health – leading to misdiagnosis and inappropriate treatment plans

WAHRS explained that these pervasive experiences of discrimination toward Aboriginal people in the clinical healthcare system was creating trauma within treatment. The group were adamant that the clinical approach had to change by understanding the trauma and harms Aboriginal people experience due to political and socio-economic circumstances. They recommended that the health care system introduce practices of dignity and respect into its trainings, so medical practitioners ask Aboriginal people what they feel and trust that they are telling the truth. Clinical practices must become non-judgmental to stop pre-determined assessments of a person’s medical needs based on pervasive and damaging stereotypes.

The WAHRS group believed that there is potential for the medical system to change if it considers blending Aboriginal approaches to care and support into medical assessment and treatment. This includes peer support treatment and talking circles, where Aboriginal people can support each other to recover, and through the introduction empowerment process of work. A blended approach to Aboriginal health care is explored in the ‘Methodologies’ Section of this report.

Defining Aboriginal Health and Wellbeing

The NCAHH is a national Aboriginal research centre looking toward a renewed public health system for Aboriginal people across Canada. It is conducting, collating and putting into action research that recognises the holistic nature of health and the way in which the health of Indigenous people is underpinned by multi-faceted structural issues. Their team are working across boundaries to connect evidence, knowledge, practice and policy.
In discussion with Donna Atkinson, the Manager of NCCAH, she explained that we should take a social determinants of health perspective when responding to overwhelming trauma and Indigenous needs and wellbeing.

**Social Determinants of Health**

The NCCAH website defines the social determinants of health as:

*encompassing the broader social forces that impact upon health. Poverty, employment, working conditions, education and literacy, social status... The NCCAH recognizes that colonization and colonialism cross-cut and influence all other social determinants of health of First Nations, Inuit and Métis individuals, families and communities.*

https://www.ccnsa-nccah.ca/28/Determinants.nccah

Donna Atkinson explained that social determinants of health are about how one’s health is shaped. This is not just about what we consider the dominant determinants such as poverty, economics, education. For indigenous peoples, it is about looking through the lens of colonisation and appreciating how this has severely eroded self-determination, self-worth and collective expressions of identity and culture, causing ongoing discrimination and prejudice against Indigenous people. This has a huge impact on Indigenous people’s health. Indigenous societal values are interrelated with and often inseparable from the primary indicators used by mainstream approaches to evaluating the health of a population.

**Wellbeing measures**

Donna acknowledged that population health promotion and prevention work is important. However, it is too often considered the primary means to address health concerns. When considering the lens of colonisation and overwhelming traumas experienced by Indigenous people this form of prevention work as a primary response is too little and too late. It is also using the mainstream indicators of health determiners which may not be useful in exploring how Indigenous people can improve their health and wellbeing.

Instead, she explained, we have to look at deep and profound knowledge translation of Indigenous health and wellbeing to intervene in crises of health. As the resource noted above on Aboriginal Historic trauma further explains, this is about understanding that there are many ways trauma is transmitted and we have to work with and from the knowledge of Aboriginal people - spirituality, connectedness and principles of reciprocity - to break the transmission of trauma, and to see a positive change in the overall health and wellbeing of the population.

**Holistic approach**

For Donna, a holistic approach is needed. It cannot be compartmentalised, she said, because it moves so far beyond the western approaches of cause and effect. It goes so far beyond the linear and the tick boxes of targeted health issues that for many people it is too big to handle. To be holistic is an attempt to research, work and act in a way that is difficult to define in western terms.

When talking with Aboriginal organisations, it was impressed on me that health and wellbeing can only be appreciated when considered holistically. The concern with trauma is that it has become a medicalised concept, a condition that it is not appreciated through a holistic lens. Defined as Post Traumatic Stress Disorder (PTSD), it becomes part of the Western medicalised model of diagnosis and treatment.
In a basic sense holism means to understand all people within context and history. In a broader more complete sense it means that the individual is connected into a collective, to the environment, to workspace, to the economy, to education and to health, amongst the many other elements of a living system.

The parts of a whole cannot be considered independently from one another. This means that when the clinical model takes on a trauma-informed practice it needs to learn to recognise that individuals are more than just the symptoms of a disease. Beyond the clinical model, holism means that every institution – schools, education, the police, corporations and businesses, the list goes on – needs to take on an approach that can respond effectively to trauma with an understanding that it is recoverable in its wider sense.

There are many resources that go into a deep exploration of health care, clinical health on the NCCAH website. The publications page can be found here,

https://www.ccnsa-nccah.ca/34/Publication_Search.nccah

A View of the NCCAH Publications page

Another Type of Care and Recovery Model

With the scale of trauma being so massive for Indigenous society and beyond, we need to consider options for trauma care, support and recovery that can blend and make affordable specialised individual or group clinical treatment pathways, with a holistic approach to societal growth, health and wellbeing. Trauma can be acute and dramatic and the symptoms displayed can require a clinical and medicalised treatment program. We need to learn how to bring these treatment programs to the community, or reduce the need for them by becoming trauma-informed within all of our workspaces.

Still, things are changing. The clinical model is taking trauma seriously and understanding it through many of the underlying principles of Indigenous holistic health. As I saw at Homewood Health, both
clinical practices and community and peer support approaches to trauma recovery benefit from taking on a holistic approach.

**Trauma and healing**

Returning to Donna Atkinson’s ideas around the social determinants of health, when trauma is understood holistically it becomes part of a larger story, part of a living history in a dynamic political, social and economic context. It can also be understood as a journey of healing. In a holistic approach, Indigenous societal practices of wellbeing through resurgence processes can be used as tools to heal and repair.

Healing when understood as wellbeing is simply normal everyday practices within a whole (holistic) societal framework. Such practices are not only used for people to recover from trauma, but are normal practices used continuously by everyone across generations for a society to be well and complete.

The predominately Western definition of trauma as a disorder needing treatment has obscured and in many instances undermined Indigenous people’s way of addressing trauma within the holistic framework described. The mainstream western approach views Indigenous societies stuck in the past, a populace incapable of addressing the dysfunction resulting from trauma through any practical application. These negative stereotypes of Indigenous people abound in mainstream society – Indigenous people are unable to ‘get over it’, lazy, living within a sob story, lacking a work ethic, and so on.

This means that the commonly understood definition of trauma keeps Indigenous people within a deficit framework. However, as trauma is becoming more fully a part of service provision, understanding trauma-informed practice is essential to bringing understanding of Indigenous holistic healing into the work of clinical practitioners and community development organisations.

(Marsh et al, 2015; Schynder et al, 2015)

**Changing the National Narrative**

**Trauma Exists and It Can Be Stopped**

For holistic approaches of healing, health and wellbeing to work on the ground the broader service delivery system needs to be ready and willing to change.

In many meetings I had, particularly in Winnipeg, the release of the Truth and Reconciliation Commission of Canada’s report seemed to have changed the dialogue amongst community members, organizations, and various institutions including government.

The report and calls to action can be found here,


In most of my conversations intergenerational trauma was used as a common term. The report had made many service providers aware of the generational impacts of trauma, particularly from the residential schools onward, and the 60s Scoop (descriptions can be found in the report). The 94 recommendations had made people, at least across the community development sector, aware that they could introduce working practices and processes that could stop the transmission of this historical trauma today.

Everyone I met with referred to the report. They explained that there was no strategy for implementing the 94 recommendations. However, people had been so overwhelmed by the
evidence of grief and loss presented in the report that they were attempting to respond to the recommendations without policy and government direction. At ‘Healthy Child Manitoba’ (2017), some of the schools that they were working with had introduced modules about the history of residential schools. For the younger children classrooms, had displays of Indigenous understandings of health and wellbeing, culture, creation, and history. I was told this was a huge step for the Canadian education system and could change the way that an entire generation relate to Canada’s history.

When the broader system is not appreciative of the impact of trauma on whole populations of people and across generations it is difficult to change discriminatory and prejudicial behavior.

Discrimination has a huge impact on entrenching both psychological and physical trauma and perpetuating disadvantage. When the public are unaware of the traumas Indigenous people have faced, and continue to face there is little public pressure to ensure Indigenous people have the adequate resources and infrastructure that they need and deserve as a basic human right.

This intergenerational trauma is perpetuated through the unequal distribution of resources to Indigenous children. The history of trauma that comes from the Indigenous Canadians Residential Schools continues in practices of child removal today, when appropriate support resources are not available to parents and families who may be experiencing a range of crisis. This has been proven by the Canadian Human Rights Tribunal – see text box below.
Case Study: ‘We Can’t Make the Same Mistake Twice’, a film by Alanis Obomsawin, a distinguished Metis director

I watched this film in Winnipeg. It explores how First Nation reserves have seen decades of underfunded essential services, which has systematically silenced and disempowered communities, entrenching collective pain and trauma. These communities, which are known as reserves in Canada, have seen little public investment, crumbling infrastructures and often a non-existent social welfare structure.

https://www.nfb.ca/film/we_can_t_make_the_same_mistake_twice/

It tracks the journey of the Caring Societies Case, led by the organisation’s CEO Cindy Blackstock, against the Canadian Government for not providing the same level of child welfare to First Nations on reserve as to children off reserves. After 10 years of fighting, the case went to the Canadian Human Rights Tribunal, which ruled that the Canadian Government discriminates against children on reserves. It was found that the government does not provide the same human services as provided to other Canadian children off reserve. As Cindy Blackstock argued, children on reserve are in greater need of welfare and family support. The less funding for family support on reserve, which includes disability support, treatments for children with unique and complex needs, child care and early education programs amongst many others, means that more children end up in the welfare system.

https://fncaringsociety.com/i-am-witness

Cindy has linked this discrimination in the present to the history of discrimination and intergenerational trauma experienced by First Nations in Canada. The lack of welfare support is a further traumatic period for First Nations in Canada’s history entrenching the cycle of intergenerational trauma.

Empowerment

It is fundamental that, as a trauma-informed approach is considered for an Indigenous organisation, all staff, Indigenous and non-Indigenous, appreciate the huge and lasting impact of colonisation.

For Indigenous staff, understanding trauma – as something which has happened to Indigenous society and not because of Indigenous society – is profound and empowering knowledge. It instantly removes individual self-blame and the blame of others, by putting pain, grief and ongoing harms into their proper context.

Empowerment – is giving authority and power to someone to do something, and is the process of becoming stronger and more confident, especially in controlling one’s life and claiming one’s rights.
(The Oxford English Dictionary, 2017)

In this sense, I witnessed empowerment as a process in all the organisations I visited. At the core of everyone’s work was ensuring that those who engaged with community organisations were fully
informed about their rights and the options available to them. The organisations I visited were constantly handing knowledge and information to those using the services.

Empowerment is the first step to breaking the cycle of intergenerational trauma. As Louis Young, the Indian Residential Schools Resolution Health Support Program Manager, from the Southeast Resource Development Council explained, when you give people the knowledge of history and trauma you are allowing them to take ownership of what has happened to them. The more people you give knowledge the more informed they are and the better collective decisions that can be made. Empowerment as the transference of knowledge is about handing authority and the power to make informed decisions over to others.

**TIP:** Being given the knowledge of what trauma is, is a necessary work process in becoming a trauma-informed organisation. Understanding and exploring the concept of trauma as a staffing body is a great way of beginning the process of equalising power across employees. In a cross-cultural work team, it is important to let those from minority backgrounds explain what it means to have a knowledge of trauma and its ongoing effects. As a group explores how signs and triggers of trauma might be present in the workplace; discuss what it would mean to change working practices in response to removing the signs and feelings of trauma.

I was told on a few occasions, that feelings of trauma are felt most strongly in the workplace through process of authority and control.
Case Study: Winnipeg Elders Gathering; Looking After Each Other

To address an issue, you don’t need to talk about it, we can talk about dignity instead – the language of de-stigmatisation

I spent time at the government department “Healthy Child Manitoba” and witnessed the work of their provincial wide Fetal Alcohol Spectrum Disorder (FASD) strategy, called ‘looking after each other: a dignity promotion project’. The team driving the strategy recognise that FASD has a high prevalence in the Indigenous population and work with a diverse group of stakeholders, including community representatives and First Nations, to end stigma around the issue. The vision for the province; “people with FASD, and women who have used alcohol during pregnancy are fully accepted and their dignity is protected”.

While I was there the team ran a two day First Nations elders gathering around positively promoting the dignity of Indigenous health and Wellbeing and appreciating the wealth of Indigenous parenting and family knowledge. The gathering was designed for service providers to listen and learn from First Nation elders.

For two days elders provided teachings about every aspect of life. They talked through narrative about healthy relationships, connection to the earth, and the meaning of the creator spirits and how to care for one another and the environment. FASD was not mentioned. In this gathering FASD was not a stigma in the room. Its status as a diagnosis was stripped, and the expertise was taken out of the hands of medical practitioners and advisors and put into the hands of Indigenous elders. When issues are understood as another part of life, it flips conventional understanding of who the expert is.

The strategy promotes the use of a common language to talk about FASD without communicating feelings of shame, blame or stigma. This gathering put the language of dignity and respect into action. The strategy team have developed a de-stigmatisation language guide on FASD. Here is an example,

Instead of using: ‘100% preventable’

Please Use: ‘Preventable’, and only use with caution. Think carefully about the context it is being used in as it can have a negative impact.

Why: 100% preventable oversimplifies a complex issue. This oversimplification removes all context in a woman’s life and defines the issue as a single, easy choice. In turn, this erodes society’s understanding and compassion for an issue with multiple factors for many women.

The elders sat beside the sacred fire which was the centre piece of the two-day gathering. They captured the holistic nature of issues perfectly by reflecting on their own fiery and fascinating histories, without passing blame or placing a diagnosis on anyone. Within all their words were lessons for generational change, and the potential for this change sits within the empowerment of their own people.

Tip: When approaching discussions about large scale and difficult issues such as FASD in a community, consider starting with an elders group or council. Take the issue straight to representatives from across community and let them decide how to talk about it and the language to use. Bring together an open gathering to ensure that elders and community are talking to service providers, not the other way around. This puts the issue in the hands of community. In gathering spaces service providers learn to hear the voices of elders and community and respond to their holistic teachings of health and wellbeing.
The Voice of Empowerment

The executive director of Sheway, Danna Clifford, expressed to me that empowerment is about voice. Empowerment is a step in making people aware that they have the right to have a voice, they have the right to be heard. Dana explained that empowerment through gaining knowledge is only the beginning.

If people are left with knowledge and no ability to express themselves, they can feel overwhelmed, helpless and trapped within their circumstances. Dana spoke about how she has seen people gain an awareness of inequality and can then become angry with those in authority for leaving them in a state of poverty. She explained that this understandable anger when expressed through aggression shuts the conversation down and ends the dialogue. A person in this position is not empowered because they are not able to be heard fully. In this state a person cannot make decisions that involve others or express to those in positions of authority what it is that they need.

It was explained to me at the Jean Tweed Centre, where they work with women substance users, that information alone does not change people’s behaviours. They gave this example:

*It's, she knows that every time she drinks she gets picked up by the police. She then can’t see her children in care. She knows this, she knows the consequences of drinking, so why doesn’t she just stop?*

This statement presumes that all people need is information, it does not consider circumstances, context, larger systems of disempowerment, events of disempowerment, and reasons for why that person is drinking.

The same is true of empowerment. Information that sounds empowering does not mean empowerment in and of itself. Dana explained that empowerment is not an end game, it is a process. When she works with women who have gained knowledge about their circumstances and context and they want to take control of their lives, she does voice and communication training. This approach is not formalised in the Sheway model but it is central to achieving their goal of supporting women’s self-determination, choices and empowerment.

**TIP: Mock Interviews**

Dana described how before women would go into a meeting, for instance, with someone offering a rental contract, she would do a mock conversation/interview. She would ask the woman: how do you feel? What do you want to express? What do you want to achieve from the meeting?

Then they would do the meeting. When statements were aggressive or demanding, Dana worked with the woman to look at rephrasing the statements and why that might help her get her point across. This process should not change what the woman wants to say. It should make what the woman wants to say be heard. Being heard can lead into discussion and dialogue and then decisions can be made based on her needs and what she wants.

Having control and making decisions that meet your needs is not just empowering – it is powerful!
Building Trust
When working with people who live within a context of intergenerational trauma, disadvantage and poverty, who have been systematically disempowered, empowerment is not achieved immediately; it is a journey of learning and trust building. **When working to empower people the principle of empowerment, i.e. listening to people and ensuring that they are heard, must be active in every work process.**

Empowerment is a two-way process. While individuals and community are supported to become empowered, those in positions of authority need to relinquish aspects of control. If they do not, empowerment can never truly take effect.

Government services, and other stakeholders who are external to community based-organisations and groups, need to establish processes to create transparent and open decision-making processes with the community. This is starting to be understood in what is commonly termed a co-design process. When co-designing programs, policies, strategies and procedures, the community needs to have an equal voice at the decision-making table, particularly when the work is designed to respond directly to community needs.

In Winnipeg I visited the West Central Women’s Resource Centre. Here they began by understanding empowerment as the unequal distribution of power in the workplace. Staff have been encouraged to see the power dynamic as being present between the employed service providers and the client seeking help and support. The employees of this resource centre had learnt to put power back into their client’s hands, and out of the hands of service providers in a presumed positon of authority.

The staff have a mantra: Women know what’s best for them. Service providers should never presume that they know what women need. Empowerment in this space is about working with, and not to, or for, the client.
Case Study: Clyde River
Empowerment is still doing to. Power is regaining control and decision-making authority

In Clyde River, Nunavut, I spent time at Ilisasquivik, the community-run health and wellbeing centre. Here the community had designed and established an accredited community counselling program. I was fortunate enough to sit in on some parts of this training. The group explained that this program was about the community regaining their power. I spoke about this statement to the support facilitator of the program. He said to me that the program is completely community-based. It is designed and delivered by community, to train the community in locally understood counselling methods. In this sense empowerment is a step that is working toward creating a system where the decision-making sits entirely within community hands, and it is up to the community who they invite in to work with them. The aim of empowerment is for power to be equalised across community and service system, and all other sectors. It is not held by positions at the top of a hierarchical structure of decision making. In this sense, the community go from being given pre-determined choices and options to determining their choices and life options.

At Ilisasquivik the community have gone from being the recipients of services, to choosing services to designing the programs and training for themselves.

The examples of empowerment provide a stepped process of work as expressed in the diagram below— the community begins by being empowered with knowledge and information to learn how to communicate their needs; to working with services and various stakeholders to make sure that the right services hit the ground to respond to community needs; to having power and control for communities to design their own programs and community infrastructure.

Trauma awareness and action

Understanding the breadth and depth of trauma and processes of recovery from a holistic perspective of health and wellbeing, enables service providers and practitioners to begin processes of knowledge-sharing and empowerment. Questioning clinical models of trauma treatment and recovery is useful in understanding what needs to be brought to communities on the ground and what aspects of the clinical model continue to discriminate and entrench harmful working practices.
Why We Are Using the Term Trauma

I will go on to explore trauma-informed practice. It is a practice which is extremely useful in helping people to survive, to reduce crisis situations and to give people a sense of control, even in the most difficult of circumstances. However, there is the risk that understanding trauma and having an awareness of it does not in itself address unequal distribution of resources and unequal access to services across society. Without addressing systemic inequalities, it may be impossible to break cycles of intergenerational trauma.

There are controversies over the use of the word trauma. As explained previously some people I met said they would not use it because of the stigma of labels which pathologize individuals. On the other hand, one theorist, Gabor Mate, who has written influential books based on early childhood trauma and the occurrence of trauma due to context, explained that trauma is the big message. He described that we must accept that it is here, it is huge, people are suffering and we have to do something about it.

Throughout this report, I will continue to use the word trauma. Everyone I met with spoke of addictions and harms as being caused by historical socio-political systems. To understand the systemic nature of harms, I believe it is useful to have a unifying word. Trauma is a way of explaining the universal nature of these harms, and simultaneously affords us a political analysis of how harms result and become entrenched in and across societies.

Seeing and understanding the layers of trauma and the resulting harms brings us all closer to being able to break down the transmission of multiple traumas across the generations.

The Evidence

Working from a well-founded evidence base is one of the foundational principles of a trauma informed practice. Evidence provides the social service sector with knowledge to inform the development of best practice community engagement and delivery models. As Sandra Bloom explains in her delivery of trauma informed practice through the Sanctuary model, shared knowledge is essential to ensure consistent and proactive action across service delivery for community/societal wide positive impact (Bloom, 2017).

Having the right evidence is the first step in understanding what sort of generational change is needed and how to make it happen. In this case the evidence informs us what trauma is, how to respond to it, recover from it, and how to stop it happening in the first place.

This section explores what it takes for the brain and body to recover from trauma and what empowerment means in a scientific sense. When reading this section keep in mind that according to science, recovery and empowerment are similar things. As I encountered more of the basic science of trauma, I came to understand the internal process of empowerment:

Trauma-informed working practices can help to release a person’s brain from toxic stress which can enable the development of resilience through creating positive relationships. Reducing stress releases the brain from focusing on survival and transfers energy to growing other neural connections. The brain begins to expand and the different areas of the brain and the body communicate more effectively, which helps a person to make more meaningful connections with people, community and the world. As these positive connections increase through curiosity, creativity and inquisitiveness the brain transforms. Its cognitive capacity increases and the result: a person whose full potential is endless.
(Perry, 2017; Ablon, 2017)

Putting this process into working practices takes a lot of hard, challenging and exciting work!

A note on this section

The field of trauma studies and the relating science is large and embryonic. This section only touches on the foundations of the evidence and some of the emerging fields of exploration. There are many areas not covered such as epigenetics, the complexities of neuroscience and hormonal changes, which all add weight to the transmission of trauma. For further reading on these subjects go to these websites and explore:

The Trauma Centre at JRI
www.traumacenter.org

Child Trauma Academy
http://childtrauma.org/

Mindful: The Science of Trauma, Mindfulness and PTSD
https://www.mindful.org/the-science-of-trauma-mindfulness-ptsd/

Toxic Stress – Centre of the Developing Child Harvard University
https://developingchild.harvard.edu/science/key-concepts/toxic-stress/
The Evidence

Trauma and Its Damaging Impacts

In high doses, it affects brain development, the immune system, hormonal systems, and even the way our DNA is read and transcribed. Folks who are exposed in very high doses have triple the lifetime risk of heart disease and lung cancer and a 20-year difference in life expectancy... Now, the exposure I'm talking about is not a pesticide or a packaging chemical. It's childhood trauma... exposure to adversity affects the developing brains and bodies of children.

Nadine Burke Harris, 2015

"Adverse childhood experiences are the single greatest unaddressed public health threat facing our nation today."

(Dr. Robert Block, the former President of the American Academy of Pediatrics, cited in Harris, 2015)

The evidence is powerful, compelling and convincing. It is telling us that trauma has damaging and lasting impacts on the mind, brain, spirit, body, to a family, community, a collective, and society. It is telling us that trauma is everywhere in society.

It is also telling us something incredibly positive: Trauma can be transformed. There is nothing permanent about the condition of trauma.

Throughout my trip, I was exposed to the science of trauma 101 and that is what I have presented here. This section explores the impact of trauma on the brain, behavioural responses and the implications this has on society. I realised as each organisation repeated to me the same explanation of trauma and its effects on the brain and body that once you know this information you feel compelled to act. We have no choice to integrate this evidence into our working practices, program design and strategic thinking about how we want our services to reach the positive life outcomes we all want to see.

I've presented the evidence here, in the same way that I experienced it, as evidence to encourage immediate and empowering action.

Plastic brains and minds

“We are always in a perpetual state of being created and creating ourselves”

Daniel J. Siegel, 2010: 221

The growing science of neuroplasticity is a game-changer. It tells us that no matter what stage of life we are in our brains have the capacity to break patterns and form fresh neural pathways. When our brains change, our body, minds and spirits change too.

Our internal system like external systems are intimately interconnected. When we do different things for ourselves, things that break patterns of negative and harmful behaviours and coping mechanisms, we are teaching ourselves to be different. We are teaching our internal system to respond and interact with the world in a positive and calming way, reducing stress and the likelihood of chronic illnesses and environmental deprivation. As I was told by... “when we understand ourselves as a holistic self, we are better able to be within and create a holistic world of health and wellbeing.”

See these links for more on how the brain can change...

Brain HQ https://www.brainhq.com/brain-resources/brain-plasticity/what-is-brain-plasticity

**Trauma 101 – Getting Rid of Blame and Shame**

The trauma informed practice organisations I visited had embedded *trauma 101*. This means that service providers and organisations understood the basic brain and body science of trauma. The result of having this knowledge is it sheds feelings of blame toward those who exhibit difficult and harmful behaviours. For those who have experienced trauma, it helps them to realise their coping mechanisms are adaptive and a sign of resilience. This science helps people overcome feelings of shame around their behaviours and actions, fostering courage to talk about issues and address and overcome trauma.

**The Brain**

The Klinic Community Health Centre runs several trainings of this type. I attended a half-day session. What follows are the learnings described in the training.

It began with the brain. Below is a diagram of our brains very similar to what I was given in a number of trainings. It highlights some of the major parts of our brains, how they grow and develop and interact.

![Brain Diagram](http://www.ascd.org/publications/books/101269/chapters/A-Walk-Through-the-Brain.aspx)

**Reptilian Brain**

Our brain developed along evolutionary lines. The brain stem, which is sometimes referred to as the reptilian part of our brain developed first. It controls our bodily functions that keep us alive like breathing and our heart rate.

**Mammalian Brain**

The limbic system formed next as the social part of our brain and interacts with memory. It formed as mammals came into existence and so is referred to as the mammalian part of the brain. It helps with processing complex social emotions in response to social cues and memory, like love and anger.
**The Thinking Brain**

The last part that exists in human beings is the pre-frontal cortex. It is the thinking part of our brain. It interacts with the other parts to understand emotions, reason and to plan. It has been described as the area of ‘second thought’ controlling the fast emotional responses of our limbic system.

**The Developing Brain**

Different parts of the brain develop at different points throughout childhood and adolescence and then can continue to change in adulthood. For example, the pre-frontal cortex does not develop until adolescence (Klinic guide). If there is an interruption such as a trauma in the child’s development it can stop or reduce the development of that area of the brain.

When trauma happens different areas of our brain can stop communicating, which can make it very difficult when we have emotional responses. It is hard to stop our feelings running away with us. Adults who have experienced unresolved trauma find it difficult to regulate emotions. It can be hard to respond in social situations, with clear judgement, rationality and safe and secure emotions. Secure emotions are those that do not harm ourselves and others.

In the Klinic training we were given some diagrams from Dan Siegel. One of them is called flipping your lid which will be used in the application of practices section. We were also shown ‘the upstairs, downstairs brain’ diagram. The Downstairs of our brain is where the things that keep us alive happen. The upstairs takes time to develop and this is where complex thought happens. They need to learn how to connect!

---

*Copyright, the momentous institute, 2017*

For a further understanding of the importance of connection and communication in our brain for a healthy life, explore these websites and resources,

Momentous Institute – blog on the developing brain
[http://momentousinstitute.org/blog/upstairs-and-downstairs-brain](http://momentousinstitute.org/blog/upstairs-and-downstairs-brain)

Connections Matter – Booklet on developing the brain for stronger and healthier communities
[https://static1.squarespace.com/static/5552947de4b0471a840f9e27/t/5839ea6915d5db6612f542b7/1480190571654/CM-Booklet_Digital_v5.pdf](https://static1.squarespace.com/static/5552947de4b0471a840f9e27/t/5839ea6915d5db6612f542b7/1480190571654/CM-Booklet_Digital_v5.pdf)
Our Survival and Fear Centre

*Stress develops from the moment we are born onwards*

We can experience trauma and its effects right from the moment we are born. Mothers who have babies in a state of stress are unintentionally exposing newborns to high levels of cortisol and other stress hormones. Straight away a child will have a heightened arousal. Areas of the baby’s limbic brain will begin developing to deal with this response and protect the baby from perceived danger. The babies heart rate, blood pressure and muscle tone will increase. If the baby is in a supportive environment this experience can help the growing brain respond to stress in a healthy way.

If traumatic events and situations continue to happen a person’s neural systems will invest a lot of energy into threat and survival responses rather than creating connections in other areas of the brain. This closes the brain down to developing and can disrupt the growth of other organs. Instead of creating positive, expansive connections and the world being curious, the world becomes threatening. (Willette et al, 2016; Central Iowa ACEs Coalition, 2016; Aguiar, W. & Halseth, R. 2015)

If stress continues over the course of childhood and into adolescence, essential areas of the brain begin to shrink as a person’s brain and mind becomes locked in a fear and survival cycle. When something triggers a trauma response the brain and body learns to go into a stressed state and works to protect itself in what it has learnt to perceive as a threatening situation.

This is often spoken about as the brain becoming controlled by the fear centre, our amygdala, and sending signals to the body to respond immediately with fright, flight, freeze, or shut-down.

*Fear and Anxiety Affect the Brain Architecture of Learning and Memory*

**Prefrontal Cortex**
Center of executive functions; regulates thought, emotions, and actions. Especially vulnerable to elevation of brain chemicals caused by stress. Matures later in childhood.

**Amygdala**
Triggers emotional responses; detects whether a stimulus is threatening. Elevated cortisol levels caused by stress can affect activity. Matures in early years of life.

**Hippocampus**
Center of short-term memory; connects emotion of fear to the context in which the threatening event occurs. Elevated cortisol levels caused by stress can affect growth and performance. Matures in early years of life.

Copyright Centre on the Developing Child Harvard University, Neglect
https://developingchild.harvard.edu/science/deep-dives/neglect/
When trauma is left unresolved our body and brain can be triggered into this state without warning. People react differently to trauma. Depending on life circumstances, and a range of other brain and bodily functions, gene predisposition, and the context of which people live within, trauma can have a lasting impact on many people. However, as the next section will explore there are people who experience many traumas’s and will barely affect them later in life.

**Resulting issues**

At every organisation I visited it was repeated that traumatic stress reactions are normal reactions to abnormal circumstances.

Brains and bodies locked in a fear cycle are dealing with toxic stress. The brain is frequently triggering the body to release stress hormones. A healthy early childhood attachment has been found to create feelings of security for a child which can lead to good health and wellbeing over the course of that person’s life. If a child is exposed to a mother’s stress hormones this can deregulated a child and stop the ability for the baby to learn self-regulation. (Shonkoff et al, 2017)

A person living in this constant state of toxic stress are living with persistent and overwhelming feelings of terror, shame, helplessness and powerlessness. This is starting to be widely documented for the experience of Indigenous peoples, historic trauma and ongoing toxic stress and deep feelings of injustice and self-worth. (Begay, 2012)

These feelings can be masked by other behaviours and emotions that act as a protective mechanism for the person experiencing toxic stress. These emotions can be presented in the following behaviours:

- shutting down,
- looking for substances or activities which numb their pain,
- retreat into isolation and solitude,
- overworking and overeating, or avoidance of work and food
- perfectionist attitude to work and life
- seeking out needy and dependent relationships
- and many other coping strategies to protect a vulnerable and fragile state of internal fear.

In work situations when everyday stressors happen, those who are living with developmental trauma may react to seemingly normal situations with “emotional chaos or numb rigidity...They can also respond to stressors with impulsivity and frustration” (Klinic p 19).

Overall, a person in adulthood who has experienced early childhood trauma, prolonged trauma and unresolved trauma will have a prefrontal cortex that cannot easily register signals from the body. This means that they might not know if they are “hungry, tiered, cold, ill, or in danger” (IBID:20). For those working with traumatised people the inability of a person being able to sense or interpret their own emotional state, could present in the following actions,

- Not attending hospital appointments
- Not buying enough food
- Overeating or under eating
- Engaging in risky behaviour, such as drink driving or swimming when drunk
- Unable to meet deadlines or come to work regularly or on time
- Compulsive behaviours such as gambling and overworking
It is well evidenced that many of these behaviours are an attempt to regain emotional control. However, as they are often a response to something happening rather than a considered decision they can lead to damaging behaviours and emotional dysregulation. (Middlebrooks et al, 2008)

Copyright, Bruce Perry, the Childhood Trauma Academy

Bruce Perry uses this diagram to explain how behaviours are developed in different parts of the brain. When parts of the brain have not developed or are not communicating the brain learns to adapt through a number of different behaviours and actions. A person who has experienced trauma may develop all these resulting behaviours as they grow.

The brain experiences the raw impact and emotions of trauma at the brain stem, while that trauma remains unresolved, as a person’s brain develops they will start to experience difficulties in how they interact and form relationships, they will deal with pain and grief through turning to alcohol, and the thinking part of the brain will reflect on all these experiences with shame and guilt.

TIP: In life, we tend to respond to people with the emotion they are showing us. Often the emotion being expressed is not what is being felt. If you are working with someone that becomes angry in the workplace remain calm and do not respond with anger. It is likely that another emotion is beneath their behavioural response. Triggers and responses to triggers will be explored in implementing working practices. It is important to remember when someone is angry, verbally abusive, shouting or have gone into a conflict response, it is likely that they have been triggered into feeling threatened. Underlying their behavioural response could be fear, sadness and hurt.
Science and Healing

In Des Moines, Iowa, USA I attended the 7th annual psychological trauma and Juvenile Justice Conference. Once again, I was struck by how the evidence prompts a response that one must take action.

The conference was run by the renowned Dr Bruce Perry, a neuroscientist and child psychiatrist, and Dr Stuart Ablon, a child psychiatrist. Both emphasise collaboration and relationships as the way we can move beyond trauma.

In between their teachings on the brain and how we can put this new found understanding of our neural connectivity into working practice, they kept mentioning that if we had resilience the lasting effects of a traumatic event and period may be negligible. (Ablon, 2014; Perry, 2006)

The Importance of Relationality - connecting with community and place

Bruce Perry was clear, it is our grounding in networked relations which fosters resilience. Networked relations are our community and family networks and our connections to place and the surrounding environment. Resilience means that we have good connections to people and place. These connections forming resilience help our brains to grow and change and are better able to recover from trauma.

During the conference, he explained that we have spent a long time talking about strong and coherent nuclear families, which has led to explosive and traumatic territory. What we need most is supportive networks and community. He gave examples of how easy it is for families today to harm children through neglect, which is a trauma. When parents are overworked and busy and cannot spend time with new born babies, the baby can experience serious neglect due to lack of attachment and meaningful connections. When a baby experiences neglect the brain stops developing and shrinks.

Case Study: Sheway and Fir Square, how evidence changes the way we work.

At Sheway in Vancouver I was told about the importance of ‘Rooming In’ (Abrahams et al, 2007). Sheway work closely with Fir Square, the first Canadian combined unit at the British Columbia women’s hospital to care for women who use substances and their newborns exposed to substances. The purpose of both places is that women and their babies are better together, no matter what they have been through. The approach defies conventional practices that when a baby is born to a woman who has been substance using the baby is taken away either for additional neonatal care or the baby is apprehended and put into state or provincial care. The evidence is now showing that a baby and woman do much better when they are kept together. Babies are less likely to need treatment for neonatal abstinence syndrome. A syndrome associated with babies exposed to a women’s opiate use during pregnancy, and it is more likely that women who have used opiates during pregnancy are discharged from hospital with the custody of their baby (ibid: 1728). Keeping a mother and child together right from the beginning keeps them together throughout life!

Research also shows that immediate skin-to-skin contact between a woman and a baby (Moore et al, 2012) creates early states of secure neurobiological patterning in the baby’s brain and body. This early skin to skin contact is related to positive health outcomes across a lifespan.

For Sheway and Firsquare this means that they work to keep women and their babies together for their immediate health and wellness and long-term generational health.
The science is informing us of what Indigenous societies have known since a time immemorial: we counteract trauma with the values of our humanity. As I learnt from Bruce Perry values of relationality and reciprocity are hardwired into our evolutionary makeup.

Bruce Perry spoke about how resilience has been formed within our very being. Societies cohere to protect, care and nurture so each generation profits from the cooperation of the other – transference of generational positivity!

**Childhood – the Foundations of Growth**

The example of a brain that shrinks through neglect can be changed when a brain is given the opportunity to connect and attach, right from the moment a child is born and put into direct skin contact with the mother (as the case study above shows). Brains grow when they are in good relationships with the surrounding environment and people.

Development, connection, attachment and growth is incredibly important during early childhood when the brain is like a sponge; “an infant’s brain doubles in size during the first year of life. By age three, it is 80 percent of its adult’s size” (Central Iowa ACEs Coalition, 2016). The brain is developmentally most active and vulnerable at this period. It is very important the children are interacted with through good attachment and relationships to increase their capacity to learn, cope and adapt to stress, and ultimately for their brain to grow, so their mind and body is active and secure in the world.

Bruce Perry exemplified this cycle of learning and the ability of the brain to create new neural pathways, continue to connect and constantly learn new skills, in a series of slides at the conference which can be found on the Child Academy best of slides page.


Bruce Perry through his neuro-sequential model has developed what he describes as a non-therapeutic practice to enable people to reintegrate areas of the brain to recover from trauma. Ultimately this is enabling the brain to grow and become plastic.

Many of the slides and talks based on this model can be found here,

http://childtrauma.org/cta-library/

**Relational Health vs Relational Poverty**

For this report, what is important to understand is that a reconstruction of good and positive relationships can facilitate a repair process in the brain to enable it to recover from trauma. This creates a healing process.

Bruce Perry was convinced that we need to start seeing relationships as the key to healing. We have spent too much time focused on an economic poverty and need to begin appreciating the wealth of a supportive network and community.

Bruce Perry and his team have created a measure to assess relational health. They are showing that when a person has good relational health they have many positive outcomes and when there is poor relational health there are negative outcomes.

Our conventional understanding of resilience is accurate. When we have the evidence of neuroscience we have the collateral to prove that trauma can be transformed.
Resilience is defined by the Oxford English Dictionary as:

- The capacity to recover quickly from difficulties; toughness.
- The ability of a substance or object to spring back into shape; elasticity.

(The Oxford English Dictionary, 2017)

With these definitions, it makes sense that relational health which develops resilience is the counter to trauma. If you have a good degree of resilience, when trauma hits, you are far more likely to have the ‘capacity to recover’, or a ‘substance/object’, like your brain, is ‘elastic’ enough to be re-wired and to ‘spring back’. This is the science of neuroplasticity, the healing abilities of our neural networks and pathways to transform our minds and bodies. (Lyons et al, 2009; Ozbay et al, 2007; Kirmayer et al, 2011)

**Why relational health and its positive outcomes matter for community and Indigenous organisations**

Bruce Perry explained that across history societies have gone to great lengths to help people recover from trauma, knowing that war, territorial battles and abusive behaviours are somewhat inevitable when we have hundreds of thousands of cultures living on the same planet. Nearly all societies have been founded and structured around recovery and healing, this is apparent in war rituals, grieving ceremonies, deliberate processes of mourning and storytelling to help us overcome trauma.

These ceremonies and rituals are still alive and well in Indigenous societies around the world. The repetition, the rhythm and the movement of these practices help regulate our brains so we can relax, mend the emotional centres of our brain and move into our pre-frontal cortex so we can both reason and have abstract thought. In other words, we can dream of a better tomorrow and have hope for a transformative future.

In Australia, an understanding of Indigenous societal practices as a form of healing are expressed through the concepts of, Dadirri, Deep Listening; and Liyan a Yawuru word for holistic health and wellbeing, expressing how people feel for their country and relating to others.

A full explanation of these concepts and methods of healing can be found on these websites,

Dadirri

Liyan
http://www.yawuru.com/our-culture/

The key ingredients of recovering from trauma and ending the transmission of trauma are,

- supportive and loving safe relationships
- extensive caring networks
- reciprocity
- resilience
- self-care and nurture
- positive and life-affirming engagement with our ecological surroundings and community

Across Indigenous societies, and in Australia, what we are witnessing in our first peoples today, is the legacy of 60,000 years of cooperative strengths, remarkable interwoven ecological knowledge
into the most intimate and intricate kinship structures, and practices and processes around reciprocity that have survived beyond private property ownership and the ideology of Individualism. All of this is a relational force to be reckoned with. It has yet to be defeated against all the traumatic odds.

**A service provider’s brain can change too**

Bruce Perry emphasised, as we put trauma informed practices into action, service providers and workers will experience their brains beginning to change also. As workers, we become more capable of dealing with complexity, we become more creative in problem solving, and become better at embracing new ideas that challenge us to reshape the way we interact in the world. We develop a reciprocal relationship between the community we are working with, with the staffing body of our organisations, and across services and as we do, we change our brains and move into a different form and mode of working practices. Sandra Bloom terms this post-traumatic growth (Bloom, 2017), which will be addressed in a latter section.

In other words, recovery from trauma is the same as a healthy and satisfying life engaged in learning and the development of self and society. The science tells us three things:

1) We know the consequences of trauma and intergenerational trauma
2) We know we can recover and heal from trauma and in doing so end the transmission of trauma
3) We know what positive health and wellbeing is and that it can be transmitted across the generations. Just as trauma enables the development of survival responses, thriving helps develop generative and healthy responses
Adverse Childhood Experiences (ACEs)

While spending time with Gladys Alvarez, the coordinator of Orchards Place trauma informed care project, I was introduced to the enormous impacts that the Adverse Childhood Experience (ACEs) study was having on the changing nature of the work of organisations across Des Moines. The Trauma Informed Care Strategy brings together several stakeholders to look at how trauma informed practice is having an impact on the effectiveness of peoples work and on creating better outcomes for all people accessing a diverse range of services, and ultimately changing the generational outcomes that have been presented in the ACE studies. (Centers for Disease Control and Prevention, 2016)

What are ACEs?

“Adverse Childhood Experiences are traumatic events that can dramatically upset a child’s sense of safety and wellbeing...these experiences shape the quality of our adult lives...the original study conducted in the mid-1990s, revealed how strongly negative experiences in childhood can derail a child’s development, and lead to a host of health and social challenges throughout a lifetime” (Central Iowa ACEs Coalition, 2016:3)

The first study conducted by Dr Robert Anda, from the centers of disease control prevention and Dr Vincent Felitti, with Kaiser Permanente, looked at 17,000 adults and their exposure to 10 categories of abuse, neglect and family and household challenges during their childhood.

The original survey, can be found on the center for Disease Control and Prevention website which holds all the original ACE materials and findings, The following information has been reproduced from the website, https://www.cdc.gov/violenceprevention/acestudy/about.html

In 2007 Dr Robert Anda developed an Individual ACE score calculator 10-qacecalc.pdf based on the original survey.

These questions are as follows,

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt? 
   No___If Yes, enter 1 __
2. Did a parent or other adult in the household often or very often... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured? 
   No___If Yes, enter 1 __
3. Did an adult or person at least 5 years older than you ever... Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you? 
   No___If Yes, enter 1 __
4. Did you often or very often feel that ... No one in your family loved you or thought you were important or special? or Your family didn’t look out for each other, feel close to each other, or support each other? 
   No___If Yes, enter 1 __
5. Did you often or very often feel that ... You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of
you or take you to the doctor if you needed it?
No___If Yes, enter 1___

6. Were your parents ever separated or divorced?
No___If Yes, enter 1___

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
No___If Yes, enter 1___

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
No___If Yes, enter 1___

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   No___If Yes, enter 1___

10. Did a household member go to prison?
    No___If Yes, enter 1___

Copyright, Dr Robert Anda, Centers of Disease Control and Prevention

If you answer yes to one or more of the questions above you have experienced a category of ACEs which range from physical and/or emotional abuse to violence and sexual abuse, family breakups amongst others.

The findings from the original ACE study showed a high prevalence of ACEs in the general population, “almost two-thirds of study participants reported at least one ACE, and more than one in five reported three or more ACEs” (Centers for Disease Control and Prevention, 2016: Major Findings)

As your ACE score increases, (the more categories you answer yes to), the more your risk in the following areas of health and life increase,

• Alcoholism and alcohol abuse
• Chronic obstructive pulmonary disease
• Depression
• Fetal death
• Health-related quality of life
• Illicit drug use
• Ischemic heart disease
• Liver disease
• Poor work performance
• Financial stress
• Risk for intimate partner violence

Ibid: https://www.cdc.gov/violenceprevention/acetstudy/about.html
This list is not exhaustive and could include every social issue that can be thought of and responded to. It tells us that trauma is high in the general population. It also tells us that our entire social service system is a response to those who have experienced very high levels of early childhood trauma.

**Seeing the evidence of ACEs across a lifespan!**

In the conference, we were also presented with the ACE survey. Here we were given a similar list alongside other worrying statistic of social disparity and disadvantage. The most striking being that if you have six or more ACEs it is likely that your life expectancy will be 20 years below those who receive a lower ACE score. For those in Australia, this is a statistic we are all too aware of in the life expectancy gap between Indigenous and non-Indigenous Australians.

![Childhood Experiences vs. Adult Alcoholism](image1)

*Copyright, Lisa Frederiksen, Changing the Conversation, 2015*

**The Following graph is the ACE score and the relationship to adult homelessness**

![ACE Score and Relation to Adult Homelessness](image2)

*Copyright, Firesteel, 2014*
TIP: I was told by several organisations that they use the ACE study survey in trauma workshops. It is a useful tool to help people understand the breadth and form of trauma. Often people will not consider their own experiences as being traumatic and will not see the connections between adult behaviour and trauma in their childhood. When they see the ACE survey they realise that they may have experienced a trauma in their life, or that others they know have had trauma in their lives. It is a good tool to use to shift blame directed at people’s behaviours. It changes the question from what is wrong with you to what has happened to you?
The real significance of ACEs is the proof that most social issues are not due to delinquency, bad behaviour or a corrupt morality. Social issues, particularly chronic illnesses, are to do with what has happened to someone, what has been experienced early on in life and over the course of a lifetime, and whether the support structures have been in place to enable recovery.

Ultimately, ACEs and the burgeoning evidence of neuroscience show that trauma as experienced through abuse and neglect, and the resulting social issues over the course of a life time could be preventable.

**Protective Factors and why, right now, ACEs matter**

Bruce Perry was convinced of this fact too. He was interested in why some people could achieve a high ACE score and not have any of the resulting risks later in life. This brings us back to resilience and what Bruce Perry calls protective factors.

This slide show by Dr Perry presents ways in which we can build resilience.

https://www.youtube.com/watch?v=qv8dRfgZXV4

We build resilience by believing in safety through strong relational communities. If things go array and we experience a trauma, or a series of traumas, knowing that we can fall back into the safety and care of community helps us to recover. (Iowa ACEs Coalition, 2016)

If this community safety net does not exist, then it is highly unlikely that we can recover. Without relational care, support and love our brains and bodies do not know how to recover with positive coping mechanisms. As the evidence explains, we kick into survival mode which leads to a higher likelihood of being exposed to social and health issues across a life span.

Right now, ACE scores matter because they explain why we deal with a raft of complex social issues that feel unsolvable. If we can build into our social service sectors and community networks a range of protective factors, we can revitalise resilience.

For example, A person who has experienced alcoholism and domestic violence in their home growing up without any additional supports becomes vulnerable to risks later in life. If this person had protective factors, such as another caring and stable family to retreat to during times of chaos and violence, this person may not have any developmental trauma responses later in life (Perry, 2017).

Protective factors versus traumatic events are complicated. However, the more protective factors we have the more likely we are to succeed. I will explore resilience as a measure of protective factors and good health and wellbeing in the last section. (Werner, 2000)

With individual, family and community resilience ACE scores should decrease. For those whose ACE scores remain high, the protective factors of social services designed around trauma-informed responses, should provide the necessary support to reduce vulnerabilities of a person later in life.
ACEs providing a systems model of resiliency and hope

“learning about resiliency gave [me] a model to understand why some can live well in spite of ACEs.”

(Jan’s Story, cited in Iowa ACEs Coalition, 2016: 10)

The ACE study has become popular around America in proving that trauma is a public health crisis. ACEs have given contextual data to trauma. For many American’s working across sectors it is providing them the necessary data to link trauma to a range of social, economic and public health issues. It is understanding the interrelationship between these issues that is helping services and sectors work together more effectively in innovative ways to reduce the likelihood of the ACE outcomes.
Iowa, as an American state, is not unusual in conducting its own population wide ACE study, 2012 - 2014. Stakeholders worked together to adapt, alter and add questions to provide more data on the types of traumatic events people experience in early childhood. The State has reported that the ACEs study,

“is inspiring a movement to respond. Emerging research shows that building caring connections promotes positive experiences for children from the start and helps those with a history of trauma heal. Individuals organisations and communities are implementing trauma informed strategies that are changing the outcomes we see in the ACEs data”
(Ibid:2)

The Iowa ACEs understand education around ACEs as a systems wide model of hope and resilience. They also see it as breaking the cycle of trauma and disadvantage in the lives of Iowans. The more support parents are given across a range of areas, the more protective factors are in place to ensure healthy childhood development and a buffering against later life vulnerabilities. Breaking the cycle begins with enabling parents and families to:

- recognise stress and improve problem-solving skills
- have knowledge of the importance of early childhood attachment
- connect to supportive and safe communities
- access to essential services such as financial, medical and educational
- support children’s development to self-regulate and engage in inquisitive and safe play

The ACE coalition believe that these protective factors can enable families to thrive, even as they face stressful situations throughout life.

For more information on the Coalitions approach check out their website, 
http://www.iowaaces360.org/iowa-aces-research.html
The Trauma Informed Care Project (TIC)

One of the primary stakeholders on the Iowa ACEs coalition is the Trauma Informed Care Project (TIC) led by Orchard Place in Des Moines, the state capital of Iowa. TIC’s intention is to “create a compassionate community that is knowledgeable and is prepared to apply TIC principles and practices to numerous ‘everyday’ settings and experiences to improve quality of life”.

Over the course of two days I met with most of the TIC stakeholders. Over a lunch meeting, a representative group of stakeholders discussed with me the importance of having knowledge, of working from the evidence of the ACEs and how they could inspire change in their workplaces and communities. The group included the judge of a juvenile justice court, youth workers, the head of a women’s detention facility, the head of the sociology department, the head of Des Moines children’s hospital, a young women’s organisation and the coordinator of an employment agency, amongst others.

The ACEs study had triggered them into action. As the judge explained to me, for him, ‘evidence matters’. He said, “I will be honest I originally thought trauma informed practice was just another fluffy term, the new favourite rhetoric for social development.” Trauma informed practice can sound like wanting to let bad children, or misbehaved and dangerous adults, off the hook.

However, the group continued to discuss, when you are presented with the evidence of what trauma does to the brain, and how this effects a person’s cognitive ability over a lifetime, increasing irrational responses and risky and oppositional behaviours, you suddenly see trauma and coping mechanisms, everywhere.

The ACE results puts what you are dealing with in your work into context. As the judge continued, you begin to see the children who come into your court differently. Instead of thinking of the isolated crime they have committed, you consider what has happened to them and why they are acting in the way they do. You start to question your own working practices and wonder if the judgement you are making today is going to affect that person’s life for worse or for better. He said, with the agreement of others, if you can act differently to change the life outcomes that the ACE study shows is likely to result, then you would.

An ethical consideration

The stakeholder group explained that you want to know the work you are doing every day is purposeful and having a positive impact. It is very concerning when the evidence presented shows that the work you are doing could be having a negative impact, not just in the present but for entire generations.

If you are presented with the evidence, then you need to make the right decision in accordance with that evidence. If you keep doing what you have always done despite the evidence, then your duty of care and ability to fulfil the responsibilities of your role should be questioned. Danna Clifford from Sheway explained a similar decision-making process. Organisations must be prepared to respond to new evidence to inform their practice of work. When taking on trauma-informed work there is a new level of responsibility for organisations. To be trauma-informed means you must consider the generational impact of work. You start asking, what has happened to someone which means you have to consider that person’s life, history and stories.
Making a Judgement to move forward effectively

The judge had agreed to have his court audited to assess its level of trauma informed care and practice, and the gaps in delivery of TIC principles and practices. He was awaiting the final report and sounded nervous about its impending arrival. He said, he is interested to see the recommendations and will do his best to respond to the necessary changes and requirements based on the evidence.

In addition to trauma informed audits of various working environments the TIC stakeholders had planned and engaged in many activities that were spreading knowledge to change people’s behaviours and working practices. This included bringing TIC principles and practices to university courses, into detention facilities and to public events.

THINK: What can you do in your workplace to make people feel it is trauma informed? The TIC stakeholder group were changing how work spaces looked. For instance, in the women’s detention facility they had a rocking chair room. They had meetings and activities where all the women were on rocking chairs. At the young women’s resource centre they had a self-care room, where young women could access sanitary items, bath stuff and face washes etc. In both places the walls were painted purple in the colours chosen by the users of the service with inspirational quotes and art work.
ACEs is making trauma real for the work that social services and all institutions are involved in. What struck me in Des Moines is that ACEs are making people realise the generational nature of their work. That what they do today can change the future. It makes people realise that they are not working in isolation but within a context, with a living history. There was clearly a renewed hope and purpose found within the work of all members of the trauma informed care stakeholder group.
The Science of Poverty
How systems and wealth can change our cognitive capacity

An interesting component of the TIC stakeholder strategy was employment and business development. The group saw the economy as an essential part of improving a population’s health and wellbeing.

Employment – engaging in meaningful work

They explained how we spend a considerable amount of our time and life at work. A trauma informed work place can improve mental health as well as offering opportunities and pathways to those locked out of employment previously. However, the group were struggling to convince the business world of the importance of trauma informed practice. It was difficult to get traction over how the changing nature of business can improve a population’s productivity and creativity. The TIC project is struggling with spreading this knowledge outside of the traditional caring sectors. For wide spread impact to be achieved to break the cycle of intergenerational trauma, the evidence must move beyond the social sector.

Business rhetoric and ethos is often about the achievement and strengths of the individual out competing others to get to the top. Economic principles look to performance, achievement and progression. Within this framework of principles, it is commonly understood that people are to be blamed for their circumstances or held responsible for addressing their life situation. That if they want to break a cycle of poverty and abuse they must do it themselves, and cannot depend on the State or other financial resources to do it for them. This rhetoric is at odds with how the science of trauma is guiding new working approaches around collaboration, care and support.

However, ‘Project Iowa’ is an essential stakeholder on the TIC group that is bridging the gap between the social sector and business. The project is applying the principles of TIC in working with people to get access to the career they want, through lessons of self-confidence, self-awareness and dealing with natural barriers in life.

The project believes that when a person has access to meaningful work, has pathways to a range of opportunities, and can engage productively in work that suits their interests and meets aspirations, they do well and business do well. In this sense, an economy which responds to people’s needs and creates opportunities is essential to good societal health and wellbeing.

Why poverty is not good for the brain

Again, science is confirming that people’s mental health, and their ACE scores are most likely due to environmental factors. In other words, people are not the cause of poverty and/or a range of abuses and reckless behaviours. Instead poverty which is intimately tied to experiencing trauma on an ongoing basis is the cause of a range of poor life outcomes.

My experience in Oklahoma confirmed this. I visited a few Native American organisations in Oklahoma and was toured around the state by a woman who comes from the Cherokee Nation. I was intrigued by the huge Cherokee Casinos amongst other Native Nation Casinos that dotted the Oklahoma landscape. These in effect were massive social enterprises.

The Native American Casinos in Oklahoma turn over a huge amount of revenue. Nationally Indian tribes generated $31.2 billion in gross gaming revenues in the last financial year, with Oklahoma one of the fastest growing regions (Ellis, 2017). It was explained to me that the casinos had resulted in
the Cherokee Nation having one of the best health care and education systems in the United States. Some of the revenue from the casinos is also distributed amongst the Cherokee band, as well as into social health infrastructure.

An article in the Correspondent (Bregman, 2016), looking at the positives of lifting people out of poverty has analysed the changes in life circumstances for the Cherokee population with an injection of funds from the Casinos.

The article reviews, prior to the opening of the Casino’s Jane Costello at Duke University had been studying the mental health of a cohort of young Cherokee people. She had found that those growing up in poverty were more prone to behavioural problems than other children. Costello found that after the Casino opened there were huge improvements in the mental health of those she was studying.

“Behavioral problems among children who had been lifted out of poverty went down 40%, putting them in the same range as their peers who had never known privation. Juvenile crime rates among the Cherokee also declined, along with drug and alcohol use, while their school scores improved markedly. At school, the Cherokee kids were now on a par with the study’s non-tribal participants”. (Bregman, 2016),

The article highlights aspects of Costello’s study which confirm much of the work of the Trauma Informed Care project and the Iowa ACEs coalition. Providing people with access to opportunities, and a reasonable standard of income, improves overall health and wellbeing. The study found that Cherokee children lifted out of poverty at a young age had better teenage mental health. Parents lifted out of poverty could save, and had more time with their children creating healthy attachments and relationships. However, for those that were persistently poor had high levels of psychiatry symptoms.

Although, they found that there was significant improvement with an income intervention for some families that could not be ascribed to the characteristics of the family, it could not be explained why there were other children whose mental health did not change. (Costello et al, 2003)

**THINK: The Importance of Culture**

An Elder I was introduced to in Oklahoma could see why the Casinos were positive for some in providing an adequate infrastructure of essential services and relieving financial stress. However, he stressed, we still need to know our culture, people need to know where they belong and their identity. He expressed how important language and ceremony are to Native American Young people’s mental health. I will explore the need for cultural security when putting in place any intervention in a later section.

The science behind this is the same as what was presented above. When people are in poverty, your brain is focused on the immediate, of what to do to survive. Energy is being used up by toxic stress which reduces cognitive capacity. A person in this state spends time feeling worried and stressed than having access to their pre-frontal cortex and being able to think rationally. This leads to what is perceived as bad decisions by others who do not live in the context of poverty. People in a state of toxic stress do not have the same cognitive capacity to think rationally.

As has been explored throughout this section, and is supported by the Cherokee example, when you change people’s context and help relieve stress, people’s cognitive capacity can dramatically and
rapidly increase. They can go from making reckless decisions to making considered and thoughtful decisions in a short amount of time. (Bregman, 2016; Costello et al, 2003)

To find out more about the chronic stress of poverty on children, communities and over a generation, read this article by the renowned paediatrician Dr Nadine Burke Harris


When applying this to work programs designed with this intention the impacts are empowering and possibly transformative.

**TIP:** if you work with people that live with trauma you might notice them make decisions that seem counterintuitive to a healthy life. They might spend all their earnings immediately on fast food and then have no money to feed the family for the rest of the week. They might drive to the next town and then have no money for fuel to get back. They then miss work and cannot earn the money required to pay for a round trip. This is the poverty trauma trap. That person may be experiencing high levels of toxic stress causing them to find it difficult if not impossible to make rational long-term decisions.

In your working practice, it is important to consider what interventions will be useful to decrease a person’s level of stress, improve cognitive capacity, so the person you are working with can make their own decisions for what they want, and set the goals and the direction to get there. Always remember that trauma and poverty are not a person’s fault. Providing someone with a quality standard of income is another mechanism of healing trauma.

**This presents challenging questions for how we work;**

- Do our interventions increase or decrease stress?
- Do we provide people with the mechanisms to change their context?
- Are programs of financial management helpful if people cannot afford electricity bills?
- Are programs based on incentives or large-scale change?
- Do we make people prove themselves to have access to income, resources and our programs?
- Do we feel comfortable increasing wages when we are unsure of the work being done?
Understanding the Costs of Trauma

This section has explored how the science and evidence helps us to understand the individual, families, societies, and how collectives organise themselves can suffer from trauma and recover from trauma.

The next section looks at intergenerational trauma. When I was in Clyde River, an Inuit community in the Canadian territory of Nunavut I was struck by the systemic causes of intergenerational trauma. It was clear that as we reproduce situations of discrimination and disadvantage trauma is perpetuated. The reproduction of trauma persists while our governments and policy makers, do not take the time to address the systemic causes of intergenerational trauma - our systems!

Trauma in the remote communities I visited particularly in Nunavut was not unusual, it is the norm, but that doesn’t make it any less severe. If we want proof of the damaging effects of trauma, and ‘its costs’ - in chronic illness, treatment centres, incarceration and welfare, we just have to turn to the areas of the world that have been ferociously colonised and where that history has never been effectively resolved.

Equally, if we want proof of people’s ability to confront and overcome trauma and transform, then we only need to turn to the exact same populations.

In the following sections I go onto explore how we can counter the costs of trauma, intervene effectively on disadvantage and poverty, and perpetuate a cycle of health and wellbeing.
Breaking the Cycle - Transmitting Intergenerational Health and Wellbeing

The aim of this work and this report is to look at organisations, community groups, practitioners and service providers who are committed to understanding and addressing intergenerational trauma.

As the previous section explored, trauma is complex and pervasive. This means that the transmission of trauma is not linear. Trauma transmits on multiple levels, at different times and in different ways between individuals, families, and on a society-wide scale. All the traumas explored in the ‘Definitions and Discussion’ section, ranging from physical abuse and structural disadvantage to patronising and authoritarian language and political disenfranchisement, make up intergenerational trauma.

Intergenerational trauma is multiple cycles of trauma all happening simultaneously.

Putting Trauma Cycles into Context

It was clear that all those who I met appreciated that we work and are attempting positive impact on a generational scale in very complex settings.

The transmission of trauma happens within context. In Des Moines, I attended the screening of the film ‘Resilience’:

http://kpjrfilms.co/resilience/about-the-film/

This film looks at the science of adverse childhood experiences, which was explored in the previous section on ‘Evidence’. It highlights the work of the paediatrician Nadine Burke Harris, one of the founders of the centre for Youth Wellness in California, as well as the work of the Centre for the Developing Child, Harvard University and the work of Bruce Perry at the Child Trauma Academy.

All these institutes are focused on appreciating the lived reality of children, families and communities and breaking the transmission of trauma in context.

However, we commonly talk about the cycle of trauma in a linear direction i.e. a child is sexually and verbally abused. That child grows into an aggressive and sometimes violent adult. That adult falls in love but is destructive in the relationship and can lash out at the partner. They have a child. The cycle begins again. The parents sexually abuse their child and the child grows up with similar behaviours.

This cycle does occur, and is starting to give an understanding of why child abuse can happen across multiple generations in communities. It provides a greater appreciation that victims learn behaviours to cope with trauma and in turn can replicate the behaviours of the perpetrator. This understanding is dissolving the victim/perpetrator binary and helping us to focus on the real issue, which is trauma.

Still, the linear example does not fully appreciate context, and context is key to understanding trauma. It enables an understanding of where trauma comes from and how the cycle can be broken if aspects of context are changed.
The ‘Resilience’ film presents an animation to illustrate the multiple layers of trauma transmitted across a child’s life. It shows that trauma is a part of our surrounding infrastructure. A dilapidated physical infrastructure and lack of access to resources transmits trauma in the same way as abuse and negative behaviours.

The story below is similar to the animation presented in the film:

*The film shows a girl growing up without a close attachment to her mother and family support network. Her parents are overworked and barely at home. They earn below the minimum wage and the apartment they have is small and rundown. There is mould growing that causes the girl to have asthma. Her father starts drinking heavily to cope with the stressors of not being able to pay bills. He cannot keep up with the rent. The debt collectors take away most of their possessions and finally the family are kicked out of the apartment. The girl is put into care and is passed from one family to another. She travels to school in a neighbourhood where many families are experiencing the same problems. She struggles at school and gets into taking drugs and selling drugs. As an adolescent, she goes to a juvenile detention centre. She does not finish school and has not learnt to read and write proficiently. As an adult, she cannot access employment and ends up selling more drugs. She falls pregnant at an early age. She continues to take drugs and drink during her pregnancy.*

Throughout the animation there are other impacting feelings and structural inequalities that are entrenching her disadvantage. These include,

- Discrimination
- Racism
- Prejudice toward lower socio-economic groups in broader society, including employers, education and health
- Stereotypes being perceived as the norm – i.e. you cannot read and write so you will never be able to achieve
- Feeling linguistically and culturally isolated from the dominant society

---

**Holistic Circle Healing – mapping trauma**

Burma Bushie is a First Nations woman living outside of Winnipeg, Manitoba on a First Nations Reserve called Hollow Water. Over 20 years ago, she worked alongside other elders in her community to understand the prevalence of child sexual abuse within families. Together they established a remarkable justice reinvestment program. They worked with victims and perpetrators often from the same families to understand why sexual abuse was happening and how to stop it. The story of how this program came into being is fascinating and inspiring. It can be explored further in this documentary, [https://www.nfb.ca/film/hollow_water/](https://www.nfb.ca/film/hollow_water/)

One of the approaches the program used was working with families to map trauma across the generations. They would put together a family tree and look at the abuse that had occurred from one generation to the next. They looked at brutal policy of child removals with the residential schools and traced the trauma’s that continued to happen, triggered by this event and other colonial policies. This helped people understand their behaviours in the present. This was putting trauma into a living history, helping people appreciate that what was happening to them was not their fault and they had the capacity to heal, change behaviours and their circumstances.
Context, in this example, is feelings, emotions, the built environment, housing, access to opportunities, being literate, being understood and able to communicate within the dominant mainstream culture. This is the infrastructure of life. When any of these aspects of life are eroded disadvantage can follow and increase the likelihood of being exposed to ongoing traumatic experiences.

Considering context in Vancouver: Depending on our birth and life circumstances what do we have access to? Nature, the wealth and prosperity of a city, commercialism, and high rates of property, and dereliction next door to gentrification.
**Adverse Community Effects**

In my search to understand the linkages between context, disadvantage and trauma, I was introduced to the work of the Prevention Institute and their ground-breaking research on Adverse Community Effects. In their research paper, commissioned by Kaiser Permanente, the same body that supported the Adverse Childhood Effects study, they explore how trauma takes hold within communities.

The Prevention Institute, based in the USA, has looked into the perpetuation of trauma in communities due to the range of compounded issues that intergenerational trauma encompasses. They describe how social, economic and physical disadvantage produces trauma and perpetuates trauma.

The keystone of their work is understanding that trauma entrenches disadvantage, and disadvantage causes more trauma. Our built environments, our surrounding ecology, our context, are key to breaking the cycle of intergenerational disadvantage.

The Prevention Institute’s ground-breaking paper on Adverse Community Effects, states,

*Multiple studies have found that levels of violence, crime and delinquency, education, psychological distress, and various health problems are affected by neighbourhood characteristics, particularly the concentration of poverty. The stressors of living with inadequate access to economic and educational opportunities or inequitable opportunities can also indicate trauma at the community level.*

(Pinderhughes H, Davis R, Williams M 2015: 5)

**The Science of Poverty**

Disadvantage is not created by people. Disadvantage is due to structural inequalities which create trauma. In our working practices and approaches it is important to recognise this. It ensures we do not blame people accessing services and community members for their circumstances.

(Harris, 2014)

**THINK:** When people are in a state of toxic stress, for example living in a rundown house and in a neighbourhood with loud all-night parties, drug taking and crime, it is unlikely that financial assistance programs, or life skill workshops will make a dramatic difference to their lives. It might work for some, but certainly not for the majority.

The Prevention Institute’s research shows there needs to be a combination of personal and social change, enhanced economic opportunities and improvement in the physical infrastructure, built environment and sense of place.

Drawing on the previous evidence section, there is emerging science showing that poverty creates conditions that heighten the likelihood of toxic stress. When people are lifted out of poverty, toxic stress can rapidly decrease. Consequently, this can change the behaviours of entire communities and can increase a community’s access to opportunities, including employment. A transformation from low to high socio-economic status can have positive impacts on addressing aspects of generational trauma.

There is no chicken-and-egg scenario here. Poverty and trauma are not inherent to some human beings and not others. They are produced by our contextual reality. They can be changed, leading to dramatic increases in positive life outcomes for whole communities.
The evidence is clear, overwhelming and undeniable, that trauma is the underlying cause of a majority of the social issues we are addressing in the social service sector. If we want to make a positive generational change, and we want to move societies from surviving to thriving, we have to address and overcome trauma by utilising and spreading the values we know are good for the health of society.

(Pinderhughes H, Davis R, Williams M 2015)

**Community is the Solution**

The Prevention Institute, like many organisations I visited, believed that the solution to counteracting trauma is growing a strong, safe and supportive community.

The Institute write of the interacting nature of people, place and economic opportunities. Their research shows that a healthy and resilient community is one which has the following qualities within three domains.

People have:
- Strong social networks
- Trust
- Willingness to act for the common good
- Norms/culture that support health and safety

There are equitable opportunities:
- Adequate living wages
- Local wealth
- Quality education

There is quality of life:
- Safe parks and open spaces
- Arts and cultural expression
- Perceptions of safety
- Availability of healthy products
- Availability of quality housing

(ibid: 29)

The Institute has written a whole strategy on how to achieve this outcome. It can be found here: [https://www.preventioninstitute.org/sites/default/files/publications/Adverse%20Community%20Experiences%20and%20Resilience.pdf](https://www.preventioninstitute.org/sites/default/files/publications/Adverse%20Community%20Experiences%20and%20Resilience.pdf)

As the Institute’s paper presents, pivotal to creating a strong and resilient community is shared knowledge and understanding behaviours amongst community members and community stakeholders of trauma and its related harms. As explored in the previous section one of the first stages of empowerment is giving knowledge to the community members and community services so that they can make strategic decisions based on sound information.

The ‘looking after each other project’ in Manitoba, the Trauma Informed Care Project in Des Moines, and the community-wide implementation of the Sanctuary Model in Washington State, are all fascinating examples of how spreading information is leading to society-wide behavioural change within communities and the practices of services delivering to those communities. This work can be found on the following websites, [http://www.fasdcoalition.ca/looking-after-each-other-project/](http://www.fasdcoalition.ca/looking-after-each-other-project/)
Case study: ‘Looking After Each Other: promoting Dignity and Respect’

The Looking After Each Other Project is a provincial wide FASD prevention strategy that is being driven by a team at ‘Healthy Child Manitoba’, a government department. The department drives long-term cross-departmental strategies for putting children and families first for positive generational change. Aspects of their FASD strategy were reviewed in the definitions section. The strategy sits within the department’s ethos that this work needs to draw on the expertise and lived experience of multiple stakeholders, including community members, First Nations, government, and a range of service providers.

In collaboration with these stakeholders the project is driving change through the following three-pillar approach. Each pillar has a corresponding subcommittee.

1) Creating a positive common language to speak about FASD
2) Participating in research to develop a shared understanding of what it means to promote dignity in relation to FASD
3) Launching a number of popular education initiatives

I met with many of the various subcommittee stakeholders. I was struck by how sharing knowledge and information about trauma and resulting harms such as FASD was changing their work practices and driving the creation of innovative programming.

These emerging areas of work include, the Starfish Project, that works through Manitoba Youth Corrections to support young people with FASD in making positive lifestyle changes around alcohol and drugs; The Insight Program, an empowerment-based mentoring program for women who use substances during pregnancy; Touchstones, which provides mentorship for those with FASD to make positive connections in community; Vision and Voices, a FASD presenter program where people with FASD present to communities to increase awareness, reduce stigma and encourage communities to create an environment of healthy living; and “Café 6, Where Justice is Served”, a social enterprise for young people with FASD who have come into contact or been within youth correction facilities. There are many more.

These programs are spreading evidence and knowledge and enabling change in the service system. Traditionally siloed areas of work are now starting to be integrated, such as health and justice. It was explained to me that by building community capacity, working with families, working with correction staff and probation officers, and within the child welfare and health systems, was keeping young people with FASD safe and opening opportunities later in life.

In this example a keystone to a healthy and safe community is institutions that are integrating evidence into their working practices to respond effectively to support, empower and secure safe communities.
Indigenous Values of Health and Wellbeing

It is important to understand the perpetuation of disadvantage and its links to intergenerational trauma. For Indigenous societies, the intergenerational nature of disadvantage and trauma is experienced differently because of the overwhelming impact of colonisation. In the present, it can be difficult to see how current traumas are connected to past events. (Gold, 2008)

What is missing in the Prevention Institute’s strategy for creating safe and resilient communities are fundamental elements of Indigenous societal values:

- culture,
- land
- community structures of self-determination based on Indigenous law and culture
- community-based organisations and institutions such as justice, health and education.

As the definitions section presented, it is important to recognise the overwhelming impact of colonisation and proceeding discriminatory and harmful policies that have eroded elements of Indigenous society. The history of colonisation and its ongoing effects is the overarching narrative of intergenerational trauma for Indigenous people.

It is important to recognise what has happened to Indigenous people, what was lost at colonisation and how that has resulted in the transmission of trauma and societal disadvantage at many levels. What is equally important to recognise is the immense strengths, values and ecological and familial knowledges of Indigenous societies and how this has built collective resilience and transmitted a range of protective factors across the generations. (Brokenleg, 2012)

Breaking the transmission of intergenerational trauma is about:

- acknowledging the harms that have been transmitted
- recovering from those harms by utilising the strengths of Indigenous communities and societies
- fostering a resurgence in Indigenous societal health and wellbeing
- exploring dynamic and contemporary forms of culture while feeling secure and safe in your cultural identity and heritage
- transmitting positive societal values and behavioural norms for future generations


As the Prevention Institute states, trauma that effects a population results in a “breakdown of social networks, social relationships and positive social norms across the community—all of which could otherwise be protective against violence and other health outcomes” (Pinderhughes, 2015:3)

These protective factors, as explored in the previous section on resilience, are essential to identify and use in community wide strategies aiming to break the cycle of intergenerational trauma. The difficulty in doing this is that the scale of trauma can be so overwhelming that we invest all our service delivery time in responding to crisis.

Community organisations need to make time to identify societal and cultural strengths and practices to bring about a resurgence in health and wellbeing. Taking the time to identify strengths can reduce crises in the immediate present and enable recovery from crisis situations.
These photos capture different elements of cultural practices that were integrated into activities and work programs. From top to bottom: A therapeutic beading session for family members of missing and murdered women Ka Ni Kanichihk, Seal skins to make boots in Clyde River, and the aftermath of the sacred fire at a large elders gathering in Winnipeg.
Developing Acceptance and Moving Forward  
Challenging and changing ‘societal norms’ and behaviours

The table below is a way of understanding what a healthy society is like when it is stable, in control, able to freely express itself and protect both individual members and the collective from harms and predictable traumas.

<table>
<thead>
<tr>
<th>A healthy, productive and prosperous society</th>
<th>Colonisation - transformative shock, ongoing massive and cumulative trauma known as intergenerational trauma</th>
<th>The impact on society and resulting social and behavioural norms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solid wellbeing, strong sense of identity and sense of belonging to place, family, society and surrounding ecology</td>
<td>Violent destruction of societal framework and massacres. Simultaneous processes of assimilation into dominant society. This initial large-scale and unimaginable trauma is the root cause of harmful addictions and many associated social issues facing Aboriginal people. Social disparities from this historical phenomenon reverberate across time and remain unaddressed.</td>
<td>Shame felt in interactions and relationships with others, shame felt toward family, culture and community and an individual’s identity within the community and broader nation state</td>
</tr>
<tr>
<td>High quality of connected familial life</td>
<td></td>
<td>Dysfunctional and abusive families and lateral violence</td>
</tr>
<tr>
<td>Strong cultural identity</td>
<td></td>
<td>Self-hatred</td>
</tr>
<tr>
<td>Strong parenting skills, based on nurture, curiosity and challenge</td>
<td></td>
<td>Hopelessness and disbelief in parenting abilities</td>
</tr>
<tr>
<td>High self-esteem in all societal members</td>
<td></td>
<td>Extreme lack of self-worth</td>
</tr>
<tr>
<td>Healthy diet meeting all nutritional needs</td>
<td></td>
<td>Eating food to feel good, overheating and the high consumption of harmful substances, including alcohol and drugs</td>
</tr>
<tr>
<td>Strong societal cohesion</td>
<td></td>
<td>A breakdown in societal connections</td>
</tr>
<tr>
<td>High levels of nurture and learning within and across generations.</td>
<td></td>
<td>A lack of support and disregard for traditional knowledge and educational practices within and across generations</td>
</tr>
<tr>
<td>Respect for all members of society</td>
<td></td>
<td>A lack of respect and general disregard for many members of society</td>
</tr>
<tr>
<td>Knowledge and learning held in high esteem</td>
<td></td>
<td>Lack of understanding of the importance of knowledge and learning as a part of societal wellbeing</td>
</tr>
<tr>
<td>A deep appreciation for holistic health and a holistic structure of societal work, communal activities and leisure.</td>
<td></td>
<td>A focus on individual needs and segmenting life into a range of overwhelming and disconnected issues</td>
</tr>
</tbody>
</table>

**Ongoing transmission of societal practices and values beyond colonisation**

Strong community cohesion and resiliency enables survivors to continue and support the healing and recovery of others beyond the traumatic event and ongoing harms. Many members of society continue to engage in ceremony, speak their language, and continue to connect to their country, sacred sites, live within kinship systems and take on familial and kinship responsibilities of care, support and knowledge transference.
The table above has drawn on several research papers and learnings from the course of the trip, this includes: The National Collaborating Centre for Aboriginal Health’s paper on Aboriginal Historic trauma which looks at breaking the transmissions of trauma, referenced throughout; the work of Martin Brokenleg on the need to break the transmission of trauma within Indigenous cultural values; Maria Yellow Horse Braveheart and her work on the impact of historical wounding from colonisation onwards; Thema Bryant-Davis who explores what it means to thrive in the wake of trauma by drawing on multicultural strengths.

All these scholars and practitioners describe the unimaginably devastating impact of historical and inter-generational trauma on the life of a collective and society. Their research and on the ground work explores the notions of culture that provide ongoing strength to populations of people to recover and heal and restore society to full health and wellbeing. These aspects of health and wellbeing, which are tools to address trauma, can be utilised as skills and mechanisms for recovery, and are ways of sustaining good societal health are summarised in the first column of the table above.

**Surviving against the odds**

Even with the impact of a large scale traumatic shock Indigenous society remains. Indigenous knowledge and societal frameworks have given Indigenous people an incredible resilience and an immense capacity to survive against all the odds. The transmission of societal practices and a wealth of familial and ecological knowledge continues far beyond the colonial frontier.

However, when a large-scale shock happens, such as colonisation, which is entirely unpredictable, and violently attacks both the foundations and structures of Indigenous society, people are left with massive and damaging physical, psychological, and physiological wounds (Braveheart, 1998). When a traumatic event like this is left unresolved, and is further compounded by structural inequality, the result is a society which plummets into a cycle of trauma. Without adequate supports and resources to address this event and its resulting harms, and ongoing structural inequalities, a society must restabilise and adapt to conditions of disadvantage. Individuals and the collective develop adaptive behaviours to cope and survive.

It is important to recognise that not all members of a society experience the same life outcomes. Trauma and protective factors interact at a range of levels and at different times in people’s lives, meaning that some individuals and families can thrive in very difficult circumstances. However, having a good understanding of this historical process gives an appreciation of the community-wide and societal prevalence of harmful and negative coping behaviours. (Madsen et al, 2010; Bonnano, 2004)

---

**THINK:** In our working practices, it is important to understand that many of the harmful behaviours that we encounter in those engaging in our services are not inherent characteristics of the individual. A person is not to blame for coping behaviours. Practitioners need to work with them to deliver knowledge and evidence about trauma and its effects and develop new coping skills. The revitalisation and re-engagement of cultural practices of health and wellbeing is one of the best way to do this.
Articulating Health and Wellbeing in Achieving Good Health and Wellbeing

The way a society and its people feel, understand and embed societal practices of health and wellbeing both as individuals and as a collective, is fundamental to achieving a high standard of life outcomes and good health for individuals, families and communities over generations. As was explored in the ‘Definitions and Discussion’ section, working from an Indigenous value base could improve mainstream indicators of health.

Improving self-worth, self-determination, collective expressions of identity and culture can have a dramatic impact on improving health disparities, reducing the life expectancy gap, raising employment rates, increasing school attendance, reducing chronic illnesses… the list goes on. A feeling of wellbeing and being in healthy reciprocal relationships, free of judgement, competitiveness and shame can be just as important as the actions we take to feel healthy. When people feel trusted and treated with respect and dignity they can make decisions about their health and their engagement with others on their own.

In other words, working from an Indigenous values base could make Adverse Childhood Experiences and Adverse Community Experiences negligible.

TIP: Every community and society is different. It is important for community groups to consider their own understanding of health and wellbeing. As organisations begin to work from a strength base, it is worth thinking about establishing a process where community members can come together to discuss what health and wellbeing means to them. The very act of articulating Indigenous health and wellbeing is also a restorative process. It helps community members, and services to move from a crisis frame, focused on deficits, to recognise work as processes enabling people to be healthy and to thrive, and build from strengths.

Preparing seal, for a feast at an elders gathering on the land in Rankin Inlet, Nunavut
The entrance at Ka Ni Kanichihk, displaying many elements of cultural and spiritual healing and security of First Nations people.

Fishing as a health and wellbeing activity and providing nutrition for a family! Rankin Inlet, Nunavut
Case Study: The Mothering Project, Ka Na Kinichi and other forms of cultural revitalisation
bringing culture to the forefront of healing and working practices

Indigenous organisations are bringing culture to the forefront of their working practices. The Mothering Project in Winnipeg supports women who are pregnant and are actively using or struggling with drugs or alcohol. The project offers a range of wraparound supports including counselling and pre-natal care, and parenting groups. Most women who engage with the project are Indigenous. Many of the programs are culturally appropriate. I saw mothers from the project perform in a traditional Indigenous drumming circle. Together with an Indigenous practitioner, the women had made the drums and learnt to play and sing together. The women who performed explained the empowerment they get from being able to participate in cultural practices, and the strength and spiritual comfort they feel from drumming and signing together.

Other organisations such as Ka Ni Kanichihk were engaging women who had experienced a range of difficulties in pow wows, traditional ceremonies and dance gatherings. The organisation was also running several talking circles (similar to yarning circles) where women could come together and talk about their feeling and experiences. I attended a circle for people who had missing and murdered women in their families. The circle was centred around traditional beading and food. This group was using traditional practices as a form of art therapy and peer support.

In Nunavut, I visited a community called Rankin Inlet and spent time at their friendship centre, here they were focusing on intergenerational supports between the young and old. They were bringing their elders together once a week to spend time at a Cabin on the land, tell stories and eat traditional food. Other places I visited in Nunavut were investing time and funds in people reconnecting with their cultural identity and practices. This included going out onto the land, learning how to hunt and make traditional clothes, tools and during the winter months igloos and sleds.

In Ottawa, I visited the Indigenous Wabano Health Centre. When people attended their clinics and programs they had to fill out an intake form. The form asked if they wanted the presence of an elder in their clinical appointment. For other programs, the intake form asked attendees to identify if they felt a strong or weak connection to their Indigenous culture and heritage, and if they wanted to be connected to an elder of their Indigenous community group. It was explained to me that many young people request connection to elders so they can explore their cultural identity and engage in cultural practices.

In these examples, culture, the resurgence of culture, reintegration into the cultural community, and utilising cultural activities as therapeutic practice is intrinsically tied to good health and wellbeing. These centres see culture, ceremonial practices and engagement with elders as fundamental to improving people’s health.
Indigenous Practices as Evidenced Tools for Recovery

Western science has only just begun to appreciate what is needed to break the cycle of intergenerational trauma and facilitate healthy recoveries. The evidence is proving the importance of Indigenous ways of knowing and doing to all forms of society. (Moodley and West, 2005)

Indigenous holistic societal frameworks offer a profound understanding of the interconnection between the mind, the body and the spiritual elements of life, including the attachment of individuals to a broader society and their surrounding ecology.

With increasing rates of anxiety and depression in western society (Hidaka, 2012), people are turning to treatment plans and therapies which reflect the fundamentals of Indigenous societies. These include, but are not limited to:

- Narrative therapies
- Sound and light therapies
- Peer support groups
- Dancing
- Meditative activities
- Mindfulness
- Gardening and being in nature
- Controlled breathing
- Art therapy

These forms of therapy and treatment are important and will be explored in the following sections on models and approaches. However, there is the risk that understanding trauma and having an awareness of it does not address the unequal distribution of resources and unequal access to services, and the ability to take time out for self-care, across society. Without addressing systemic inequalities, and reverting to therapeutic treatments as the solution to trauma, it may be impossible to break cycles of intergenerational trauma over the long-term.

Conclusion

It is becoming widely appreciated that Indigenous groups and community-based organisations are creating some of the most innovative strategies and programs for healing and regaining strong health and wellbeing. Placing Indigenous knowledge and practices at the forefront of the work of community organisations ensures that programs delivered to communities are culturally relevant and appropriate. (Pinderhughes H, Davis R, Williams M 2015)

Bringing about a resurgence in societal practices, ceremonies, rituals, and deep knowledge around the healthy and calm interactions of people with their families, their communities and the environment, is central to breaking the cycle of intergenerational trauma.
Models and Approaches
This section explores what it means to develop and apply models and approaches to work in response to a philosophical and evidenced understanding of intergenerational trauma.

During my travels, I was interested in organisations that had taken this philosophical and evidenced understanding of work, explored in the previous sections. I wanted to see how this framework of understanding is changing the nature of work. What I encountered were organisations making big changes, such as Orchard Place, who were adopting models that were changing elements of all their programs and practices. There were those that were taking smaller steps and developing programs around the awareness of intergenerational trauma. Other organisations were clear about the philosophical and trauma-informed position they had started from, such as the Jean Tweed Centre; The Mothering Project; Sheway; and Herway. All these organisations were working with women using substances at different points in their lives and during pregnancy. Many of the organisations and community groups explained the difficulties of taking on an entire model of practice when they were having to comply with funding contracts.

However, I was impressed by the way organisations were working to align programs and projects with their philosophies, values and principles, grounded in an understanding of their contextual reality and an awareness of intergenerational trauma. This was despite the challenges of service agreements which dictate a very different methodology and approach to work. (Gold, 2008; Ward et al, 2011; Carson et al, 2015; Jennings, 2004)

A note on this section
This section will consider the different models and approaches an organisation might take on and how they can do it most effectively. It also looks at some of the challenges organisations might face and important points to consider before taking on any new work.

This section also provides suggestions on some of the techniques and skill-building activities that can help organisations understand trauma-informed practices and how to embed them.

It is difficult to know what comes first – the model, the approaches, or the healing and recovery activities and strategies. It is likely that many of these things will happen simultaneously, as this section will explore.

The most well-known models that are explored thoroughly throughout this section are trauma-informed practice models. They remain within the western service delivery space although some Indigenous organisations have taken elements of the practice on. How to understand their application, adaptation and reform for Indigenous organisations needs further research based on application and implementation. However, the fact that they have been taken on by western service provision shows a shift in the culture. Organisations with a trauma-informed practice model are more open to new ideas and responding to community expertise and experiences.

Many Indigenous organisation already work from a holistic position which encompasses a profound understanding of trauma-aware and healing practices. In order to achieve vastly improved outcomes, it is time for the western service sector to find ways of being open and embracing of these holistic approaches to health and wellbeing. Becoming trauma-informed is a significant step in achieving this. (Delaney, 2014)
Models

A model or framework of work defines everything an organisation does and/or will come to do. Models are a systems approach to work. Much of the work in addressing and breaking the cycle of transmitted trauma is focused on systems change, operating at multiple levels simultaneously from the individual to effecting policy changes. In this regard, it can be very effective to design, implement or adopt a pre-existing model of principles and practices for organisations seeking to break the cycle of intergenerational trauma.

Models of work reflect or come to determine what the structure of an organisation is, how it looks and feels, and the way individuals, including all staff and those engaging with the services of the organisation, interact and behave. Overall, a model is a philosophical, values and principles-based approach to organisational design. (Bloom et al, 2008)

Approaches

Approaches to work are often a set of practices, a program, or a project that sets out how to manage and enact the work in a particular service delivery area or amongst a team. Whereas, models are a philosophy to understanding and approaching trauma, practices are tools that do not necessarily change work culture or service delivery (Elliott et al, 2005). For instance, there are many trauma informed practices, such as grounding techniques to relax and calm yourself after a triggering event, or ways of talking when addressing trauma experiences, amongst many other approaches.

There are also trauma-informed principles of empowerment, strength-based processes and collaboration to aid in good program design, organisational strategies and team project work. Sometimes approaches are universal across an organisation and at other times they vary. All of this will be looked at in this section.

For organisations looking to become more trauma-informed, trialling new approaches is a good way of learning about what works on the ground. It tests the waters for how responsive or resistant staff are to working differently, helps to recognise many of the trauma-informed strengths that already exist and how to build from them, and helps consider what appropriate and effective implantation of new approaches will look like over the long-term.

Ultimately, testing out new approaches allows organisations and communities to determine what fits best for them. Sometimes the successful trial leads to new approaches becoming embedded and a new model of working practices and operations emerging.

Trauma-informed models and approaches

As you read through this section it is important to keep in mind the definition between trauma-informed practices as an organisational model and trauma-specific care. As I learnt, these approaches can be blended within a model, but they are still distinct for many practitioners and service providers.

In a meeting with Nancy Poole from the British Columbia Centre for Excellence in Women’s Health, she explained that to fully appreciate trauma-informed work and how to implement it, organisations and people need to be clear on the difference between, Trauma-specific care and trauma-informed practice.
The Resource from the British Columbia Centre for Excellence in Women’s Health (BCCEWH), “Trauma-Informed Practice Guide”, which can be found here [http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf](http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf) offers insight to the different approaches taken with trauma informed and trauma specific models. The Jean Tweed Centre, in its resource, “Trauma Matters’ has an extensive section on the differences between the models and an entire chapter on how to implement trauma specific care approaches.

[http://jeantweed.com/wp-content/themes/JTC/pdfs/Trauma%20Matters%20online%20version%20August%202013.pdf](http://jeantweed.com/wp-content/themes/JTC/pdfs/Trauma%20Matters%20online%20version%20August%202013.pdf)

Nancy Poole, directed me toward the following definitions in the Practice Guide, which states that the entire guide is built on the important definition between the two;

**Trauma-Informed services and practices**

“Trauma-Informed services take into account an understanding of trauma in all aspects of service delivery and place priority on the individual’s safety, choice and control...trauma-informed practice is more about the overall essence of the approach, or way of being in the relationship, than a specific treatment, strategy or method...In trauma-informed services, safety and empowerment for the service user are central and are embedded in policies, practices and staff relational approaches. Service providers cultivate safety in every interaction and avoid confrontational approaches” (BCCEWH, 2013: 12)

**Trauma-specific services and care**

“Trauma-specific services more directly address the need for healing from traumatic life-experiences and facilitate trauma recovery through specialised counselling and other clinical interventions. They include specific interventions such as trauma focused cognitive behavioural therapy”, and other counselling and treatment approaches which can include Indigenous and non-Indigenous healing activities.

(Ibid: 13)

**THINK:** Both Resources, caution not to put trauma-specific programs into effect before a trauma informed practice is embedded across all services of an organisation.

**CONSIDER:** It was explained that a fully implemented trauma informed practice model across an organisation ensures the safety of those going through a recovery or healing process. When a trauma informed practice is not properly understood by all employees it creates a knowledge and practice gap across an organisation, which can lead to an inconsistent and contradictory response to those engaging in a variety of services and programs within an organisation. This can unintentionally cause more harm and the re-traumatisation of service users, and service providers.

This is a clear case for putting a trauma-informed model in place before a set of approaches to address intergenerational-trauma. A model that unites all employees with a philosophy and principles may lead to the more successful and long-lasting implementation of programs designed to end the transmission of trauma and facilitating recovery and healing choices.
It is important to note that these resources do not focus on Indigenous healing and recovery techniques, skills and pathways. Indigenous healing approaches as a part of understanding trauma and determining recovery options could be very different from traditional Western understandings of Trauma-specific Care. This will be considered later.
(Bloom, 2008; Hummer et al 2010)
The Principles of a Trauma-Informed Model

I spent time at three organisations that have implemented a trauma informed practice. These were the Klinic Community Health Centre in Winnipeg, The Jean Tweed Centre supporting substance using women in Toronto, and with Nancy Poole from the British Columbia Centre for Excellence in Vancouver. Each centre has produced Trauma-informed resources. The following draw on my learnings from spending time at these centres and their resources, all of which have been mentioned and cited in each section.

A trauma-informed model sets out a philosophy of principles and practices to enable an organisation to do trauma work effectively and from an evidence-based, best-practice position.

Below are the principles of trauma-informed practice which I have brought together from across the resources.

I have included the last three bullet points from my learnings in Indigenous organisations. Many Indigenous organisation spoke of the essential need to address the trauma, pain and hurt arising from unequal power dynamics, and the resulting lack of respect and dignity and low self-worth and esteem people feel when operating in hierarchical and authoritarian structures. In responding to these feelings caused by the trauma of colonisation, Indigenous organisations are turning to frameworks of genuine self-determination where all community members and employees are either involved in decision-making or fully informed about why decisions are being made.

Indigenous principles of engagement have a universal applicability. The case study of the Boldness Project present principles which enable a deep and reflective community engagement. Their principles are a commitment to ensuring community feel aware and are involved in choices being made and in control of the direction an organisation and work approach is going. The following trauma-informed principles are a framework which enables the form of community engagement work the Boldness Project speak and write about.

---

**Case Study: Indigenous Principles of development:**

The Boldness Project, a social innovation project based in Winnipeg has engaged in community based research in an area with a high Indigenous population. They made a commitment to doing their work based on Indigenous principles of engagement. The Boldness Projects work is based around community has the solution to social issues. This solution focused work has to be developed and implemented through community driven strategies. The principles are as follows:

1) **Community control** – creating processes to ensure community develop, approve and implement work

2) **A respect for individuals and community** – creating many forms of participation for different people to contribute to work in ways that suit them

3) **Participatory method of engagement** – using a range of methods to allow people to express their knowledge and expertise and incorporate this into designing processes

4) **Join co-learning processes** – having a reciprocal relationship in knowledge sharing with the intention that work drawing on community voices builds community capacity

5) **Reciprocity and Responsibility** – placing the highest value on community contribution and giving all research back to the community in ways that the community can act on the findings

6) **Balancing research and action** – putting theory into practice to see what works for the community rather than just drawing on community knowledge.

Copyright, The Boldness Project, 2016
10 core trauma-informed principles:

- Trauma awareness
- A strong focus on safety and trustworthiness in all relationships – recognising that this takes time to create and feel, particularly in working environments where people have been colonised
- Opportunity for choice and control, collaboration and connection
- Strength-based skill building and empowerment forms of work
- Acknowledgment – recognising that trauma is everywhere and can spread everywhere, from the individual to society. Service providers need to be self-reflective in work practices to ensure belief and support and be non-judgemental of colleagues and community.
- Relational approaches to work amongst employees, those engaging with services and community
- Empathy and compassion toward all colleagues, service users, and everyone interacting in and beyond the workspace
- Respect and dignity shown and demonstrated to all
- Environment of equality and shared power
- Self-determination, and inclusive and informed decision making

TIP: If you like these principles copy them and print them out. Work through what the principles mean for your work and organisation. Engage colleagues and community members in the discussion and decide what principles suit your organisation and you’re interested in exploring.

Principles agreed to by the organisation can be used as a guideline for developing programs. At Homewood health, it was explained to me that trauma-informed principles were stuck on the walls visible for all to see, as a helpful reminder of how to do work. At Homewood health if all the principles were not being met in a current work practice, the work practice needed to change. It also helped with reducing conflict situations. When colleagues were oppositional on what approach to take, they would turn to the principles to help come to an agreement.

Principles work when they are embedded in organisational culture

The ‘Trauma Matters’ resource by the Jean Tweed Centre, described how in a trauma-informed practice model:

“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”. (Trauma Matters, 2013:103)

Each resource follows the trauma-informed principles with explanations and skill sets for putting them into practice. They describe:

- how embedding principles changes an organisation work culture and enhances its work
- the type of work practices required to reflect and embody the principles
- the skills required by all staff to enact the principles and apply relevant work practices
- the organisational guidelines, policies and procedures, recruitment processes, training and supervision frameworks to keep principles embedded.
These principles translate into an entire body of extensive trauma-informed work practices. As the staffing body embarks on a process of learning these practices it enables an organisation to,

- Gain a deep knowledge of trauma effects and triggers in people’s lives and the co-related nature of trauma with substance use and other harms
- It creates a non-judgemental, non-blaming positive and happy working environment, based on feeling of hope and resilience.
- It enables better decision-making improving all working relationships the effectiveness of work as staff engage with each other and community.
- It creates a stronger strategic direction based on principles of safety, harm reduction and a commitment to stopping traumatization and looking at initiatives that will stop the transmission of trauma.

Overtime as these practices are learnt and embedded across a whole organisation, the entire culture and work approach changes and a trauma-informed model may emerge.
Change – the Reality of Taking on a New Model

Taking on new models can challenge an organisation’s old or current models of operation and structures, whether the existing structure has been formalised into a model or not. (Bloom, 2008)

An example of the difference between a trauma-informed model and not trauma-informed model can be found in the table below. Most organisations will have elements of both structural characteristics and working practice methods. As explained to me, as organisations venture to become more trauma-informed they will find many of their working approaches in community development, harm reduction and general principles of safety are reflective of the trauma-informed approach. In other words, most organisations will already be doing a lot of this work. For many it is just a matter of growing strengths.

However, as described to me in one organisation, a strong trauma informed model can highlight more clearly practices which have become embedded from a non-trauma informed way of working. In other words, the contrasts between old and new working practices become stark. These contrasts can cause friction but, with strong leadership, approaches that are not trauma informed can be addressed and changed.

CONSIDER: non-hierarchical ways of working do not mean that you have to change your organisational structure. Defined positions of leadership and decision making is vital when running and managing an organisation. Lines of communication around lead responsibility on projects and the management of projects is important for people to feel secure in the work being done and being able to achieve outcomes. Roles with defined responsibility enable us all to do our work effectively. However, when hierarchy stops collaboration and transparency around decision making and strategic direction that is when it is not trauma informed. Trauma informed principles and practices helps to introduce productive collaboration and shared control in the work place while still maintaining clear roles and responsibilities.
<table>
<thead>
<tr>
<th>Trauma-informed practice model</th>
<th>Not Trauma-Informed working model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using a collaborative approach with all those interacting and engaging with the services of the organisation. Open and honest discussions within agreed upon safety principles and parameters. Inclusive and informed decision making.</td>
<td>Top-down hierarchical management based on command and control. Authoritative and exclusive decision-making. Information given on a needs-to-know basis.</td>
</tr>
<tr>
<td>Recognition of culture and practices that can be re-traumatising. Understanding that hierarchical structures can reflect situations of oppression which trigger trauma responses.</td>
<td>‘Tradition of Toughness’ and reliance on confrontational approaches. Punitive and punishment measures on staff who are seen to ‘have done the wrong thing’. Inflexible working arrangements.</td>
</tr>
<tr>
<td>Power and control are shared; those engaging with the service/organisation and the organisation employees work together collaboratively.</td>
<td>Power and control reside with staff over service users. Management use power over staff members to direct work and tasks without feedback from staff. Inflexible emphasis on rules and compliance.</td>
</tr>
<tr>
<td>Education and training of trauma-informed practices and related practices, such as anti-oppression training and cultural competency. Ongoing supervision by those holding expertise in these practices, enabling staff to respond to trauma, and adaptive behaviours.</td>
<td>Lack of training causes uniformed/scattered inappropriate and un-evidenced response(s) to treating and dealing with trauma. A blaming and ‘gossiping’ work environment. Seeing the community and those engaging with services as overly complex, attention-seeking, in denial or not ready to engage in programs or healing.</td>
</tr>
<tr>
<td>Transparent system open to ideas and collaboration across the organisation and open to advocacy from and collaboration with relevant and helpful outside services and organisations.</td>
<td>Closed system, sharing of ideas and collaborating across teams is discouraged. Services operate in silos. Attitude of ‘we are the experts’ and do not need outside help.</td>
</tr>
</tbody>
</table>

This table has been drawn from a number of the different resources in the trauma informed resources and explanations given to me over what a trauma informed organisation is and what are not trauma informed practices.

Overall, it takes most of the design and layout, and many element of a trauma informed practice from the ‘Trauma Matters’, resource, the table of ‘Trauma informed practice’, working features can be found on page 9. There is a following table in the same resource of ‘trauma-informed practices, Vs Not trauma-informed’, found on page 16.

Sometimes, as a whole set of new approaches are considered, a pre-existing model of trauma-informed practices can help organisations establish a process of careful and considered implementation, so as not to cause distress and uncertainty amongst staff. A sudden change in an organisation’s model, which can alter a range of operational procedures and practices can itself be stress inducing and trigger people into a trauma response. (Elving, 2005)
Implementing New Models and Approaches – Some Key Lessons

It takes time

New working models and a set of approaches cannot just be adopted, they must go through a series of steps to become implemented and then embedded in the organisation’s working culture. Models such as the ‘Sanctuary Model’, by Dr Sandra Bloom, have a series of trainings and implementation stages to enable the whole of an organisation to become trauma-informed.

I visited two centres that had and were implementing the Sanctuary Model: Homewood Health, just outside Toronto, and Orchard Place, in Des Moines, Iowa. I also had a meeting with Trudy Townsend who had worked to implement the Sanctuary Model across an entire community in Washington State.

Case Study: The Sanctuary Model

The model was designed and developed by Dr Sandra Bloom, she has written a series of books on the social service sector, health services and the mental health sector in the United States, all based on the need to dramatically change the system. The Sanctuary Model website describes the model as a set of interactive tools which change people’s minds and the way work is done. http://sanctuaryweb.com/TheSanctuaryModel.aspx

It is described as a “theory-based, trauma-informed, trauma-responsive, evidence-supported, whole culture approach that has a clear and structured methodology for creating or changing an organizational culture” (website).

The intention of the model is to create organisations that are able to facilitate healing from psychological and societal trauma. Sandra Bloom’s books on “Destroying Sanctuary” and “Creating Sanctuary”, describe how the social service sector has become orientated around a set of principles dictating competitiveness, efficiency and financial restraint. These principles have destroyed what the social service sector is intended for to create sanctuary and enable positive transformation in people’s lives. Her books are clear that these workplaces are traumatising for both those accessing the services and for service providers. To enable people to heal from trauma organisations must change their working cultures and become a space of sanctuary. As the Orchard Place’s (explored below) CEO Anne Starr expressed, “an organisation can be working from a trauma informed and trauma specific place for a long time, but the trauma-informed and trauma response change model, which is the Sanctuary model, is still needed to create a common language and an organisational community”.

When an organisation or group takes on the Sanctuary Model as I saw at Homewood Health and Orchard Place they commit to key principles.

Seven commitments of a trauma informed organization

1) Non-violence – helping to build safety skills and a commitment to a higher purpose
2) Emotional intelligence – helping to teach emotional management skills
3) Social learning – helping to build cognitive skills
4) Open communication – helping to overcome barriers to healthy communication, learning conflict management, reducing acting out, enhancing self-protective and self-correcting skills, teaching healthy boundaries
5) Social responsibility – helping to build social connection skills, establish healthy attachment relationships, and establish a sense of fair play and justice
6) Democracy – helping to create civic skills of self-control, self-discipline, and administration of healthy authority
7) Growth and change – helping to work through loss and prepare for the future

Learnings from Implementing the Sanctuary Model – Orchard Place

I spent time at Orchard Place in Des Moines, a child mental health and residential care service, where they were nearly two years through committing to a three-year process to implement the Sanctuary Model across their entire organisation of 400 staff and four divisions operating on different sites. I met with the CEO Anne Starr and the VP Nicole Beaman about the journey of implementing the Sanctuary model. Their big message was that it takes time to put a model into practice. Not only does the practical side of it take time, but it takes time to understand the purpose of a model and for staff to feel comfortable putting new practices into action.

They explained that they had worked with models to change their structure and enhance their organisational culture but it did not get traction. When they took on the Sanctuary Model everyone was engaged in training so the knowledge and philosophies were shared amongst the entire staffing body almost immediately. In this way, everyone, from the counsellor to the student mentor and cleaner, could support one another in putting practice into action.

Anne explained that implementing an organisational wide model embedded a common language, common knowledge and values which built a shared resilience across the organisations community. They said a number of things have emerged due to the implementation of the model that has changed the working culture. These include,

- **Empowerment and Democracy** – people feeling like they can present new ideas and work together to turn ideas into reality
- **Equalizing power** – having a shared knowledge base dismantled power differentials between staff and their relative trainings or qualifications
- **Culture of trust** – knowing that you can ask for help and staff will be supported and coached because they know the organisation wants them to be successful
- **Culture of innovation** – feeling like a community that will support one another to take risks and feel comfortable and safe to take risks
- **Common language** – created a consistent working culture which was not specific to the silo people work within.

As the women reflected, they told me in hindsight there were the right conditions for the model to be implemented.

**Being ready is key**

The question is, how do you implement a new model over an entire organisation, not just a large organisation, but one that has been established for years? Orchard Place has been running for 131 years.

I was told that an organisation needs to be ready. Orchard Place has many counsellors and workers that were working from a trauma-informed perspective and with trauma-specific practices, but were not necessarily using the trauma-informed terminology. The same was true of Homewood Health who were well known for their trauma-specific residential care program for those suffering from PTSD. They had an awareness of trauma-informed practices and they could help develop a caring,
supportive and innovative working culture. In this sense, there was a willingness to change, motivated by previous success.

**Having a Champion**

Orchard Place had a trauma-informed champion. Gladys Alverz, who showed me around Des Moines, led the Trauma Informed care strategy. The strategy was explored in the evidence section. Her mandate as the lead of the strategy was to spread the knowledge of trauma informed practice. Her only tangible task in doing this was to run a conference every year about different forms of trauma informed practice and its implementation. In effect Gladys had primed people with what a culture and philosophy of trauma-informed practice is. She worked across the organisation to explain trauma-informed organisational approaches and in the process she had created a culture of readiness.

The Executive Director of the organisation explained that at first people could not quite understand what Gladys was talking about. It was difficult to grasp an organisational change strategy based around trauma informed practice. Overtime, Gladys created a language that everyone began to respond to.

Believing and having faith in champions shows that the organisation is willing and responsive to the ideas and knowledge of its staff. It shows a flexible and caring organisation that can respond to changing needs and emerging evidence.

**Investment in staff**

Caring about all staff members, their individual needs and growth, creates a strong and cohesive community. This enables a whole staffing body to feel comfortable in working together to implement a new approach.

Orchard Place have a very high ratio of supervisors to staff. This ensures that staff feel supported and encouraged at work to develop and implement new skills. It also encourages growth and development. As staff learn and show interest in different areas of work, Orchard Place bring in internal trainings to support staff in their professional interests and pay for outside education and courses. This shows an organisation is committed to individual learning and improvement as well as creating an organisational culture of growth and support.

In doing this Orchard Place had demonstrated a commitment to always adopting the best practices and encouraging staff to learn and implement these practices. In a working culture which pushes best practice and supports staff in exploring these practices, each staff member is then prepared to adopt a new working model.

**Leadership**

One of the first principals of trauma informed practice is to be collaborative in discussions and decision making, which means creating working spaces that are open to feedback and input from across staffing teams. The leadership of Orchard Place advocated an open-door policy while bringing the sanctuary model in. She explained to me her excitement that a staff member had come to discuss a new idea with her. She said before the Sanctuary Model they did not have a working culture where people were prepared to take risks and challenge working practices.
A leadership that is open, communicative and ready for change can support employees through an organisational change process. This helps an organisation to feel secure, it reduces conflict and enables everyone to feel confident in adopting the new model and its work practices.

Altogether, strong leadership enables employees to be open to learning, grows confidence, encourages creative approaches, and ultimately improves effectiveness and engagement in work.

It was impressed on me that to do this well, the leadership of an organisation must be willing, strong, committed and enthusiastic about implementing the model and must be able to demonstrate this to all employees.

**Picking bits and pieces**

Anne explained, if you are not ready to make a three-year commitment that you can choose to learn and implement parts of the Sanctuary Model. This is true of most models, you can learn about aspects of them and attempt as an organisation to put them into practice without any external assistance.

The difficulty experienced by organisations who attempt to do this is that staff, who have several commitments, become too busy to actualise trainings. Some staff may take it on better than others resulting in inconsistency of practices across the organisation. This can lead to a lack of support and at times confrontation across staffing teams as they do their work differently and from a different philosophical and values base.

A scattered approach to new practices also makes it difficult to evaluate whether a new approach is effective or not.

The downside of selecting a defined model is that an organisation may become committed to something that it may not be suited to, or that it does not have the capacity to effectively respond to and implement.

On the other hand, the executive team of Orchard Place felt very confident with their decision to take on the entire Sanctuary Model. It was explained that it was shaky to start with but after watching it take really hold over the course of a year and a half they had seen some big changes.
Applying Models, Approaches and Practice in Context

All the centres that had developed resources for trauma-informed practice approaches were clear: when applying these practices, culture, society and their context really matter. Women, families, children and communities are not homogenous and have a diversity of experiences and societal norms and practices. (Ward et al, 2011; Centre for Substance Abuse Treatment, 2014)

Practices and how they are implemented are likely to change depending on who an organisation/service represents or is working with and/or for. Nancy Poole has spent time working across Indigenous communities, policy makers, government bureaucrats, and community organisations. She is aware of needing to take the time to learn which trauma informed practices work, what needs to be changed or re-thought and how to adapt and implement practices based on context. (Gone, 2013)

In the trauma-informed practice guide, there is a section on approaches with different populations. It states that a key aspect of trauma-informed practice is understanding how trauma can be experienced differently by different populations (BCCEWH, 2013: 14-15). As service providers, it is very important to understand the forms of trauma a population has been impacted by, as the previous section explored on intergenerational trauma.

The Klinics practice guide mentions the colonial intergenerational trauma of Canadian First Nations, Inuit and Metis, and the huge and devastating traumatic ramifications of the Residential Schools. The Klinic’s Toolkit has an entire section from page 44 – 57, on “Historic Trauma: The Legacy of Colonisation and Residential Schools”, the resulting impact this has on individuals, family, community and culture. It then goes on to talk about indigenous cultural teaching and healing practices which include:

- The role of Elders
- Ceremonies
- Teachings

Klinic Executive Director, Nicole Chammartin, told me that she acknowledged that although they had many indigenous clients and showed cultural respect and humility, true healing is done by giving power and authority back to the Indigenous community. Earlier in the month she had made the decision with her team to hand the funding for one of their Indigenous healing programs to Ka Ni Kanichihk, an Indigenous women’s organisation. She explained how appreciating where the expertise lies and addressing the unequal power dynamic by giving funding away enacts a process of healing at a societal scale. It acknowledges that trauma is also caused by the unequal distribution of resources to societal institutions, and the distrust that governments can show toward Aboriginal organisations.

This post from Nicole Chammartin’s blog explores that process of healing and reconciliation

http://klinic.mb.ca/2017/05/how-do-we-reconcile/

Nancy also explained the importance of moving beyond recognition of historical and intergenerational trauma as a service provider, to giving the explanation of trauma, grief, loss and recovery to Indigenous people.

She worked to facilitate a process with Aboriginal women participating in treatment at National Native Alcohol and Drug Abuse Programs (NNADAP), to identify principles of working practices for
service providers to apply when supporting Aboriginal women’s healing from illicit drug use. The women developed the RECLAIM principles.

- **Empathy** – understanding the difficulties women experience because of problematic substance use such as the removal of children
- **Acceptance having a non-judgemental attitude** – accepting about women’s past behaviours e.g. Involvement in prostitution
- **Inspiration** – act as a role model and show that change and healing are possible
- **Recognition** – the impact of trauma in women’s healing
- **Communication** – two-way non-hierarchical dialogue with the women
- **Care** – show passion for your own role as a service provider
- **Link to Spirituality** – support link to spirituality and culture as part of healing
- **Momentum** – assist in moving toward the future after acknowledging the past. Fostering women’s ties to communities will help break generational cycles

Copyright, National Native Addictions Partnership Foundation, 2005

There are many approaches to developing culturally based and community-based alcohol and substance use treatment programs, some of these are listed in the references of this section (Jiwa et al, 2008; Marsh et al 2015)
**Cultural Competencies**

All centres emphasised that when working in diverse settings there is an inseparable interrelationship between cultural competency training and trauma informed training. Cultural competency training should provide service providers with an understanding of trauma, strengths and resiliencies of a population in context.

It also gives service providers the skills to engage sensitively and appropriately in discussions addressing difficult topics about trauma and related responses. This approach further enhances a trauma-informed principle of acting from a strength base, acknowledging the equal knowledge and expertise of the people you are engaging with and believing that they have the skills and capacity to change in the ways they want.

**Trainings**

Trauma Matters resource states that all trauma-informed services should take steps to develop cultural competencies in their staff and in their organisational practices and policies. It states, “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”. (Trauma Matters, 2013: 6)

The guide has a section that looks at cultural competency and anti-oppression training. There are many guidelines including ways of working in which a service provider never makes an assumption about a person’s culture.

It further states, “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” (Ibid: 41).

The resource goes on to explain the necessity of anti-oppression training in this regard. It is important to recognise that any form of authority can reflect and/or trigger experiences of oppression which can amplify the impact of trauma. A similar type of training was delivered to all the staff of the West Central Women’s Resource Centre in Winnipeg. They saw anti-oppression training as foundational for women working in cross-cultural settings from a range of backgrounds.

**A word on the term Cultural Competency**

The WHRAS group, who I heard present, see case study in previous section, took issue with cultural competency. They said it can stereotype Aboriginal people. It can be a tick-the-box exercise that does not change the way service providers and systems interact with Aboriginal people. In fact, it can do the reverse of what it is intended to do and homogenise other people by creating a ‘them’ and ‘us’ binary and a power dynamic between the trained and those being studied or engaged with.

The WHARS group emphasised, just as in trauma-informed practice, that context is key! When a service provider takes the time to listen and learn they will treat those with whom they are engaging with equal respect and dignity. WHARS were unanimous, this is basic human being engagement competency.
Implementing Models from the Ground Up

All the trauma-informed resources focus on implementation within the service system. For the Practice Guide this is directed at the Canadian health system, which is a western model of governance and service delivery. For the Jean Tweed Centre, it is for women’s substance use services. Their target audience is service deliverers and how they can take on the practice. The resources look primarily at the service provider and client relationship.

There are few detailed or comprehensive resources which look at implementing a trauma-informed practice in community groups or for Indigenous organisations and settings. Healing from trauma for Indigenous people can be a very different process of recovery which may or may not involve a clinical treatment approach. (Chino et al, 2011)

As explored in the previous section healing approaches can be interrelated with feelings of empowerment, ownership and control. Putting the knowledge of trauma and healing options into Indigenous hands immediately, may be the first and most vital step in implementing a successful trauma informed model in Indigenous community organisations and across the service sector.

However, organisations and services still need to understand the importance and necessity of healing and how this can transform a community’s service system needs and interactions. Services need to be open to restructuring service systems to ensure the necessary wrap-around supports to Indigenous trauma and healing approaches, and vis versa.

Empowering a community to determine what trauma is for them, how to heal from it, and achieve good health and wellbeing as a first approach, could change the very fabric of clinical treatment plans and referral pathways, and what becoming trauma informed means for organisations.

This approach would involve the service system listening and learning from community and responding with openness, dialogue and actions to change as expressed by the community.

The diagram below shows how the different areas of trauma practice and healing and recovery approaches interact and influence one another. It shows how having an Indigenous healing and recovery approach to trauma can change and shift the evidence base and best practice approaches, which in turn influences trauma-informed practice model and philosophy an organisation comes to understand and embed.
Developing a shared knowledge platform across employees, service engagers, stakeholders and community members

- Utilising current evidence-based
- Utilising current best practice

Contributes and changes evidence-base and practices.
Grows a local evidence base of specific healing practices around health and wellbeing that considers, adapts and localises non-Indigenous approaches to trauma and recovery.
blends Indigenous and western approaches to addressing trauma and recovery.
contribute to national and international knowledge of best-practice healing, trauma informed and recovery approaches.

Trauma informed practice model
- philosophy
- values, principles, practices, skills and guidelines
- Systems change

Trauma specific care
- approaches and programs
- counselling
- cognitive behavioral therapy

Recovery and treatment plans
- peer support groups
- self-care
- rehabilitation
- residential care programs
- yarning circles

Indigenous Healing Practices
A holistic Societal framework of health and wellbeing
At this point in time

As an approach for community groups, organisations and other services trauma-informed practice models are the most well-known set of working approaches for responding to trauma and are a dramatic departure from the traditional clinical approach of diagnosis and individual treatment plans (Ford et al, 2008).

As an evidence-informed model it has come the closest to reflecting aspects of Indigenous societal principles of collective care and support. There are also many Indigenous healing models looking at breaking the transmission of trauma that incorporate trauma informed practice in a holistic frame, as was explored in the previous sections. Also, trauma informed models seriously appreciate the generational form of this work, in realising that the issues being dealt with in the present are part of an interconnected cycle of intergenerational trauma, and that no one person, or ‘client’ as often defined by these models, is isolated from context. In this sense, it has elements of a holistic model of recovery, health and wellbeing. The working practices popularised through these models are grounded on strength-based, empowerment and resiliency forms of communicating and engaging. These are practices which reflect a hopeful and optimistic belief in everyone’s potential to change, as the evidence clearly presents in the previous section. Trauma-informed principles can also facilitate better cross-cultural and community engagement practices. (Marshall et al, 2003)

Organisations and services which implement a trauma-informed model are more open to systems change in response to individual and community needs, ideas, principles and practices (Johnson et al, 2008; Bateman et al 2014). Therefore, implementing a trauma informed model could open organisations to embracing Indigenous healing practices and supporting a resurgence in Indigenous health and wellbeing.

THINK: For service providers and organisational leaders its worth considering when a model and approach is implemented who should control and have ownership over the model. Is it your staff, or the community members who engage with your services? If you respond to community principles first how can you make sure your organisation and services are ready to respond to what community need and want from the organisations working practices?
Applying Practices

As explored throughout the last section models and approaches work best when they are embraced by the organisation’s leadership and structure, and are guided by a philosophical and principled framework.

The working practices explored in this section are ways to,

1) Implement models and approaches
2) Actively do trauma informed and responsive work

Like the evidence section, many of the practices and suggestions explored here are trauma and empowerment work 101. What I learnt is that the 101 practices are the foundations for getting started. They start to create a cohesive working culture and community beyond the siloes. They are practices that enable staffing teams to feel united by a shared philosophy and evidence base, and committed to achieving common outcomes. (Bloom, 2006; Bloom and Farragher, 2013; Fallot and Harris, 2009)

Getting trauma and empowerment practices 101 right creates the fertile ground necessary to respond effectively to trauma and to consider innovative ways of stopping the intergenerational transmission. The work we do today can change people’s futures for the better. As I was told by the Klinic staff, this is an incredibly powerful thought. Trauma informed and responsive work is a very powerful reality.

A Note on this section:

Many of these working practices can be a significant departure from how people have been trained to work professionally. It takes time to learn new ways of communicating and being in empathic and compassionate relationships with colleagues, community and people engaging in services. As evidence is starting to show compassion and empathy must move beyond the rhetoric toward creating an environment and context that fosters these relationships (Cole-King et al, 2011; Spandler and Stickley, 2011).

With everyone I met who had put a trauma-informed practice into operation they said, “do not panic or get frustrated when things do not work, or it is difficult to bring everyone along at the same time.” These practices take time to learn and they can be challenging.

Bruce Perry (2017) explained that adults in the work place are some of the hardest people to change. Once we start work our brains feel locked into neural pathways that tell us to work in a set and structured way. Anne Starr the CEO of Orchard Place, said, “our brains like sameness and routine...we need to change, we need to learn to be flexible...our brains are not good at it”.

When we put these practices into effect and continually repeat them our brains can change. This means that we all can work and live differently. Our relationships can change; in the workplace with colleagues, between service providers and service users, within community life, within families and within our societies. What is most exciting is that as our brains change our organisations and services become open to innovations. Embracing this work improves everyone’s lives and has the potential to change our systems.
THINK: Most of these working practices have been explored and researched in a western context. Indigenous healing and health and wellbeing approaches are predominantly seen as a program rather than a model of best practice approaches to work. This can have the effect of treating Indigenous practices as an adjunct to model design and implementation, serving to re-entrench feelings of marginalisation and disempowerment.

If you work in the community development sector, with Indigenous people or in a cross-cultural settings, think about how the working practices presented could be adapted or done differently to fit the context you work in.

Ask yourself and colleagues the following questions:
How can community have ownership and control of these practices?
How can my working practices change in response to what works for community?
How can I address power dynamics as I help to design and implement new working practices?
Evidence, Theory, Practice and Action

I was shown several resources that can help organisations and individuals put these practices into action. They are designed to be trauma-informed activities so colleagues support and encourage one another to keep practicing them, so eventually they become second place in the workplace.

All the centres explained to me that when becoming a trauma-informed organisation, or trauma-informed individual, it starts with having positive and supportive engagements with the people we work and interact with.

Relationships are the foundations

As human beings, we are hard-wired for relationships. From the intimate to the community and the nation, all our structures are built on relationships. Our relations matter. From the moment we are born they give us resilience and strength for life (Balbernie, 2010). So, wherever there is the capacity for relationships, which is everywhere, we should be investing a lot in ensuring they are good ones. The better our relationships, the better our lives, our structures and institutions at every level.

Bruce Perry said, “we have got to stop talking about economic poverty, and start talking about relational poverty.” When we do not have community and support structures reaching beyond the nuclear family, our sense of self is diminished.

The Gatehouse is an organisation working with adult survivors of childhood sexual abuse. They are nestled in leafy park on the edge of a busy street, near Toronto’s lakeshore. I met with the Executive director of the Gatehouse, Arthur Lockhart.

Feeling comfortable in the space

On arrival, he offered me a hug, which I accepted. He asked me if there was anything I wanted to drink. They brought me a coffee straight away. We then sat on a comfy couch in the front room that looked like a living room. I was asked how I felt, how I was enjoying Canada and whether I was breathing ok. By the time we focused on my breath I realised how measured it was, how relaxed and calm I was, and how ready I was to engage. I was told that this was being done with purpose and I was being engaged with real intention.

Arthur explained to me that when people are healing from trauma we have to engage them in safe and nurturing relationships. People need to remember that positive and enriching connections exist in society. Beyond those who are recovering, he explained that this is important for all of us. Creating healthy relationships prevents trauma from happening in the first instance.

When we engage, we must be purposeful in how we do it. Arthur said, we must be purposeful in our communication, which includes verbal and body language.

He cautioned, “intention can’t be faked.” If we fake intention the person we are engaging with can tell (on all sorts of complex neurobiological levels, and the release of stress hormones) and you can’t form positive relationships. In fact, faking a connection can further damage a person’s trust in believing that forming positive relationships are possible.

More information on the gatehouse can be found here, http://thegatehouse.org/

In the Gatehouse and many other organisations, often dealing with high levels of trauma they had brought trauma-informed approaches down to the simplest elements of life. As Arthur explained, if we applied these techniques and forming positive relationships, across society, maybe we would
never have to deal with the consequences of trauma that are witnessed in these recovery environments.

Similarly, at Homewood Health the managing director of the PTSD clinic said,

“What I am doing with you [when we engage] is what we do here. IT IS BASIC. I want to develop a relationship with you because I care. I am being inquisitive and inquiring because I am interested in you and your connections. That is how people recover from trauma, they realise others care and they have hope. When you have hope you continue to live”.

THINK: A simple way service providers can strengthen community is to release stress in people’s lives. Remember the evidence on poverty, people living in difficult circumstances can feel constantly stressed which detracts from community life. By enabling people to navigate situations like paying bills or filling out a form, or being paid on time, helps to free up their mental capacity. In other words, instead of being fixated on a problem or issue, people have more time to focus and connect with family and community. Not being able to access money to pay a bill or get food for the family for a week, can build up toxic stress, leading to people needing an immediate release from these overwhelming feelings. This is often when people start drinking or taking drugs. If we find ways to release that stress in our work, we are indirectly supporting the growth of healthy relationships and resilient communities.

Creating a supportive and relationship building work environment lays the foundations to build positive and empowering relationships with everyone we interact with. This is a step toward resilient and healthy communities.

**Start broad and consider where to begin, together**

Once we feel confident in our relationships, supports and the culture of our working environment we can consider more in-depth practices (Fallot and Harris, 2009). This part explores steps an organisation can take to begin implementation of the trauma informed models and approaches introduced in the last section. Many different principles were presented in the last section, from good Indigenous community development principles, to the 10 core principles of trauma-informed practice, and the principles of organisational culture which emerged at Orchard Place as they embedded the Sanctuary Model.

For established organisations, it is a good idea to start broad, and review sets of principles which relate to your organisational ethos and vision. Consider;

- How principles of trauma inform practice fit with the organisation and its existing values and purpose?
- What principles are already embedded in the organisation’s work, and what the organisation is doing to be trauma informed and responsive?
- Where there are gaps and what can be done to begin a process of change or strength-building of trauma-informed skill sets and practices?
To get the ball rolling principles and practices can start to be considered by a group that is established and meets regularly. As Nancy Poole suggested this could be the organisation’s management team.

**Playing games to translate principles into practice**

Nancy Poole gave me a two-page document. One side is four squares of trauma-informed principles and their definitions, and the other side is “trauma-informed principles In Action’ which correspond with the definition squares. These squares can be cut out and used as trauma informed principles and action cards.

Here is an example of one of the cards. I have adapted it to include similar trauma-informed approaches highlighted from other organisations and have changed some of the language to ground it in a community approach.

**Side 1: Principles**

**Choice, Collaboration and Connection**

Trauma informed services encourage opportunities for working collaboratively with people of all ages, genders and cultures. This experience of choice, collaboration and connection often involves inviting community involvement in evaluating the services. It also means that community and all employees understand the what, why and when of a service operations, decisions, program delivery etc. Involvement could involve feedback boxes, or visual feedback surveys for community engaging with the organisation. It could also mean creating a community advisory council who provide advice on program design and the rights, grievances and complaints of community members involved and engaged in the organisation and its services.
Nancy explained that you can use the double-sided squares as a game with colleagues and managers across an organisation. When she worked with organisations becoming trauma informed, she encouraged them to start each manager’s meeting with one of the cards. Together, managers can review the definition of the principle and then consider how to put them into action. Then the card is flipped over and the group can see if their ideas answer the questions on the practice side of the card.

**Constructive criticism**

Where there are gaps or the group has answered differently to what the questions asked, it is important to have a critical discussion about what is missing in current working practices and why. This way a team of managers can see where the organisation is trauma informed and where it is not, and how to improve and move forward, along with appreciating achievements and how to grow from a foundation of strength.

I was told numerous times that an essential aspect of working with people who have sustained trauma is to be critical of your own working approach. This doesn’t mean self-abuse or self-deprecation, or blame and judgement of other people’s approaches. This means open to honest feedback from the participants of programs and from colleagues. It means both enthusiasm for learning and not being afraid to change the way we work.
It is very important to have a critical approach when considering how trauma-informed principles and practices are being put into effect. Believing that everyone’s work and your own is trauma informed when the staffing team has not been through a shared learning and implementation approach, can lead to a false understanding of trauma-informed practice and ineffective or half-hearted implementation. Many of the organisations I visited explained this challenge and there are trauma informed practice guides that describe the difficulty of getting everyone onto the same page at the same time (Thrive, 2010:4-5).

**Moving forward**

1) Together, the group can agree to look at one trauma-informed skill it identifies as being important in the organisation and work on embedding it across the entire organisation.
2) Alternatively, the group can work together to develop a new trauma-informed approach by filling in the gaps identified in the organisation’s working practices.

There are many other things that can be added to these cards. Additionally, employees could be asked to research what choice, collaboration and connection looks like in a trauma informed service and bring back examples to the next meeting.

**Embodying Principles in Our Working Practices**

The Klinic highlights ways a service provider gives choice and control to their clients when they are working together. I have highlighted a few that could work within a community organisation setting,

- Allow those you are engaging with to **set the pace, slow down and take breaks** as required.
- Learn about who the person is and **develop the appropriate skills** to work with them. Ask about their culture, and understand how your own cultural background can influence interactions with the person
- Become **involved in the cultural community** that is being served
- Work through historical distrust – issues may exist from the past that disrupt current work. Understanding that this is **normal and not personal** will help to build a strong relationship.
- Teach **western ways as another skill set** not to change or influence someone’s identity and way of life (Brokenleg, 2008, as cited in the Klinic Toolkit).

(klinic, 2013: 20-21)

**How can we be open to change?**

Being open to honesty means we must invite it. This enables us to put into practice essential elements of trauma informed principles.

The Klinic highlights that one of these elements, which can lead to constructive criticism and change is the working approach of – Doing with and not doing to.

**When we work with people, we have to work with them.**
If our decisions are made in isolation, we are probably doing the wrong thing, and unintentionally making someone feel uncomfortable, reluctant to share ideas with us, and ultimately unsafe. This runs the risk of entrenching trauma, and without us realising it we can easily construct a power dynamic which disempowers the person we are attempting to build a relationship with.

Tip: Always address the possible power dynamic. Realise that you may present yourself as the expert because of the position you hold as the employed service provider. In a community organisation working with colleagues in a cross-cultural environment service providers from the mainstream cultural background should be aware of their perceived dominance and power over other colleagues from minority backgrounds. It is important to acknowledge the existence of the power dynamic and find ways to equalise power so you are working with and not doing to people or colleagues.

If you hold the perceived dominant position start conversations and work planning by asking your colleague or community members engaging with the service, where they want to begin? Do not tell people what you want to do, and then expect them to do it. Instead, inquire about their ideas, thoughts and feelings and work from where they are at.

Only talk about people when they are there

The Wraparound Northumberland team have a policy: never talk about the person you are supporting when they are not there. Talking about people when they are not there can lead to several incorrect and misguided assumptions:

- That you (as the service provider) have the authority and expertise to make better decisions than the person about their life and their work.
- The person you are engaging with does not understand at this stage what is best for them and needs to be taught
- You decide on what the issue is and why someone is not engaging or doing their work without their consideration

Taking this approach, of making decisions about someone instead of engaging with them, at whatever stage of work means that the service provider is not working with but doing to.

THINK: how often decisions are made at your workplace without the involvement of the people concerned. When you bring someone into the discussion at every point they can contribute and change the nature of the discussion, improve the work you are doing, and develop solutions and outcomes that are effective. This is inclusive and it is smart. Doing work with, in every part of your working practice, makes work better.

A key skill of working with, is never to assume that the service provider’s solution is the right one. When a team of workers are considering an idea, make sure to talk to the person who the idea concerns. See how they respond to it and what they think. They might have a very different reaction than what service providers originally expected. As we explore in the next section this is a form of
‘Collaborative Problem Solving’, it helps to regulate us and change the way our brain works. When we engage and collaborate we learn together. When we think and act in isolation as an individual or a team, we inhibit the learning process for everyone concerned.

Ultimately working with people means we share responsibility and although it might be challenging at first, we come up with better ideas and solutions that suit everyone.

**Meet the person where they are at**

The West Central Women’s Resource Centre, the Mothering Project, Herway, and Sheway all have working principles *of meeting women where they are at.*

When you work with people where they are at you approach your work with non-judgement, understanding and no expectation about what someone should be doing or what they are wanting to achieve.

Having no expectation about where someone is at does not mean we should not raise expectations. Raising expectations about what someone can do and achieve is important to help people realise that everyone is capable of change. It was explained to me that it is good to set goals and raise expectations around what people can achieve. Never presume or make the judgement that due to past behaviours and actions people cannot change.

People can change, sometimes it just takes time, or being exposed to a whole different skill set. A trauma informed working practice enables organisations and service providers to meet people where they are at and facilitate a positive change processes. To achieve this a service provider should always work,

- With no judgement toward service users/community members about past or current behaviours
- Believing in aspirations and raising expectations about what can be achieved
- Exposing people to new skills and challenging the service user to try again and again
- Believing every action is a lesson learnt and can be built on
- Acknowledging that it takes time for change to happen while still focusing on driving change
- Showing passion and commitment in all interactions that change is possible

**Embedding Self-Reflection**

Organisations I visited talked about the importance of investing in staff development, education and an ability to self-reflect and self-care. Many organisations had high levels of staffing supervision. This ensured that self-reflection requirements were met and were appraised in a positive way within supervision meetings.

Self-reflection helps us all to keep on track and keep ourselves and other employees accountable to each other’s work practices and how we engage with service users and the community. It helps us build positively on putting the principles of trauma informed practice into effective action. Most importantly it keeps us feeling good, stable, secure and cared for.
As one organisation I visited explained, one person can’t do everything, it is not physically or mentally possible. We need to learn to support colleagues and respect the skills and expertise that each one of us has. Again, this responds to the trauma-informed principle of equalizing power and improving our capacity for critical and constructive self-reflection.

TIP: Do not come into a service or working relationship with an ‘I know best attitude’, because of experience and clinical expertise. Always check your ideas with the people you work with, and the community engaging with your service. Ensure you take their feedback on board and respond to concerns and constructive criticism. Be willing to change your work practice and ideas if necessary. Search out support in colleagues who have a skill set you may be lacking. If a staff member asks you for support respond to them constructively without judgement. When we work like this we are developing constructive relationships grounded in self-reflection.

The Jean Tweed Centre encourages organisations to embed self-reflective practices in staff working approaches and appraisals.

Some questions for staff to consider in self-reflection, particularly when working with women:

- Are you attentive to signs of a person’s discomfort or unease with work approaches? If so, are you able to respond positively and change what makes them feel uncomfortable?
- Have you had discussions among staff about ways your program can maximize honesty and transparency?
- To what extent are community member’s priorities given weight in terms of what the services to community are and the goals to be achieved?
- Does your service give the message that community have to ‘prove’ themselves in order to ‘earn’ other services or supports? If so how can you change this?
- Do community members have a significant role in planning and evaluating your program’s services?
- How do you ensure that feedback from community members is acted upon and how do you communicate this to them?
- Are community members and colleagues involved as frequently as feasible in program and project planning meetings?
- Does your program communicate the conviction that community members are the ultimate expert on her own experience?
- How can your services be changed to ensure that experiences of empowerment and the development or enhancement of skills in those engaging with your services are maximized?
- In each contact with your service, how can community members feel validated and affirmed?
- Do those who engage with your services/community members on staff/ community members who have experienced trauma have a significant voice in the planning and evaluation of services?
- Do you provide opportunities for regular input and feedback about service provision via suggestion boxes, surveys, evaluations etc.

These questions have been sourced and adapted from examples provided across the ‘Trauma Matter’s’ guide (2013). The questions begin on page 27.
Developing Core Competencies and Skills

Once an organisation has looked at the high-level approaches it is good to be able to focus in on the specific skills, as stated below, and begin offering trainings to staff to ensure that everyone understands the basics. Further, it is important that colleagues encourage each other to put the basic trauma responses into action daily.

The Klinic Community Health Centre state that a trauma-informed service provider, system and organization:

- Realizes the widespread impact of trauma and understands the potential paths for healing;
- Recognizes the signs and symptoms of trauma in staff, clients, patients, residents and others involved in the system; and
- Responds by fully integrating knowledge about trauma into policies, procedures, practices and settings.

(Klinic, 2013: 16)

An example of the ideal levels of skills required by staff, which I have paraphrased from the Klinic’s Toolkit, are,

- **Empathy** – service providers use non-judgemental, non-confrontational language and communication to communicate to clients and staff that they are seeking to understand what they are experiencing and feeling
- **Able to talk openly** – service providers must be capable of talking about feelings, issues and experiences to trauma without judgement. Service providers shouldn’t feel uncomfortable or unable to say certain words relating to trauma
- **Willingness to learn from clients** – important not to replicate the power dynamic that can be displayed through service provision superiority with knowledge. Service provider is not the expert of clients’ lives; they are the experts and you must be willing to learn from them. Letting them teach us about their world is the best way to become knowledgeable.

(ibid: 99)

The Jean Tweed Centre states that within a trauma-informed model of operation the minimum standard of skills required by all staff are,

- Basic knowledge of how to react to trauma responses, including grounding and safety techniques.

(Trauma Matters, 2013: 76)
I was impressed by the deep and meaningful range of trauma-informed skills that existed across the organisations I visited. It was clear that trauma-informed and empowerment based organisations had invested in trainings to upskill staff and to put new learnings and knowledge into practice.

TIP: when you have identified gaps in your trauma informed practice consider what trainings are required to upskill staff across the organisation. A first step could be developing a trauma informed practice training schedule to expose staff to the same sets of knowledge and practices. Staff that are trained at the same time are on a learning journey together and can support each other to practice and embed new skills. Orchard Place trained a core team of 35 staff members in a five-day intensive training of the sanctuary model. They became the messengers and champions of the Sanctuary Model as all staff went through less intensive sets of training. If you choose to do this the organisation must be prepared to respond to the learnings of the group who receive the core training.

At the Assante Centre in Vancouver Alyson Pooley, the Executive Director, explained to me some of the challenges about trauma informed training. She said that there has to be a commitment to implementing the practices learnt from training. Too often organisations invest in training and stop there and do not significantly change. She said this often puts us in a state of trauma awareness, where we accept that trauma is happening but we don’t do anything about it. She said, having an implementation plan means that we need to move from awareness to action. Our organisations have to accept needing to change to do something significant about trauma.
Putting Core Competencies into Action

At the Klinic, I was fortunate enough to attend one of their half-day trainings. They offer a range of trainings from an introduction to the basics in trauma-informed approaches for service providers, which I attended, to a 2 day “Becoming Trauma informed: Mind/Body approaches to creating connection”. Their more dynamic in-depth training, as was explained to me, is around building on trauma-informed practice and looking at recovery. The intention is to challenge working practices and consider a paradigm shift in how we understand recovery and healing processes.

Again, they state, that the trauma informed trainings, “differs from a more traditional hierarchical/expert approach to one of curiosity, partnership and empowerment (Klinic, 2017)”

In a meeting with the Klinic’s trauma-informed education centre team, they discussed with me that teaching people about the principles of trauma informed practice is one thing, the other is, “helping people to understand from a broader perspective that we all have a role to play in this.”

Mary Jo Bolton and Cheryl Mathews explained that when you have the basic skills to attend to the trauma “you have an opportunity to stop it from moving forward into other generations. That is a powerful thing to think about. [trauma] is preventative. It is not just addressing the issue at the time”.

This is the Klinic’s teachings on how to address trauma responses, triggers, and de-triggering. All these terms are defined in the evidence section. They believe these lessons can change our actions in society to lead to better and positive outcomes for everyone.

Core Skill – recognising triggering and de-triggering

This information should be helpful for EVERYONE, whether you work directly with trauma or not, it is our day to day relations and interactions that keep society calm and safe. As we were told in the workshop, no one is immune from the impact of trauma.

Below is the lesson we were taught.

The Situation

- We encounter someone who is visibly stressed. They’re angry, afraid, anxious, aggressive, crying. They are showing many emotional signs of discomfort.
- This person could be a friend, colleague, family member, partner, client, they could be someone that has walked into your life as a stranger. This person could be anyone at any moment.
- It seems that you can’t reason with them. In your attempt to calm them down, telling them to stop it, telling them you’ll get someone if they don’t stop, in other words, you’ll intervene with authority, only makes them worse.
- The more they are told to calm down the more they retreat into themselves, shut down, or shout louder.

The Reaction

- This person for whatever reason has been triggered.
- It could have been something you said, something they felt, saw or sensed that has reminded them of a traumatic experience. This doesn’t happen consciously for the person; it
just suddenly happens. Sometimes a person can feel emotions building but the overwhelming moment when they are suddenly unleashed is difficult to predict.

- Something has triggered that person and their emotions have been released.
- What you see as anger and aggression, is most likely that person feeling sad, lost, alone, afraid and scared
- This person probably has no understanding of what it was that triggered them because they are not connected to the rational thinking part of their brain.

**What’s happening**

- As Gabor Mate has written, an internal process is happening because of an external event. [http://www.alternet.org/drugs/gabor-mate-ayahuasca-maps-conference-2013](http://www.alternet.org/drugs/gabor-mate-ayahuasca-maps-conference-2013)
- That person has engaged their limbic system within their brain (it drives our emotions and is connected to many nerves) to save and protect them.
- They are acting as if they have been threatened and are in danger.
- To use their energy effectively their brain and body is only working on instinct and emotion – flight, fright and freeze.
- Blood is going straight to their thighs in case they need to run. Their digestive system is shut down. They are on high alert and are only ready to react.
- Their prefrontal cortex has been disengaged which means they can no longer rationalise what is happening.
- These are helpful evolutionary mechanisms when you have to save yourself in a life-threatening event. It is not helpful when you have been triggered in an everyday setting.

**What to do?**

- You need to bring the person’s prefrontal cortex back into action.
- They need to be able to think again and respond to you effectively.
- It doesn’t help if you ask them rational questions or give them rational solutions. Such as, why are you so angry? Nothing bad is happening here so calm down. Or, I didn’t say what I think I’ve said, you miss heard me. Stop crying nothing is wrong.
- Distraction is the best way to re-engage. Engage with their emotional brain by indicating senses.
- Ask, do you need a tissue? Here is a cup of tea... mention the sound of something nearby, the temperature or the weather. Offer a hug or a touch of the hand, but don’t give it if it is refused.
- **Suggest watching something funny** – a YouTube clip
- Some of these distractions are elements of grounding techniques (explored later on)
- Talk to them about how you understand how tough things are.
- Relate to them kindly, say a gentle word or an affectionate term. Always keep it emotionally related, not rationalising the situation.
- That person will start to calm down. They will bring their prefrontal cortex back online and they will be able to think again.
How to remember this?

Dr Dan Siegel teaches about using your hand as a fist. When someone is triggered the fist flips open and your rational brain goes offline.

He calls this flipping your lid.

“Flipping One’s Lid”

The big emotions, anger, fear, anxiety etc.

Prefrontal cortex
P.F.C.
“THE WISE LEADER”

“Flipped Your Lid”

“TIP: When you know it, this ‘handy’ hint, makes ‘sense’! That’s another hint, always engage the senses that will help to re-engage the thinking brain.”

Copyright, Sharon Selby, 2015

Find it out online with some other very useful resources for keeping yourself and others calm. http://www.drdansiegel.com/resources/everyday_mindsight_tools/

Once we were taken through this exercise I could see so many people in this situation, myself included. When any of us get mad or angry to one degree or another we are being triggered and this is what is happening to our brains. When we know these skills, we are better able to work with each other to never make someone feel stupid, judged or blamed for their reaction, but to work with them and their brains to re-engage.
Another Core Skill - Ensuring Safety

Safety is often considered in terms of someone doing harm to another. In traditional practices, service providers will consider safety and the need for safety planning in times of crisis or when the immediate need arises to escape violence. This remains important when doing crisis response work. Still, safety, whether you are doing crisis response work or not, should be considered as an everyday experience and state of being in relationship with others and the context you are in.

Trauma-Informed Safety Planning

Safety planning is when everyone, staff and community members, learn for themselves, and in support of each other to:

- recognise triggers, and associated behaviours
- harmful or negative coping strategies and mechanisms
- identifying strengths to develop into positive coping strategies and mechanisms

The ideas presented below give ideas and guidance to how to engage in this form of safety planning.

What do we mean by safety?

In trauma-informed practice safety is considered as the state of an individual’s mind and body and the collective experiences of people in tense, stressful and anxiety inducing situations (Bloom, 2010). When people have experienced and/or continue to experience trauma their sense of safety can be continually threatened. Safety in this sense is physical, emotional, spiritual, cultural, societal and intellectual. These elements make up our holistic self in relationship with a holistic world. In other words, safety is an integration of every aspect of life.

Much of what safety is has already been explored. An unsafe environment are the things that traumatise us and continue to trigger us into a trauma response. For instance, for those who have experienced policies of colonisation such as Residential Schools in Canada, and the Stolen Generations in Australia, a person in a position of authority, say the manager in the workplace can create an unsafe intellectual environment. This can happen if the managers tone of voice and body language is authoritarian and confrontational causing a person to feel inadequate, inferior or stupid, all of which can trigger a trauma response.

When a person’s sense of self in this holistic frame is threatened, they can be triggered, as explored above. It is important when working with people who have and do experience trauma that we actively reduce triggers by addressing all elements of safety in this holistic framework.

Signs of Safety

Creating this holistic experience of safety can begin with signs of safety in the physical environment of a workplace.

We can do things to contribute to more relaxing environments that make people feel immediately at ease. As I was taught at the Klinic these are signs of safety, inclusiveness, anti-discrimination, soothing colours, relaxing sounds – the running of water or the twinkling of wind chimes – candle light, and calming or exciting music to help with the release of emotion and creating feelings of energy and positivity.
The Klinic building displays many flags to show that people of all nationalities, gender and sexuality are welcome here. It does not discriminate.

The Klinic healing and conversation room displays many pictures and colours to ensure that all first nations people are at home in the space.

Reminding mothers that breastfeeding in public is welcome, but if they want a private space they can ask for it too. All these visual cues are very important in keeping people in a relaxed mind and body.
Helping People Process, Respond and Work Through Their Own Triggers

It should be a priority to always create safe and comforting environments. However, it is impossible to remove all triggers. Organisations can ensure a safe environment in all the ways explained particularly when acknowledging the needs to confront discrimination, oppression and social injustice. However, individuals all experience trauma differently and have many different triggers, which are not easily recognised by a collective sense of what safety is.

As Gabor Mate explained to me, we cannot remove every trigger. People need to learn to recognise, manage and overcome triggers by appreciating the trauma that has caused them in the first instance. For Gabor if you are triggered then you have experienced a trauma and at some point you will need to learn to deal with it. For him it does little good to remove triggers, because when they occur, which inevitably they will, a person will blame whatever has triggered them rather than acknowledging what has happened to them.

This takes us to a key point of creating safety in a work environment. Becoming trauma informed stops service providers asking the question of what is, 

Wrong with you?

To asking the question, 

What has happened to you?

This means that it is the responsibility of service providers to help people acknowledge that they are not the problem that for instance, they are not an addict, but something has happened to them which has created potentially harmful behaviours and coping mechanisms in the present.

It is the responsibility of service providers to recognise their own triggers. Recognising triggers helps to learn skills which keep us calm and able to carry on. Recognising triggers, and learning how to de-trigger and/or preventing triggers happening in the first place makes us more effective at our work

ADVICE: This acknowledgement does not mean service providers should dig into someone’s trauma history or encourage disclosure. As a trauma-informed service no one needs to tell anyone the traumas they have experienced. All you should do is acknowledge that trauma has occurred and make no assumptions about an individual’s behaviour. It is up to an individual to consider their own trauma and explore trauma-specific approaches for recovery and healing. Choice here is key. It is also a responsibility of service providers to recognise that if someone is in need of trauma-specific skills that the person should be referred to the appropriate service, but only if the service user agrees to this.
and at engaging in positive and healthy relationships with others, at work, at home, with our families and communities.

There are many things that can be done in a trauma informed workplace to help people create safety for themselves. Community members and those engaging with services can learn to recognise feelings and emotions which indicate that they are not safe, such as,

- Getting angry
- Becoming anxious
- Reckless behaviour
- Not sleeping
- Consuming harmful quantities of alcohol and other substances

An organisation can work with people to consider how to reduce these feelings and emotions, or coping mechanisms by identifying a person’s strengths. The idea is to build on these strengths so a person can utilise positive practices when they need to release emotions, de-trigger and calm down and relax. These strengths vary for everyone, but they often include,

- Supportive family members and friends
- Exercise – walking, running, swimming
- Connecting to nature – going fishing, camping, swimming in the river
- Being spiritual – going to a place of worship, having a smoking, making a fire, chanting or praying, burning incense etc.

Many of these strengths are what organisations learn when implementing trauma informed practices. For staff to learn stress reducing techniques and practices of self-care is good for the work environment:

- reducing the possibility of vicarious trauma,
- boosting staff morale,
- improving work effectiveness,
- and most importantly enabling staff to support and help those engaging with the services without risk of burnout.
Nurturing Practices

Safety includes having knowledge of grounding techniques. When people identify what grounding techniques work for them they can be utilised for self-soothing and nurturing practices whenever difficult situations are encountered. It is important to encourage everyone in a trauma informed workspace to take the time to care for and look after themselves and encourage and support others to do the same.

THINK: It is important to recognise that self-nurturing needs to be accessible to everyone. It is likely for those who live in stressful situations and have and continue to have experiences of trauma that they may never have experienced nurture. A trauma-informed organisation should enable equal access to nurturing experiences, teach what self-nurture is, and allow for time-out to engage in self-nurturing and self-soothing practices.

Remember, as our organisations consider what self-nurturing is and how to develop it that our brains are relational and we learn from our interactions with others. If a person has never experienced love or care it is very difficult for that person to understand what it is (Perry, 2017). They must be shown and have feelings of love and care from others. The best way of enabling this learning to take effect is to connect people into supportive and safe community networks.

TIP: Tell someone that you care for them. Connect them to a supportive network of people. Show them love and then work with them for them to believe that they can love themselves. In essence, this is the role of a trauma-informed organisation.

Recognising your own body and feelings

The ‘Trauma Matters’ guide, states how service providers can help people recognise the feelings and sensations of their body and mind that are indicating they have been triggered and your stress level is rising. This includes: a tight chest, nervous feeling in your stomach, sweating or feeling hot, heart racing, your mind fixates on the same thoughts and will not shut down.

It is important to work with people to understand what triggers them in activating these stress responses. They may know that being spoken to in a particular way will cause a high anxiety reaction. As people get good at recognising their triggers they can ground themselves before it happens or explain to others that particular situations will trigger them and they should be avoided. However, if a situation cannot be avoided colleagues, community and family members can work with the person to ground them, keep them relaxed and get through the situation as calmly as possible.

There are many grounding strategies that we can all use in our lives and working practices, and when engaging with people we work with who are wanting our advice, or accessing our services.

Groundings are like how mindfulness and breathing techniques help to release the brain and body from stress, enable good communication between different parts of the brain, and bring the mind and body to focus on the present.
There is extensive writing on how mindfulness can change the brain. Through committing to mindfulness techniques, the brain can grow, develop new neural pathways, and keep calm while better able to deal with complexity. (Treadway et al, 2010)

Groundings are a way of helping people bring the same practices of mindfulness into the things they like doing in their own lives. To keep calm, we do not have to sit and meditate, we just have to find a practice that suits us, and within the context we live. However, a dedicated mindful process that goes beyond moments of grounding could change the mind.

**Groundings**

- Walk around a garden, smell a flower and touch its petals
- Put your hands under running water
- Go fishing and bird watching
- Draw or paint pictures or just cover a page in colours and lines
- Sit in a chair with hands holding the sides, feet planted firmly on the floor, close your eyes and name all the sounds you can hear
- Read a poem
- Get a soft object and squeeze and release a number of times
- Make a cup of tea, pay attention to boiling the kettle, pouring the water and gently sipping as it cools down
- Bathe your feet in warm water

The Calm website has many strategies to recognise triggering and work out what grounding techniques work for you,

http://calminthestormapp.com/customize

The British Columbia Trauma Informed Practice Guide has a very comprehensive list of self-care and grounding techniques.

---

**TIP:** In your organisation, do something creative with grounding. Have a collective grounding at the beginning of a work week involving all staff. Ground before a stressful meeting. To develop the normalisation of grounding practice do it in regular meeting environments such as the managers meeting

When an organisation has normalised grounding tactics they use them whenever they recognise a trauma response inducing situation. Staff members might see a colleague in a state of anxiety and work with them to ground them such as suggesting a cup of tea, a walk around the block, watching a funny you tube clip to help their colleague or a group continue with the day positively.

Once you learn these techniques try not to force work when someone is clearly anxious. This can result in someone being triggered and a conflict situation that escalate for no reason, leaving everyone feeling deflated and ineffective.
Empowerment
Expressing care, nurture and an ability to self-sooth in a positive way can be incredibly empowering. It helps a person to take control of their bodies and minds, without a crisis intervention from someone else, which is disempowering.

When service providers ask, what has happened to you? A process of work begins where the skills explored above are given to the person engaging with the services. When a person is free to articulate what has happened to them and what they are experiencing they begin to shed self-blame and shame around the behaviours they have developed to cope.

As the staff at the Klinic expressed to me, “once you know these techniques...you are stopping trauma from occurring in the future. And then when you look at the structural barriers that cause trauma, you are not just stopping trauma for a few people but for many in the future”.

Many of the techniques of grounding, self-soothing and self-nurturing are important to embed in work and life to feel good health and wellbeing. They are also important for all of us whether we have experienced trauma or not. When we bring these skills and practices to life we are creating a healthy, strong and resilient society. As explored in the previous section a society that is resilient can break the transmission of intergenerational trauma.

More specific skill sets to keep calm, and work through trauma responses
There are many other techniques and practices that organisations need to continue to learn and employ as they become trauma informed. As expressed previously many of these need to be understood within the context of a place and culture. Some may feel universal such as principles around creating safety, de-triggering, and grounding, which have been explored and presented here. However, the details of these practices and how they should be implemented will be different for each place, individual, community and working environment. Organisations need to be prepared that it will take time to explore and implement. A commitment to a training schedule and developing a strategic pathway for putting practices into action is essential.

Moving beyond the minimum skills required means a higher level of understanding and experience in how to work and talk to people about trauma and helping people to process some very difficult or entrenched behaviours.

The resources that I have used for navigating this section offer many working examples that go beyond the core competencies explored here. The ‘Trauma Matters’ resource has extensive guidelines and suggestions on how to put complex trauma work into practice.

Integrating Practices into the Operational Structure
There are many ways organisations and working environments can ensure that the practices presented throughout this section are embedded and remain in tacked. Many of the organisations I visited had incorporated trauma informed principles and practices into their policies and procedures. As was explained to me this was not a tick-the-box exercise, these policies and procedures have to be living and felt across the organisation so they are meaningful.

Policies and Procedures
Living policies and procedures hold staff and the organisation accountable for enacting trauma informed practices in everything they do. This includes policies and procedures that guide,
- The design of programs and projects,
- implementation and delivery of services
- all staff and community engagement interactions
- strategic planning
- informed decision on appropriate interventions and desired outcomes

**Recruitment**

Many of the organisations I visited had taken the practices and incorporated it into their recruitment processes. This included employing staff who had knowledge of trauma informed practice and their application. The skill sets required to do this were made explicit in job descriptions and in interview questions.

**Organisational manifesto**

Some places I visited had written a one page statement committing the organisation to understanding, implementing, and embedding trauma informed practices into their work.

These statements were designed and signed by the leadership of the organisation. It was explained to me that this inspired employees, and was a clear statement of intent that this was the organisations ethos and explicit strategic intent.

**TIP:** If you are the leadership of an organisation bring your staff together to write a statement about the organisations commitment to trauma-informed practice. Include the principles that are relevant to the organisation, an approach to implement those principles and why the organisation is committing to trauma-informed practice. Be visionary and practical to show the possibility of making large-scale impacts.

**Assessment tools and Checklists**

The Practice Guide, developed by the British Columbia Centre for Excellence in women’s health have put together an evidenced checklist of the essential elements and conditions of becoming a trauma-informed organisation.

The Klinic have also developed an extensive assessment tool to work out where you sit on the continuum of becoming a trauma informed organisation. The Assessment tool breaks up parts of the checklist into a number of categories and associated questions. The leadership can work with the staff of organisation to answer the questions honestly. This helps in appreciating where there are strengths to be built on and where there are gaps to work on.
**Methodologies that Change the Brain, and How We Engage**

The working approaches explored in brief here are methodologies that can be applied to every working interaction. It starts with exploring an approach specifically designed to change the brain, to community support and empowerment approaches that follow a similar methodology, to a blended approach that brings Indigenous healing together with clinical work, and then a community ground up approach that is changing who has ownership and expertise over programs and strategy design. When we change who has control, and how decisions are made, programs and innovations emerge that have been lying dormant or oppressed for decades.

Releasing the potential of an individual or community, is the same as releasing the potential for the brain to grow and make positive and creative connections.

**Collaborative Problem Solving (CPS)**

The Collaborative Problem Solving (CPS) approach has been developed in full by Dr Stuart Ablon (Ablon, 2005; Think: Kids, 2017). At the conference in Des Moines, he delivered a full day workshop on the introduction and methods of this approach in collaboration with Bruce Perry. They had combined their models to integrate neuroscience into an applied practice approach. The information presented here is an overview from that workshop.

CPS and Bruce Perry’s neurosequential model are about the application of good stress to form resiliency mechanisms in the brain. The following is a method designed to break patterns of negative coping behaviours and develop patterns of positive problem-solving skills.

**Evidence-based practice and paradigm shifts**

Stuart Ablon spoke about how he had helped implement CPS across a range of working environments and within large scale institutions, including prisons and the police force (Polastri et al, 2013). He explained to the audience that taking on this approach is an absolute commitment by an organisation that cannot be wavered from. If an organisation wants to see success, then it needs to be diligent in its implementation of the approach. Alongside Bruce Perry, the two were unanimous; trauma informed work is a paradigm shift. It is designed to change our working structures and our brains, not just for those we work with but for ourselves in our own working practices.

**The science of good stress v. bad stress**

As explored in the evidence section Bruce Perry explained how we build resilience by believing in safety through strong relational communities. Stuart Ablon adds that we build strong communities and resilience through normative stress. Stress can be a good thing. It challenges us to build new neural pathways, to think differently and to innovate. However, this stress must be small and repetitive, and if things go array we must know that we can fall back into the safety and care of community. When we have safety to fall back into we can cope with high levels of stress.

If stress is huge and unpredictable, and there is no care or support to fall back into, when things go wrong, our brains and bodies remain on high alert, and we have no access to our pre-frontal cortex. There is no ability for our brains to be empowered and innovative. In other words, there is no resilience, because not only do we not feel safe but we have no ability to change and adapt if we need to.

Dr Stuart Ablon explains that when we have had to cope with overwhelming stress and no safety net we adapt by developing the coping mechanisms that help us to survive. Those coping strategies can
lead to damaging behaviours that are destructive to the individual and society. CPS is based on the fact that particular cognitive skills have been developed while other cognitive skills are lagging.

We can change those behaviours, as Stuart Ablon explains, we do this by activating the neural network that has developed the coping mechanism with the application of stress. He provides an example of working with children that have few self-regulation skills.

“You have to activate the stress response (stress the child) in order to change the stress response”

He stresses, you need to activate the stress response safely, which means doing it with a predictable, moderate and controlled dose and pattern of stress.

(Ablon, 2017)

The Approach – Plan A, Plan B, Plan C

The following is a summary of what Stuart Ablon presented at the 7th annual psychological trauma and juvenile justice conference in Des Moines.

The approach is about focusing on the problem not the resulting behaviour of an individual. As explored in the evidence section behaviour can manifest in ways that do not show the actual emotions or feelings a person is experiencing.

I.e. the behaviour can be aggression and the feeling is sadness or fear.

By focusing on the problem, we are more capable of identifying what someone is feeling so we can enable the development of new skills and a change in behaviour. Stuart Ablon explains that our conventional wisdom is wrong, when we encounter challenging behaviours in kids and in the work place, it is not because that person is lacking in will power to improve their behaviour. That person is lacking a skill set.

His approach, is about how collaboration allows for people to solve complex problems rather than making people do what we want through methods of power and control. Power and control can make people comply, but it rarely changes people’s behaviours and serves to hide complex issues rather than solve them effectively.

Plan A, Plan B, Plan C – is how to trigger the right amount of stress, through collaboration, to create new neural pathways that develop positive skills to cope and solve complex problems. The way to do this is to work within the space of Plan B. It is the most difficult working technique but is the most effective at getting work done in the right way. Plan A is our conventional way of working, and tends to be the least effective. Plan C is sometimes the only option available, it allows service providers, community members, and in the following examples, children and teachers, to keep going under challenging circumstances.

The following are a copy of Stuart Ablon’s slides they are in relation to working with children who exhibit challenging behaviours. However, he emphasised that collaborative problem solving can work between adults, particularly in the workplace.

Plan A: Impose Adult Will – I want you to do this and this is how you have to do it...

- Activates stress response
- Increases power differential risking dysregulation
- Dose of stress is too intense – child or person you are talking to is triggered, they shut down or go into a dysregulated stress response
Plan B: Work toward solving the problem in a mutually satisfactory and realistic manner - use language that is neutral around recognising that there is a problem that you want to address not the behaviour

- “I’ve noticed that…”
- “It seems like…”
- “It looks as if…”

Then inquire

- “what’s up?”
- “what are you feeling?”
- “what’s going on?”

The way Plan B works is by:

- Activating the stress response
- Decreasing the power differential between the people engaging
- It is a safe dose of stress

Plan C: Drop it (for now at least)

- Decrease power differential
- Does not trigger child/person or activate stress response
- No dosing

TIP: When applying plan B to your work practice you must keep an open mind. It is important to realise that you alone do not have the solution. Plan B is about finding the solution together and the outcome might be very different to what you originally expected. It is also important to explain to the person you are engaging with that you are using this method. This means you are being transparent and the person feels safe and secure in the discussion you are both having. It also means they know you are not coercing them toward the outcome you desire. Coercion, and leading questions to get toward what you want is just another plan A.
An example of a successful plan B for a child misbehaving in class: The child identifies a method to self-regulate, this allows the teacher to continue teaching without the child’s behaviour distracting the class and enables the child to engage too. This result meets both expectations of the child and the teacher, and is an outcome that the teacher has not predetermined.

Putting the principles into practice

CPS utilises many of the principles of trauma-informed practice such as,

- Empathy
- Reciprocity
- Collaboration

Stuart Ablon explains that collaboration is a form of co-regulation. When we collaborate we are all developing skills. As Sandra Bloom has explored, that when we are not collaborating we can easily dysregulate others. Dysregulation is contagious, it can turn a calm workplace into chaos. When we engage with others we are helping ourselves and the other to regulate, and often we are helping a group of people to feel regulated too.
Collaboration works when we are empathetic. Empathy is the key to regulation, when we can appreciate and express our appreciation of how someone else feels, we keep them calm. If we are not capable of understanding how someone feels and deeply appreciating their concern through our language, tone of voice and body language, then it is almost impossible to collaborate.

Stuart Ablon explains that when we begin to problem solve we should rock between empathy and collaborating. This is a rhythmic, repetitive and relational way of being in conversation. Rocking back and forth moves us between empathy which is regulating and stress which is dysregulating. If a person becomes too dysregulated, rock back to empathy to regulate them.

**TIP:** remember the grounding practices! Being empathetic is a way of helping someone to ground. Sometimes we just need to be in a space of comfort and understanding to keep calm and carry on.

The beauty of this approach is that it has taken trauma-informed principles, applied it to a working method, and shows how it changes our brain. Stuart Ablon has worked beside Bruce Perry to show how moving between empathy and collaboration integrates the different regions of our brain. Beginning at the brainstem where the experience of empathy helps to regulate emotions, moving to the limbic region where we relate through reciprocity and sharing, to the prefrontal cortex where we can collaborate and brainstorm.

**THINK:** next time you are in work and you feel dysregulated or someone else is, find a way to ground yourself and another. Have a go at being empathetic to what another person is experiencing. If you are attempting to solve problems with a person or a group, and it’s not working, think about your own approach. Are you using Plan A, Plan B, or Plan C?

This approach like all of those explored throughout this section is not easy to implement. It takes time and practice to get it right. As Stuart Ablon states, this work is not magic. It involves everyone including service providers and practitioners learning new skills. This means that we must break old and entrenched patterns, stress our neural pathways and develop new connections.

This work will dysregulate us, it is challenging and can hurt but when we come out the other side our brains will have grown and we will be in a transformative state!

**Other Approaches and Methodologies**

The following approaches and methods are ways of enabling transformation both within the workplace and within community settings. They do not utilise the brain science to prove why they work, but they do function along similar lines of empathy and regulation, stress and challenges, collaboration and exploration.

Many community development organisations have an implicit understanding of trauma informed approaches and the underlying evidence of neuroscience. This is because of their commitment in engaging with the people they work with in context by giving them choice and control and responding to who people are with respect and dignity.
Trust, Encouragement and Empowerment Approaches

The approaches described in brief here have a similar basis to Collaborative Problem Solving. They are empowerment based and use a technique where a service provider helps move a person/community member from dependence on services to independence. Each approach is around building trust with a person in a vulnerable position to make them realise they can achieve their vision and aspirations.

Underlying this approach are the values of trauma informed practices of engaging with empathy, creating a reciprocal caring relationship, and collaborating and challenging a person to think and act differently.

Like Collaborative Problem Solving and the evidence presented around the importance of integrating the different regions of the brain to enable transformation, rocking back and forth is key. Rocking from empathy to challenging a person to develop new skills, enables that person to act on their own for their own sense of self and achievement.

These working approaches, whether it is realised or not, are about applying just the right amount of stress for positive transformative change.

Wraparound Northumberland

I visited a wraparound service just outside of Toronto. Their work is based on supporting people with complex needs to identify a goal and achieve something that they need in their lives. Sometimes this can be working towards getting children back who have been taken into provincial care, or it can be about needing to achieve a qualification, or getting housing.

However, when individuals engage with wraparound staff their visions and aspirations change as they become empowered.

The service is about enabling people to think and come to decisions on their own terms. Wraparound staff support an individual to create a self-selected team of supporters, usually composed of family and friends. Through encouraging family leadership and self-efficacy, control and choice, individuals learn to achieve their goals on their own.

The wraparound Northumberland team described this to me as a theory of change, called

*Do For...*

*Do with...*

*Cheer on...*

These steps can take time, and, as was explained to me you often need to rock back and forth as someone builds trust, confidence and feels security in a supportive and caring network where they can take risks and achieve what they want in life.

Ka Ni Kanichihk

Ka Ni Kanichihk is an Indigenous organisation in Winnipeg delivering high quality and culturally safe programs. The organisation’s name is an Ininew/Cree phrase meaning “those who lead”. It embodies “the vision of self-determination, self-sufficiency and the empowerment (Strategic Plan, 2017-2022)” of the indigenous community the organisation work with.
I met with two of the organisations employees, Dodie Jordaan, and Angie Hutchinson. They explained how they have embedded this vision into their programs.

Ka Ni Kanichihk has designed a mentoring program that describes a series of work practices to be put into effect by the organisations staff. The work practices are grounded in cultural safety and putting Indigenous values and practices of health and wellbeing at the forefront of how they build relationships with the community. The mentoring method utilises practices in empathy, self-reflection and increases capacity with those who are being mentored through collaboration and advocacy.

Relational theory is at the heart of this approach. Ka Ni Kanichihk describes how “participants sense of connectedness to others is central to their growth, development and definition of self”. Similar to the wraparound approach this method is associated with a theory of change.

Mentors facilitate empowerment with the individuals and families they work with to motivate them, move into a decision-making stage, which leads to self-efficacy. Again, mentors move back and forth along this continuum of change with those they are working with. The understanding is that as behaviours change a person can reach a point of transcendence and move into a different sense of self. As explored previously, this process enables stages that integrate the brain so it reaches a point of change where an individual, family or collective can transform.

Dodie Jordan, explained this to me as facilitating people’s growth by creating trust in the services we offer. This process works by,

- making people feel trust and form an initial dependence on the work of a service and mentor
- This leads to an ability to transfer knowledge and skills to that person
- That develops interdependence between mentors/ workers and the person accessing the service
- As the person grows they become independent and can make their own self-determining decisions.

Dodie further explained that this relates to another model they use at Ka Ni Kanichik called the Circle of Courage developed by Dr Martin Brokenleg (2017). The Circle of Courage Model is also grounded in Indigenous values and follows a similar process of achieving holistic health and wellbeing and self-determination in one’s self.

The parts of the model are, Belonging, Mastery, Independence, Generosity (Brokenleg, 2017).

All these models of facilitating support and empowerment follow a similar pattern of helping the mind and body integrate so it is capable of independent transformation.

**A Blended Approach**

I finished my time in Ottawa at the ground-breaking Wabano, an Aboriginal holistic health centre. The building that this integrated healing and clinical health service is housed within is spectacular. Its architecture is grounded in principals of cultural safety and security.

**Empowerment embodied in space**

In the centre is an auditorium, with a domed ceiling.
This auditorium echoes one of the primary principles of the centre which is the empowerment and confidence building of Aboriginal people, to feel strong in their sense of self and have security in their cultural identity.
When you stand in the auditorium and speak, your voice echoes back entirely intact. Word for word, you can hear what you have just said repeated perfectly. This is designed for when Indigenous people speak in this space they know their voice has been heard, and the sound and sentiment of what has been said has purpose.

The centre’s impressive architecture reflects Canadian Aboriginal understandings of health and wellbeing. Rooms are predominantly round, and walls are curved. It was explained to me that many Aboriginal people understand that spirits can get trapped in corners. Wabano is designed to release any negative or trapped energy, and to feel open, inclusive, safe and calm.

**Making the clinical accessible with cultural security**

Wabano is renowned for this approach, in creating a safe, clinical environment by ensuring the presence of integral elements of spiritual and cultural safety. They have released a best practice guide to how cultural safety can be integrated into work places, and the importance of developing cultural safety when working with Aboriginal people.


As was explored in the definitions and discussion section it is becoming well documented that Aboriginal people experience discrimination in the medical and clinical systems of health. As the WHAR group in Vancouver described this means that clinical approaches feel unsafe and stop Aboriginal people from going to hospitals and receiving basic healthcare. When cultural safety is not incorporated into the clinical system Aboriginal people feel unsafe, and it is a sign that practitioners in the clinical system have not been trained to appreciate and respect different cultural practices and heritages.

*Cultural awareness and cultural competency is explored in the Models and Approaches section.*

Wabano’s aim is to achieve health equality for Aboriginal people across Ottawa. For this to happen barriers to the clinical system must be removed. Access to clinical care should be improved and this happens through cultural safety, non-judgemental and non-discriminatory working environments.

On my tour of Wabano I was told that the clinical practice at the centre remains intact, Aboriginal healing practices have not changed the clinical practice. What has changed is the inclusion of cultural approaches such as Elders or translators being present in appointments, or smudging which is the burning of sage or a bundle of sacred plants. It helps people to release energy and feel calm and secure in their environment and in the presence of others.

**Referral into holistic health**

Beyond the clinical appointments people can be referred to other health and wellbeing programs across the centre. Like the evidence of the importance of resilience as a protective factor to trauma, the staff at Wabano appreciate that connection into a strong and resilient community is essential to achieving sustained health and wellbeing. They have talking circle spaces for peer support and intercommunity counselling. There is a healing room were smudging, prayer chanting and drumming take place and many other programs based on nutrition and movement that are blended with Aboriginal cultural practices.

The centre has begun running a youth diversion program. Wabano have collaborated with the police across Ottawa to understand how they can change their approach to working with youth who come into contact with the juvenile justice system. The police are bringing young people to Wabano to
help them connect back into community and culture. The referral forms completed for the young people are not based around whether they have committed a crime but their connection to culture and cultural identity, and connection into communities. They are asked:

- Do they want connection to an elder?
- Do they want to be more engaged in their cultural community?
- What activities are they interested in?
- Who are their family and how are they connected into the community?

**Recognising Intergenerational trauma as a determinant for health today**

This process with the youth is reflected in many other programs in Wabano where the focus is on cultural resurgence. For Wabano it is important to combat intergenerational trauma by creating health equality through safer and more secure clinical pathways and a resurgence in cultural practices.

Wabano understand that a blended approach that combines Western and Indigenous health expertise improves holistic health and wellbeing. One without the other is proven to have life-threaten impacts and increases the health gap.

Wabano remain clear that the underlying cause of health inequality for Aboriginal people today is intergenerational trauma. It is not clinical practices in and of themselves, rather it is how policies of discrimination and marginalisation have been practiced since the beginning of colonisation and the prejudice that has spread across the delivery of essential health care.

Displayed in a gallery above their auditorium is the history of intergenerational trauma, from colonisation, to residential schools, the 1960s scoop and continual removal of children today. It was explained to me that this living history is presented to let people know that they are not to be blamed or shamed for current health disparities.

I was also told that encountering this history is revealing for Aboriginal people who have not be taught it within the education system. It is a process of healing realising what has happened to your society. It opens a pathway to resolving pain and grief which is essential for good health.

**The Community Approach – Putting Principles Straight into Practice**

Ilisaqsivik is a community health and wellbeing centre in the Inuit community of Clyde River in Nunavut. I spent a few days there observing and participating in their Inuit to Inuit counselling training called “Our Life’s Journey”. The course has five modules and has been both in development and been running for just over 10 years. It is important to recognise that development and running have happened simultaneously. This is a learning by doing course and it’s based on practice to action. There are separate modules each with different themes from trauma and addictions to traditional Inuit therapeutic practices. It immediately gives ownership of the practices and topics over to the group being trained so they get to own the discussion and exploration of the topics.

I witnessed and heard this taking place with the aid of a headset. Three interpreters spoke softly into their microphones translating directly into English or Inuktitut, depending on what language was being used. Overall, it was Inuktitut.

This was privileging Inuit language, Inuit voices and worldview. The participants, facilitators and interpreters, who all held an equal place in the circle that had been constructed for the training, talked about their trauma and the trauma of others, their healing, and their strengths in complex and layered ways.
As they were preparing to be councillors they all explained to me that they had been on significant healing journeys. They brought their ability to self-regulate and reflect on their triggers, in honest and courageous ways, to their training as councillors.
The Community of Clyde River, and Ilisaqsivik during summer and 24 hours of light.

**The development of the course**

The course has been designed with foundational principles of community ownership and control. These principles had come to inform the delivery of the training, and the contents taught within the course. These principles included,

- **Privileging Inuit knowledge and history** – deep appreciation for Inuit connection to the land and the wealth of knowledge that has developed over a long history, enabling Inuit people to survive and thrive in the Arctic
- **Trust** – working with a non-Indigenous facilitator who would hand western methodologies to the Inuit community and not have power, authority and control in the delivery of teaching them
- **Language** - Delivering the course in Inuktitut, with translators present for those that choose to speak and listen in English
- **Local knowledge** - The honouring of Inuit healing and health and wellbeing practices.
- **Lived expertise** - Recognising community expertise in dealing with crisis on the ground
- **Designed from the ground up** - Inuit owned and controlled
- **Collaborative** - Participant led allowing for exploration and deep thought over what counselling practices are and how they can work in context
- **Addressing power differentials** - De-Privileging Western knowledge and expertise by giving the knowledge of western skills and practices in counselling to Inuit people to explore, adapt or discard if not appropriate
- **Theory into practice** – understanding how tools and skills are useful through immediate application

This principled approach flips western conceptions of a trauma-informed model and the need for delivery of trauma specific care from qualified experts. The community recognised that they needed additional skills to council and develop appropriate self-care while counselling, but they had to determine what expertise meant for them on the ground. The principles do reflect some aspects of trauma-informed principles. However, they are being put into practice for the benefit of the community not for service providers to be able to engage more effectively with the community.
The model in Clyde River is one of moving immediately into independence so the community can support other community members into a position of independence and empowerment, without relying on western systems of assumed expertise.

How the course came into being

I spent time with Terry Garchinski the non-Indigenous facilitator of the course, who had supported its establishment and development. His organisation lifeworks, counselling and training services is in partnership with Ilisaqsivik in developing ‘Our Life’s Journey’. He has been documenting how the course works, what it is achieving, all while the course was forming, and while it continues to form and develop. He explained to me the way it came into being. (*The summary bullet points below are a combination of Terry and Jake’s description of how the program came into being*)

- Ilisaqsivik recognised that western councillors were not making an impact in Clyde River. Their expertise was not fit for context.
- Most counselling courses were in English and not appropriate for first language or monolingual Inuktitut speakers.
- Counselling training that was available to community members was theory driven and not designed around applied practice.
- Counselling courses designed around western theory, privileged the education of western institutions, discriminating against other knowledge sets. The courses available did not recognise the counselling skills of Clyde River community members, deeming them not ready to become councillors.
- Ilisaqsivik brought elders from across Nunavut together to recognise their expertise and knowledge and people’s readiness to become councillors.
- Community members believed it was important to learn from a variety of counselling approaches to see what would work but without there being overarching Western authority. This was a way of bringing Inuit and Western knowledges together and making it right for Clyde River community.
- They brought in a non-Indigenous person with western counselling experience and training in psychology who the community trusted and had worked with previously.
- Together with the elders, the staff of Ilisaqsivik, and the non-Indigenous facilitator they explored the healing and counselling practices that exist on the ground and the importance of embedding them into Inuit counselling training.
- Over a period of 10 years they put theory and knowledge directly into practice and designed a course through an iterative learning experience.
- The driving aim of the course was to ensure it was Inuit led. To do this as the course was being designed with the non-Indigenous facilitator they put into practice facilitation training.
- The course was developed and became accredited while simultaneously ensuring Inuit people were training Inuit people.

As the executive director Jackob Gearheard explained to me, this community driven approach challenges the notions of the western educator and how education and training is delivered. It calls into question how western society has determined what professional treatment and recovery practices are from trauma, and how best practice approaches are developed. Often the most highly qualified counsellors and social workers are unable to deliver effective healing and recovery approaches on the ground, because they have limited understanding of the context and are often unable to communicate and form relationships with the community.
I witnessed Inuit people being trained by Inuit people in counselling techniques which were fit for context, culturally and locally appropriate, and grounded in an understanding of healing and recovery from trauma.

**Working from the ground up is strength-based**

When we look to traumatised populations we often determine the resources and expertise that do not exist. We then look at what’s needed in relation to the gap and the current inability to provide it. Rarely do we look at the remarkable array of achievements, skills and strengths that belong to human beings on the ground and in place.

In Clyde River I saw that to change a system, we must recognise the relationships and care structures which network communities into vibrant societal frameworks full of strengths and talents.

The reality is that trauma, healing, and the production of an exciting life full of strength and creativity all exist at the same time. Often, we talk about trauma, healing and strength as three distinct phases. Most of the time we do not see the strengths as they happen beyond the overlay of service delivery. Furthermore, we rarely identify strengths but work to create them as if they do not exist.

**Shifting ownership and power**

This model of development has put principles straight into practice. This enables a community to determine what trauma is for them and how they will recover from it without external intervention. I was told that this act of control is a healing process: it allows Inuit people and community to reclaim power.

There was no translation from evidence to theory to practice. This was an active training enabling evidence, theory and practice to exist in the same space at the same time to immediately address trauma and recovery on multiple levels.

- The training was actively addressing and overcoming the trauma of political oppression and institutional marginalisation from mainstream society, by taking expertise out of Western hands and putting it into Inuit hands.
- It was addressing societal and community trauma by training local councillors who can utilise local knowledge to engage effectively with the community.
- It was acknowledging trauma resulting from immediate crisis such as suicide and other serious injuries and death.
- It was allowing individuals to explore and experience their own traumas. I was told this removed the false barrier between the professional and personal.
When we hand the discussion over and stop insisting that it needs to be in English or heard through a predetermined lens the outcomes are fascinating and completely unpredictable. In many ways, I was told that this was more than counselling, it is a process of empowerment.

As people find their voice, ‘we regain our power’. When people regain their power what they determine as the best ways of working and the type of society they want is beyond our current imagination. As people spoke through their pain and grief, they all spoke of needing to confront their trauma and rectify it so it is not passed to the next generation.

This is stopping the transmission of intergenerational trauma where it is having the greatest impact, on the ground.
Changing Systems – What Does It Take to Transform?

We know that through new working practices our brains can change.

As the previous sections explored the science of neuroplasticity shows the plastic nature of our minds. It is difficult to change patterns and actions of thought, but it is certainly not impossible. When this science is applied to working practices, a model emerges that shows us that if we work in a particular way we can reshape neural pathways and our brains can grow. This means we can break patterns of thought, which leads to changes in our behaviours and our actions. Ultimately, if we could break enough patterns, in a regulated and methodical way, we can change the structures and the systems of our work!

Breaking the cycle of intergenerational trauma is possible. Empowerment is being told that we can do it. Power is doing it.

There is hope, and hope helps us change

I was struck by the possibility and the hope given to the social service sector by this evidence. This report has presented working practices to fully support the most vulnerable in our society with the full knowledge that they can transform.

The science of neuroplasticity that has been embraced in the working models of Dr Sandra Bloom, Dr Bruce Perry and Dr Stuart Albion (2008; 2013; 2005) prove that if our brains can change our systems can too. We do not have to work within the same structures believing that they are the only way to deliver services. Every program I saw was working in ways to move beyond the conventional, or to challenge the conventional. Breaking patterns in our brains, breaks patterns in systems, and can enable them to reform around new and exciting ways of thinking.

Trauma informed practices enables systems to be regenerative. They can be open to new thoughts from service providers, teams from diverse disciplines and across sectors. A trauma informed and responsive practice and empowerment based organisation opens itself to a resurgence in Indigenous societal practices of health and wellbeing.

There is so much hope in this evidence that everything can change for the better. Quite literally we just need to put our minds and brains to it!

A note on this section

We can transform trauma.

As Sandra Bloom (2017) explains we can learn from trauma and enter a state that she calls, the emergence of post-traumatic growth. The emergence of this growth is transformation.

This section will explore what the emergence of spaces enabling transformation look like. It will consider how the social innovation model of research and development, combined with trauma-informed practices and the models presented above can get us there.
Innovation

The surprise learning of my trip was how frequently innovation came into the discussion. There is a clear intersect with innovation and approaches to trauma and healing work, and that intersect is the space of transformation. Everyone I met with who works in the field of trauma believes fundamentally that they are working within the space of transformation.

The difficulty that trauma informed practitioners, service providers and clinicians feel is that even though they understand the essential importance of providing trauma informed practice skills to changing people’s brains and, society, the question always arose; how do we change the system? It is the systems of inequality, prejudice, marginalisation, structural and socio-economic disadvantage amongst many other intersecting disparities that keep reproducing trauma. While the system continues to reproduce trauma, our society will continue to require trauma specific programs and recovery centres to respond to traumatised populations.

Why do we have to transform?

From the evidence presented throughout this report it is clear, when individuals need support to transform, their context needs to be transformed too (Pinderhughes H, Davis R, Williams M 2015). To do this effectively we need to be able to analyse and be critical of the greater historical socio-economic political structures that have brought the context of trauma into being (Gold, 2008; Begay, 2012; Centre for substance abuse, 2014).

There are not enough trauma-informed services and individuals

The Jean Tweed centre explains how trauma informed organisations are expected to

- Work with people in empowering and therapeutic relationships
- Remain at the forefront of emerging evidence to inform the best working practices
- Collect and use the evidence of the on the ground work to lobby for policy change
- While continuing to deliver essential services under government funded contracts which expect compliance to working methods that are usually not trauma-informed

This would be difficult for any large-scale institution to achieve, let alone scattered and small empowerment based and trauma informed resource centres. The expectation of what this work should be able to achieve fails to appreciate the overwhelming nature of intergenerational trauma and people’s contextual realities.

Currently, with limited appropriate interventions it is difficult to shift disadvantaged contextual realities. Without the level of resources required this current reality is simply too much for a minority of underfunded trauma-informed services to respond to, let alone transform. To make matters more difficult other essential human services and welfare programs are not trauma informed. These services are responding to the same population base as the trauma informed
services with different messages. In many instances, the work of essential services can be re-traumatising. This increases the burden on limited trauma informed services in enabling transformation (Reeves, 2015).

One of the clear difficulties here, is a message I was told repeatedly – service provider’s work to empower and give people hope, and people must go back into the same environment that disempowers and tells them there is no hope.

Other things in the system need to give to release this burden and end damaging practices which re-traumatise, and often trap people in states of vulnerability. Other things in the system need to change, and change dramatically and quickly if we are going to see the necessary transformation without seeing the transmission of trauma for generations to come.

**What and where is the solution?**

Ultimately solutions and processes cannot be imposed. As explored with the trauma informed practice, imposition of ideas and programs can re-traumatise. Trauma informed practice like social innovation looks to the fact that people and places are fertile ground for the emergence of new ways of appreciating health, wellbeing and resilience and embedding this into our work practices and lives (Westley, 2013). Systems need to recognise this, by effectively responding to on-the-ground strengths, resilience and vitality.

The solution in this sense, is doing work in a way that will unleash the solutions on the ground, within the community. As this report explores the solution(s) cannot be pre-determined by the system. What is more, as social innovation states, solutions cannot be found by existing in ‘problem serving’ (Young, 2008), they must be found in believing that the problem can be overcome.

Trauma-informed work believes this too. It encourages practitioners and community to not live within the space of the issues – drinking, drug taking, gambling, excessive eating, anger and blame. Instead, people must learn to understand what has happened to them and to society and how trauma and states of disadvantage are perpetuated. It is the underlying patterns that manifest in harms which need to be understood and changed (ibid). We need to start to consider what our social service systems would look like if we were to address root causes, and underlying societal patterns. Would the symptoms, which we spend time and funds responding to as crisis, vanish overtime?
TIP: Social innovation is about working within the space of our visions. How do we do that?

Set up a visioning workshop for your organisation. Make sure there is good representation from across your services and the community you engage with. In the workshop get everyone to imagine a highly functioning societal system. This is a system that creates and sustains good health and wellbeing and a creative, energetic and engaged population.

What are all the elements that a societal system needs to make this happen? Think about what an individual, family and community need to feel good in themselves, in their connections and place of belonging?

When everyone has contributed their ideas look at the system you have all created. Does your organisation or workplace work in a way that makes this society a reality? If not, what does your organisation need to do to get there? Your organisation will probably need to continue delivering essential service delivery but, what else can it do to create the society you all envision? How can you work in the space of the healthy society you can imagine today, rather than continually putting programs in place to get you there?
It is All a Continuum
One of the last resources Nancy Poole gave me was a continuum diagram. The focus of this diagram was how organisations work to understand gender. The continuum begins with working approaches which create gender inequality in an organisation, and looks at how working approaches change over stages to achieve gender equality in the workplace. The diagram states that getting to gender equality is a transformative state, where the system is prepared for and embraces change. It is a place where things do not remain fixed.

![A Continuum of Approaches to Action on Gender and Health](image)

Nancy explained that this continuum approach can be used for other areas that are being addressed both within an organisation or society at large.

She said when organisations are looking toward embedding a practice to shape the way that they work in addressing an issue, they should work out where they are on the continuum. Once an organisation has placed itself on the continuum it can acknowledge the journey it needs to travel and the necessary steps to reach a transformative stage. On the other hand, an organisation might feel comfortable in the position it is identified as being in, and the leadership may decide to remain in this stage and strengthen the skill base it is working from.

The continuum for moving from intergenerational trauma to stopping the transmission of trauma and achieving good health and wellbeing, could look something like this:
Sandra Bloom sees the potential move toward transformation in a similar light. As explained earlier the Sanctuary model emerged out of a realisation that the form and structure of social services had to change (2008). In a recent article, reflecting on the current state of politics in the USA, Sandra Bloom reemphasises the pressing need to change our systems of work (2017).

She asserts, similarly to Gabor Mate, that our society is in trauma, and our systems are not helping us address or overcome trauma. In fact, a lot of the time, they are re-entrenching trauma.

She explains that we are at a critical point in time where we are in ‘the age of chaos’. This could be the moment when society is experiencing just the right amount of stress to trigger a collective transformation. This transformation could bring around an entirely different system of operating and responding to people’s needs. In this state systems, practitioners and community need to work to utilise this stressful energy and mould it toward transformation.
She explains what I proposed above, that if the science of neuroplasticity shows that our brains can change, we should be able to take the same theory of change and apply it to our systems. This is because systems are a sum of their parts and these parts are us - human beings, and their brains and bodies. When we believe we can change, we believe that our societal structures can change too.

**Growth beyond Trauma**

Sandra states, when a trauma has happened, “The sought-after outcome is post-traumatic growth, which represents a transformative leap into an unknown future that makes it more likely that we learn from our mistakes and avoid repeating the traumatic experience” (Bloom, 2017:2). She explains that this transformation brings about better adaptions, enriched life experiences and creativity. However, “what is to prevent a leap into catastrophe? Likewise, what is to prevent a hopeless repetition of the past as we keep circling that black hole of trauma? (ibid:14)”  

She calls this needing to reach a state of equilibrium with chaos and stress that will help us to achieve and transform. This is instead of disequilibrium where we fall back into repeating a cycle of despair. In other words, it is like being stuck at the beginning of the continuum presented above.  

This way of working with stress in a methodical, repetitive ‘dosing’ way to bring about change, is similar to the collaborative problem solving approach explained in the last section. When we stress ourselves or someone just the right amount our brain changes and we can learn new skills. If we stress someone too much that person becomes dysregulated, their pre-frontal cortex shuts down and they are left in an emotional state where they revert to negative coping mechanisms to get them through (Ablon, 2005). In a work context, this can mean the perpetuation of ineffective work practices. In a societal and political context, this could mean the perpetuation of structural inequalities and a welfare system that traps and can punish the most vulnerable instead of empowering them.

Sandra Bloom says, “we need to keep pushing our system toward the “edge of chaos” – as uncomfortable as that is” (Bloom, 2017:13). It is an art and we must figure out the art in our working practices for real and meaningful systems change.

The diagram below shows the two states she explains. Post-traumatic growth being the achievement of the equilibrium. Post-traumatic stress is remaining in disequilibrium and constant dysregulation. This diagram draws on her description of both states throughout the article.
There is danger and risk associated with being in this position of needing to push toward a new state of transformation. Sandra Bloom warns, we could destabilise the system entirely, so we end up in chaos. However, the other option is that we remain in the ‘dark hole of trauma’, which continues to cycle downward into chaos. In this state there might be a veneer of effective functioning at the service system level, but dysfunction increases at the community and societal level. Either we grasp the creative and motivational energy of stress and chaos and become excited about what could emerge, or we edge our systems and community toward being in a fixed state of chaos.
The Challenge – Social Innovation

This is challenging, and at times, risky and uncomfortable work. As Anne Starr the CEO of Orchard Place explained when you work from a place of unity, care and support across the entire staffing body, together you can embrace change and risk.

Putting a model in place that is trauma informed prepares everyone to feel comfortable in a predictable space of uncertainty. It is predictable in that it helps people appreciate that change is inevitable and people will be supported through a change process.

The challenge lies in having the commitment to do the work together as an organisation. Staff have to be supported by leadership and management to take risks and be supported and guided through challenges as they arise (THRIVE, 2010).

Social Innovation Models

Social innovation provides many tools and skills for how a ‘transformative effect’, can happen to address some of our largest social issues and make a huge impact. Social innovation is a way of working that says, what is the change that we need to see and how do we bring that change into being?

I was told strongly by a social innovator to think of what an innovation is? An innovation is a disruptor, it breaks patterns, and it changes everything dramatically. Ideally an innovation is brought about by a combination of social thoughts, ethics, evidence, science, a cross-disciplinary team and a community group with lived expertise that sets out to introduce massive change. It is striking to how similar this is to what neuroscience is telling us about the ability to break patterns in the brain. Breaking patterns is a process of removing what does not work to introducing new tools and skills to help us repair and recover. What is most exciting is that it opens a space of growth into an emergent state of being, into a transformative state.

Social innovation views the world, and work as belonging to open systems with many complex inputs (Enkel et al, 2009). Our lives and ways of living do not belong to closed bureaucratised systems with clear command, control, and action and outcome structures. Social service systems are difficult bureaucratic systems to navigate. For the social sector to break cycles of crisis it needs to reflect the reality of what the social is otherwise it will always be at odds with what it is attempting to achieve!

Eric Young, a professor of social innovation at Ryerson University, defines social innovation as, “not just about improving the innovative capacity of social organizations. Rather, it is about innovations in our capacity to organize social and financial resources to achieve large-scale social impact.” (Eric Young cited by Pearson in Buckland (eds), 2013).

Eric has done work around needing to be bold in our social innovations to make this wide scale impact. Through his work I was connected to the Boldness project in Winnipeg.

I met with the Executive Director of the Boldness Project, Diane Roussin, in the North end of Winnipeg where the project is based.
Putting Research and Development at the Heart of Social Design

Iterative learning

The Boldness Project is working in a socio-economically deprived area of Winnipeg to bring about large-scale change for children in that region over a generation. They have identified that children do most of their development in the first nine months and first five years of their life. If they have the right conditions for development during that time they will likely succeed across their life.

This project brings community expertise together with the science and evidence of early childhood to create innovations that will change the lives of children and families and effect systems change.

The Boldness Projects studio space is located in an industrial area and consists of one large white room and an office at the front, which you walk straight in on off the street. The first thing you see is white board walls with ideas for social change mapped around the space. Collective impact, which is a collaborative cross-sector approach to systems change, covers one wall while social innovation covers others.

I was told as we went into the larger room that this is where the community focus groups meet. This is where the team learn how fertile the ground is for transformation. Outside of the service delivery system where people live within the space of responding to problems, here communities are encouraged to highlight how they are engaging in their own transformative work on the ground.

Another type of grounding

The Boldness Project privileges the knowledge and expertise of community. They work to identify and support what they call ‘natural support systems’. However, when people are struggling and there are many blocks in the service system to achieving success. Local knowledge can be eroded over time.

Bringing community together is a way of seeing a resurgence in a local knowledge system, enabling people to believe in the strengths and the expertise on the ground, while also exposing people to new skills and evidence. The combination of empowerment and being open to learning can dramatically improve parenting and a child’s development. It can also open opportunities for people on the ground that have never been considered. Adults might be inspired to open businesses while children grow to engage in anything they are interested in.

Instead of thinking about keeping children out of prison, these innovation approaches put community and organisations in the space of enabling children to believe in possibility. Children could grow to become neuroscientists, artists, astronauts, even social innovators!

The Boldness projects works to mobilize knowledge and ideas to create, what trauma-informed practice terms, an environment of positivity, hope and resilience.

Where to begin?

For Boldness, it is important to highlight the stories of transformation that exist on the ground. These stories hold the solutions to how people grow and succeed in life against all the odds. This is like Sandra Blooms description of post-traumatic growth, where people recover from trauma, incorporate it into their lives, and learn from it to enter a stronger more emergent state of being.
If we can analyse these stories of transformation and identify the conditions that have enable people to succeed, take them and turn them into learnings, and then turn them into an innovation, can we change many people’s lives?

This process in social innovation is called a design lab. A team brings ideas, lived experience, evidence and knowledge together to co-create solutions with the intention to make a big impact in people’s lives. These solutions are developed into prototypes, what social innovation calls proof of possibilities (POPs). They are trialled on a group, evaluated, reviewed, improved or changed and then designed to scale up so they can have a large-scale effect.

The team at the Boldness Project explained to me that they were looking at a number of prototypes. One, being a baby basket that is given to mothers and parents in the first year of a child’s life, containing items proven to help and support a child’s development.

Working with the community helps the team and then the broader system appreciate exactly what roadblocks in the system inhibit and cause distress in people’s lives in the present and over the course of a generation. It further empowers the community to determine what success looks like for them and put the road maps in place to change the course of history for generations to come.

This social innovation program is looking beyond intergenerational trauma to intergenerational health and wellbeing. As Diane explained to me “our work is not about bridging because poverty keeps the community trapped”, it is about innovation, an idea that becomes a reality that releases people both from material and relational poverty.

Like trauma-informed practice transformation begins with the mind and body and is best effected when we create an environment of empowerment through listening, learning and putting community ideas into action.
Community Holds the Solutions

The Boldness Project is utilizing a number of methods to put this work into action, beyond community leadership councils and advisory groups they are using arts based processes to gather community knowledge and feedback. This includes photo voice projects, where community can record and capture their stories in a way that reflects how they see and feel the world. They are also attending community events to listen and learn from what is happening on the ground.

I went to a number of organisations that are using these techniques. Community based art, or engaging with community through art can happen in many mediums, both conventional and with digital media and visuals.

This is not just a way to learn from community, it is a way for services, and organisations to really engage in the life of community. It also enables community to have a supported mechanism to share their own strengths and beliefs.

The leader of Wraparound Northumberland, Jane Ashmore, explained to me that when service providers work with community they have to listen to community, not to the ideas of other service providers about what community should be and what it needs to achieve. Jane explained that the work of Wraparound staff was to be the champions of community members. To cheer individuals on so they can achieve self-efficacy with the support of their families and other community members.

Case Study: Championing community

At Wraparound when a person is seeking help they are supported to put together a team of supporters. The wraparound staff help bring the team together as identified by the person. As this is a community driven model of care, it was explained to me that it is not case management. Case Management is often about service providers telling people what to do, when this is the reverse. The people on the team are those the person considers important and trustworthy in their lives. I was given an example of how these teams can work. I have modified the story to mask any identity indicators

The story: The person in this case is a teenage boy. He is not attending school and is getting into serious trouble on the streets. He wants to find a way to engage but feels alienated and judged by the school environment. He has brought together a team which consists of his mum, his best mate, a teacher he trusts and a few others. Although he has engaged with many services he hasn’t chosen any service providers to be on his team.

Together, he works with his team to think about what he likes doing. What keeps him engaged happy and healthy. He likes bikes and riding bikes. With the help of the team he decides he wants to learn how to fix bikes. The team divide up responsibilities to connect the boy up to a program which teaches basic mechanics and fixing bikes. The teacher works out that this can be part of his school credits and the engagement which he likes and is improving his skills becomes part of his learning.

This is how a system and community can respond to people’s needs in the present and with an eye toward that person’s ongoing development. i.e. generational change

Jane Ashmore, described how change and transformation all comes down to our community connections support and care networks.
It was explained to me that when a community is fully engaged and connected with each other they provide the reciprocal care and support that the service system has taken hold of. This includes age care, health, housing and shelter, and education. Overlaying a compartmentalised service system onto interconnected communities can have damaging effects. When a service system reflects, and enables the joined up interconnected nature of community it can dramatically improve people’s lives. Jane said, imagine the services we wouldn’t need if we were actively supporting community to thrive?

**Family by Family**

In Vancouver, I spent time at a series of design lab/social innovation workshops run by a team called In With Forward. They were working across sectors and with community to look at how the social service sector can go from being a safety net to a trampoline. I will explore their working models and theory of change below.

In With forward grew from a project that had originated in Adelaide, South Australia. The project was designed by In with Forward’s Dr Sarah Schulman, Lead of Social Impact. It is based around the idea that families who have experienced difficulties and have come through a hard time, have the best experiences and are the most informed at supporting other families who are having a difficult time. In many ways, it is similar to wraparound. Service providers do not tell families or a person what their goal should be and how to achieve it. Goal setting and support is identified and determined by the people at the centre of change – the families themselves.

These models of change are children, people, family and community centred. Again, this is about communities having the solutions, and being empowered by community organisations to share them, to spread them, and help others transform.

In With Forward are designing many methods to engage service providers and community in believing that different ways of working are possible. They base engagement around ethnographic work, problem solving across diverse stakeholders, and design labs amongst many other engagement, research and design tools.

At a summer learning session with In With Forward looking at how to develop a reflective and iterative design strategy when confronting a large social issue – they gave teams flash cards with strategies and practices and a set of issues to respond to.
Accountability Down, Not Up!

How we can make policy applicable and accountable to the community?

At a breakfast session on theories of change Sarah Schulman presented the 7 reasons that social services stay the same. They are:

1. Workforce for caring — not innovating.
2. Strong hierarchies.
3. Compliance cultures.
4. Accountabilities up — not down.
5. Little perceived control & agency.
6. Limited on-the-ground data.
7. No remit or resources for Research & Development.

Copyright, In With Forward

All these reasons stop services from keeping solutions grounded. The organisations I visited knew that for transformation to occur solutions must be grounded, they must be owned by the community, and be fit for context.

It is important that community organisations re-gain power on the ground where they hold the expertise and can determine the best way to channel funds and investments to make real, meaningful and sustained change in people’s lives.

TIP: Do you do ethnographic work? In With Forward are looking at better ways of understanding every aspect of a community member’s life. This is to gain a better appreciation of the structural barriers and strengths that exist on the ground. They are living people’s lives beside them not just making assumptions from an office. This ethnographic work is empathy, collaboration and innovation that comes from the ground up.
At a breakfast session with In With Forward look at change theories and behavioural change models in the social service sector.

To do this it is worth considering what is really meant by accountability down? It is the upward accountability that can inhibit creative solutions from emerging. In our current structures community members are often accountable to services providers. Often, to access a program people have to respond to criteria or a set of guidelines to determine their eligibility. Services and community based organisations are then accountable to their funders. Funders often sit within government departments and are accountable to the heads of department. Heads of departments are accountable to the heads of government. This means that those determining decisions and designing policy are completely detached from community, due to a large bureaucratic structure of upward accountability.
As has been highlighted throughout this report, having a strong principle, value, and philosophical base is important when keeping your organisation accountable to the work it says it will do for community. Organisations cannot respond to everything communities say they want. Values and principles create accountability, strong working guidelines and safe frameworks to do the work within. It also creates transparency for the community to understand why an organisation is doing the work it does and for what purpose.

**Research, development and design**

Flipping the decision-making system takes time. For organisations to take the risk in changing the way they work so that they bring solutions up from the ground and design their programs around community, they need to have the confidence that funders and policy makers will be able to respond. If policy-making is incapable of responding to community solutions, then the efforts of service providers and organisations will be fruitless. Roadblocks will continue to emerge in the welfare structure and programs will be imposed that are not appropriate for the communities they are delivered to.

It is like investing a lot of time, funds and resources to plant a lush garden, without any water for it to grow and take fruit.

In With Forward place research and development at the forefront of how change can happen. The sessions they ran presented many approaches for research and development. It was clear from these approaches that it takes time to seriously consider what the purpose of the social service sector is and what needs to be changed and achieved to make an impact.

The Stanford Review on Social Innovation define research and development in the social sector as the method to “optimize our interventions before we invest in replication and scaling. We need intentional processes that enable us to take calculated risks, test and refine new approaches, and launch better-designed initiatives before we move to rigorous impact assessment” (Long, 2012).

**Interventions**

This form of investment into R&D in the social service sector would change the way we understand interventions and the work required following the intervention to create sustained change and large-scale impact.

In With forward see social services as being pivotal to introducing R&D to change what is happening on the ground and influence and change policy. Social service organisations may feel stuck but their position as a leverage point between government, funders, and policy and the community makes social services the change makers of the moment.

Social services are delivering the services to the ground. They are at the heart of the feedback loop of whether something works or doesn’t work and what can make it better. If the right mechanisms were put in place within a service or community organisation they could be the perfect research and development space. A space where evidence can be brought together with practice and where theory can translate into people’s lives and action, and where innovative processes can be documented to show how sustained change is possible.

In With Forward suggest that we do not spend enough time researching – society is complex and interdependent. If we are going to understand it and create the right interventions for change, we have got to do the hard and exciting yards. This involves the simultaneous happenings of study and action.
Research & Development for Trauma and Healing Work

When thinking about what needs a social innovation...

Social innovation thinks big and it looks for big things to intervene on to make a dramatic difference.

There is not much bigger in terms of social problems than addressing trauma. It is an underlying factor affecting the entire globe that is being proven to be interwoven into complex interrelated issues of socio-economic disadvantage and health. There is nothing that demands transformation like trauma does. As this report has outlined, the evidence of trauma is irrefutable, trauma is real, and as new working practices are proving, trauma can be transformed.

Dedicating time to research

It was stressed to me in many places that trauma informed and responsive work is a dynamic and emerging field of practice. When an organisation commits to becoming trauma-informed it is not only a commitment to understanding the evidence that exists, but researching and analysing the constantly emerging evidence.

Dana Clifford at Sheway said to me that our work is never best practice. Practices evolve and grow as the evidence base shifts and expands. She said our practices need to be informed by the best evidence and constantly pushing us to do our work better.

Learning from Google?

If this is the case, then how can the social service sector keep up? In With Forward have taken their learnings from one of the most well-known companies for innovation – Google. Google have embedded innovation into everything they do and drive. They acknowledge that time is needed to do things differently and that is why they support their staff to spend 20% of their work time on innovative projects that can benefit Google.

In With Forward believe that this is exactly what needs to happen in the social service sector. We are dealing with complexity and need to invest the time to research and innovate.

It takes time, tenacity and creativity to implement new projects, document and learn from them and work out what works so we can scale-up and spread innovative interventions that mean big positive changes in people’s lives on the ground.

The diagram below, was presented in the models and approaches section to assess where organisations might begin with intervening on trauma. Here it is presented to understand the changing nature of knowledge.

When we design and trial new approaches the evidence we begin with can be influenced and changed. To understand the changing landscape of knowledge and how this impacts work, organisations must learn to become iterative, reflective and commit to continual evaluation of work. What we do today could change the way practices are understood and implemented in the future. This is all about fine tuning the work to make the biggest impact possible. Social Innovation conducts this form of work in spaces and methodologies called ‘design/living labs’ (Gasco, 2017).

Evidence is not static. Trauma-informed and healing organisations are working in a dynamic space. They are simultaneously,

- Evidence informed
- Contributing to emerging evidence
- Forming new and evidenced work practices, and
- Transforming the evidence base

Developing a shared knowledge platform across employees, service engagers, stakeholders and community members

- Utilising current evidence-based
- Utilising current best practice

Contributes and changes evidence-base and practices.
Grows a local evidence base of specific healing practices around health and wellbeing that considers, adapts and localises non-Indigenous approaches to trauma and recovery blends Indigenous and western approaches to addressing trauma and recovery contributes to national and international knowledge of best-practice healing, trauma informed and recovery approaches.

Trauma informed practice model
- philosophy
- values, principles, practices, skills and guidelines
- Systems change

Trauma specific care
- approaches and programs
- counselling
- cognitive behavioral therapy

Indigenous Healing Practices
A holistic Societal framework of health and wellbeing

Recovery and treatment plans
- peer support groups
- self-care
- rehabilitation
- residential care programs
- yarning circles
What does this look like in practice?

Researching and understanding the evidence, translating evidence into practices and making sure practices are fit for context, is hard. Ilisaqsivik, as explored in the section on methodologies, has spent 10 years creating a community approach that explores how the community can own evidence, put theory into practice and assess what works for them. They continue to develop the process today, documenting and reforming as they implement the Inuit to Inuit counselling model.

Although it takes time, when this iterative process is put into action the result is a dynamic model of blended knowledges that are adapted and/or designed for the local population. In other words, they are practices that work, have the impact intended, and are owned and controlled by the community. This approach ensures that new practices are designed, embedded and sustained on the ground.

Social Innovation calls this work prototyping. As explored in the previous section the Boldness Project and In With Forward are creating prototypes for social change. These design ideas are then tested again and again on the ground until something sticks and works, and people on the ground are able to benefit from it.

Measurement and Evaluation
As has been explored throughout this report the field of applying a distinct set of practices and trauma informed tools to the social service sector and community development environment is new and emerging. There is a wide variety of programs and empowerment methodologies which exist on the ground. These are practices designed to restore health and wellbeing and see great potential in ending generational transmissions of trauma. However, understanding how these practices can be consolidated and the body trauma informed practices work together to produce the wide scale positive social impact we all want to see, remains relatively unknown (Kusmaul et al 2014).

There are research institutes and community organisations that are beginning to assess the impact or trauma informed and responsive work. The ACE study is just the beginning of proving that context has an impact on people and the generational nature of their environments. As Pinderhuges et al (2015) have explored with Adverse Community Experiences, we can design multipronged, multi-stakeholder community owned strategies that can make ACEs negligible and change the nature of context for to form generationally healthy and resilient communities.

Some examples of Evaluation – the co-creation of evidence
While I was in Canada Nancy Poole convened a group of high performing trauma informed, harm reduction organisations that were working with substance using and substance-involved women.

Three of the organisations present at this co-creating evidence meeting were Sheway, Herway and Breaking the Cycle. They have all worked with Nancy Poole and The British Columbia Centre for Excellence in Women’s Health to design and conduct evaluations for their individual organisations. These evaluations look at co-relating outcomes at the program, participant, community and systems level. They can be found here,


They found that interventions which improve relationships reduces substance use and for children with complex needs it improves child’s development and mental health.

At the meeting in Victoria they were asking: What does it take to understand how this evidence can transcend organisational and regional boundaries to help nations and the international community of service deliverers, appreciate how a set of practices can create meaningful impact and generational change?

Co-creating evidence to prove impact

All these organisations gathered around a table in Victoria, British Columbia’s provincial capital to discuss what does it mean to evaluate and co-create evidence the impact of their work and inform best practice across the nation going forward.

All the organisations were sure of one thing, the work they are doing is hard, and working out what to evaluate to show generational impact was going to be tough. But they were committed to co-creating exceptional evidence. They talked about the different modalities of their work (service delivery) and how this was operating in a complex context of intergenerational trauma, and the need for change to happen at multiple levels. Ultimately, they needed the evidence that trauma-informed ways of work were having an impact so it could influence policy and systemic change and in turn enhance people’s lives on the ground.

Ultimately, all the services sitting around the table agreed that the data they were collecting was communicating the richness of women’s lives; why they are exposed to vulnerabilities and why they make choices they do given the circumstances. These organisations were understanding where women are at so their lives, their lived realities develop our questions around what our organisations need to do and what we should be evaluating to show that we are making an impact.

For instance, these are things like if women identify that their biggest concern is the removal of their children into state care then our work should be measuring how we are reducing the number of children being taken into care. This could happen through a number of work ‘modalities’, such as empowerment courses and parenting skills training, but essentially it would all be happening through the philosophical and evidence based practice of trauma informed care. The measures would be showing results indicating that this work is having a generational impact.

These organisations are at the beginning of big and exciting work. The evidence they collect could change the nature of what the social service sector understands best practice as being at contribute to a far greater understanding of the impacting nature of trauma informed work.

Resilience Measures

The Young Women’s Resource Centre in Des Moines is part of the Trauma Informed Care Strategy Stakeholder Group. The CEO of the organisation has transformed the working practices and programs of the organisation to become trauma-informed and create empowerment to transform the lives of young women.

She explained to me that we cannot accept the status quo of ACEs. The knowledge of ACEs should empower us to transform the way we work and people’s lives. She had embarked on creating an
evaluation of all the programs at the young women’s resource centre based on a resilience measure. She had spent the last year researching and trialling the measurement. It cannot be reproduced here due to copyright and reproduction reasons.

She explained that becoming trauma-informed meant that the organisation had dedicated time to research and evaluation. The board had afforded her a year to put together an evaluation tool based on resilience. She worked across programs to assess program participant ACEs at the beginning of the year. Over the course of the year as the young women engaged in trauma informed empowerment work they were asked questions based on whether protective factors were being enhanced in their lives. The more protective factors that they have, the more resilient they are, and the more likely that their ACE score will not dictate later life outcomes.

The Wraparound Northumberland service just outside of Toronto explained a similar process of evaluation based on resilience. The services evaluation report can be found here, http://www.excellenceforchildandyouth.ca/sites/default/files/gai_attach/EDG-1436_Final_Outcomes_Report.pdf

Understanding exactly what resilience is and relating protective factors, and using these as a strength based evaluation framework to assess the impact of trauma informed work, is an emerging field of study (Machelle et al, 2010). It could provide many assessment tools and mechanisms to understand and prove what it takes to break the cycle of inter-generational trauma.

**Starting this work on the ground in the Fitzroy Valley**

At Marninwarntikura, in Fitzroy Crossing, we are already learning from the work presented throughout this report. We have taken the social innovation theory of change models and their commitment to research and development and applied this to exploring and embedding trauma informed practice and healing work.

The diagram below is the beginnings of understanding how research and development can function in a community based organisation, to provide a whole new set of effective working practices.

This is a community based research and development model to explore trauma informed and healing practices, and how they can be implemented, in context, and designed for impact.
Surrounding the model are the different knowledge systems that circle the operations and strategic approaches of Indigenous community based organisations. As explored with Wabano these knowledge systems can be blended to enhance practices within both systems to improve the health and life outcomes for Indigenous people. Overtime, this methodology, enables a body of local evidence to emerge that continues to inform the creation of best practice trauma informed and healing work on the ground.

**The Future**

This work is complex, challenging and exciting. To make it effective, the social service sector and community organisations, need to carve out space and time, and invest the resources to making this work a reality. As trauma-informed practices teach us, when we are methodical, repetitive and reflective in how we approach the development and implementation of new work, the innovative practices and approaches that emerge could be ground-breaking.
As we grow these practices we can begin to identify the indicators of resilience, protective factors, and health and wellbeing that can help us measure and evaluate how this work is breaking the cycle of intergenerational trauma. What is clear is that trauma-informed practice and methodologies have to be meaningfully embodied and embedded in all that an organisation does for it to have the desired effect of generational change. When the philosophy and nature of the work are understood, it is then possible to start measuring successful interventions as presented in the evaluations supported by Nancy Poole and the British Columbia Centre for Excellence in Women’s Health.

All the work presented in this report, when implemented and embedded with careful consideration, can intervene on the multiple transmissions of trauma, and begin to restore societal health and wellbeing. We can break the cycle, but we must do the work.
**Recommendations**

The following seven recommendations are made in relation to the findings, information and analysis presented throughout this report. Overall, the recommendations correspond with each section of the report. Each recommendation can be considered independently or seen as a series of recommendations for an organisation, community group or service developing an implementation plan to becoming trauma-informed and recovery orientated in all its program designs, strategic planning and outcomes.

These recommendations have been created based on what has worked in the range of organisations I visited during my Churchill Fellowship travels. Some of the places I visited were implementing several areas of work reflecting the recommendations that are outlined here. However, there was not one organisation doing every area of work. The recommendations presented here are an ideal scenario. If each one could be fully implemented, then an effective trauma-informed and healing system of service delivery and innovation could be created from the ground up.

It is important to note that organisations highlighted many challenges in understanding, implementing and sustaining this work. The most prevalent challenge was implementing this work in the face of funding and resource shortages and incompatible and often contradictory government policies. Having an overarching funding and policy system, which is not conducive to this work, has created stress and pressure within community-based organisations who put this work into practice.

The following recommendations address this evidence, policy and research gap by highlighting the need for an information sharing strategy approach across community, multiple stakeholders and sectors.

1) **Determine the organisational/service’s philosophical, value and principle framework of work and commit to turning the framework into working practices.**

The framework can be used as a decision-making guide in determining organisational policies and procedures, program design, strategic direction, and to form a unified and healthy organisational culture committed to achieving common outcomes.

2) **Develop a staff training schedule to enhance and strengthen skills across the organisation/services in line with the principles framework.**

This schedule enables the creation of a shared knowledge platform to drive similar practices in work across service delivery areas and silos. There are many trauma-informed and empowerment trainings that should be considered against transforming organisational principles into practices. Trainings highlighted throughout this report include anti-oppression, Collaborative Problem Solving and the trainings delivered by the Bruce Perry Child Trauma Academy. Enrolling an organisation into online courses is an effective way of engaging an entire staff body in relevant knowledge and practices.

3) **Create a community driven multi-stakeholder Trauma-Informed Project strategy.**

Establish a team and trauma-informed and healing champions to work with community, organisations, service providers, partners, government and other relevant stakeholders to spread knowledge and implement evidence-based trauma-informed and healing practices. This can enable a community, region and system to become responsive to innovative working practices designed for generational change.
4) **Invest and create a Research and Development hub/team to drive the creation and implementation of trauma-responsive and recovery work.**

Consider a team within an organisation or a separate consultancy or research group invested in researching and analysing relevant and emerging evidence around trauma and recovery to translate into working practices, program and strategy design. Ensure that evidence is being collected from community to design relevant trauma-responsive and recovery approaches that respect local expertise, skills and knowledge.

5) **Assess regional impacts of trauma and resulting levels of harm, and the service system response.**

Conduct a regional Adverse Childhood Experience study or an Adverse Community Experience Study that looks at the multiple facets of trauma, its impact on society and the related economic, social and health costs. The study should be community driven and informed and designed to provide baseline data to begin measuring the impact of trauma-informed and responsive work.

6) **Consider purchasing and implementing an evidenced model of trauma-informed practices, such as the Sanctuary Model.**

There are models that provide the philosophical and principle framework of trauma-informed and responsive organisational work. A team of consultants can guide in model implementation across an entire organisation over a series of modules to ensure the effective growth and development of the organisation in line with model implementation.

It is important to consider regional and local differences that may or may not be compatible with a purchasable model. It is important to assess pre-existing models against the organisations principles and how it can be adapted to ensure cultural appropriateness and security and to be fit for context.

7) **Develop a measurement and evaluation tool(s) to assess interventions designed to break cycles of trauma at the program, participant, and community and systems level.**

Identify where an organisation or area of work is looking to intervene and make a positive impact on trauma and resulting harms. Assess how overcoming trauma can be understood against a series of locally appropriate health and wellbeing indicators. This report highlights the emerging trauma-informed measurement and evaluation frameworks as being based on protective factors and developing and enhancing resilience in individuals, families, community and across society. These frameworks are deigned simultaneously to address trauma, recover from trauma, end the transmission of trauma and promote societal health and wellbeing.
Bibliography by Section
Discussion and Definitions


Goodman Ashley, Kim Fleming, Nicole Markwick, Tracey Morrison, Louise Lagimodiere, Thomas Kerr, (2017), Western Aboriginal Harm Reduction Society. “They treated me like crap and I know it was because I was Native”: The healthcare experiences of Aboriginal peoples living in Vancouver’s inner city, Social Science & Medicine 178: 87-94


Healthy Child Manitoba, Copyright © 2017, Province of Manitoba, Website Accessed May 2017


Revai, Tina in collaboration with the Sheway team (2015) Sheway model of care, University of Victoria, Accessed through website June 2017 Sheway model of care


Western Aboriginal Harm Reduction Society (WAHRS). A series or resources on harm reduction and Aboriginal peoples experience with Western Health Care Systems. Accessed through website June 2017 http://wahrs.ca

The Evidence


Bloom, Sandra L (2009), The Sanctuary Model: A Trauma Informed operating System for Organizations, Centre for Nonviolence and Social Justice, School of Public Health, Drexel University.


Central Iowa ACEs Coalition. Beyond ACEs: Building Hope & Resiliency in Iowa. 2016.


Middlebrooks JS, Audage NC. The Effects of Childhood Stress on Health Across the Lifespan. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2008.


Perry, Bruce (2013) Childhood Trauma Academy Accessed through website June 2017


Breaking the Cycle


Models and Approaches

Bloom, Sandra L (2009), The Sanctuary Model: A Trauma Informed operating System for Organizations, Centre for Nonviolence and Social Justice, School of Public Health, Drexel University.

Bloom, Sandra L; Sreedhar, Sarah Yanosy. (2008) The Sanctuary Model of Trauma-Informed Organizational Change


Johnson, Michelle, Michael J. Austin (2008) Evidence-Based Practice in the Social Services, Implications for Organizational Change Pp 75-104


Peter Delany (2014) Becoming Trauma Informed, by Nancy Poole and Lorraine Greaves (Eds.), Journal of Social Work Practice in the Addictions, 14:2, 207-208, DOI: 10.1080/1533256X.2014.905121

Reclaiming Children and Youth; Bloomington,17(3):Pp 48-53.

The Boldness Project (2016) Promising Practices in Community Driven Research and Development: The Winnipeg Boldeness Project Parent Guide Group, Winnipeg, Created by the Boldness Project team


Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia - a national strategic direction January 2014
Authors: Bateman, J and Henderson C 2013, Mental Health Coordinating Council (MHCC), NSW Australia, Authors: Kezelman, C, Adults Surviving Child Abuse (ASCA)


**Applying Practices**


Perry, Bruce (2017) 7th annual psychological trauma and juvenile justice conference, two-day workshop


**Methodologies that Change the Brain**


Orchard Place, 7th Annual Psychological Trauma Conference, slide handout of Dr Stuart J. Ablon’s Collaborative Problem Solving Approach


**Systems Transformation and Research and Development**


