Becoming Trauma Informed: A Research Practicum Exploring Haven Family Support Staff Experiences of Trauma Informed Care

A Research Practicum Report
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Abstract

The following report presents the findings from my research practicum with Haven Family Connections, Haven Family Support program in Saskatoon, Saskatchewan. The purpose of this research practicum was to assist the agency in meeting their identified need for staff capacity-building on vicarious trauma and trauma informed practice. The research practicum was guided by the following question: How can Haven Family Connections, Haven Family Support increase staff knowledge of vicarious trauma and trauma informed practice and improve their capacity in delivery of trauma informed services? A literature review was completed to determine emerging themes and identified key knowledge areas on trauma and trauma informed practice. This review also informed the development of a staff trauma informed practice self-assessment tool. The results of the self-assessment, which asked staff about their knowledge and skills related to trauma and trauma informed practice, informed staff focus groups and provided a baseline for assessing the current knowledge and skills of staff on trauma and trauma informed practice. Data collected from both the staff self-assessment tool and two focus groups were utilized in training recommendations and the development of a staff training guide. The findings revealed areas of strength as well as areas for further development in terms of staff training and practices.

Keywords: Trauma, vicarious trauma, compassion fatigue, secondary trauma, burnout, self-care, wellness, trauma informed practice
Land Acknowledgement

I would like to begin by acknowledging that this research project was completed in Saskatoon, Saskatchewan, on Treaty 6 Territory and the Homeland of the Metis Nations. Being a Metis person, I felt this acknowledgement to be extremely important as I strive to respect and honour not only my ancestors but all of the ancestors of this land and their descendants, and acknowledge their invaluable contributions.
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CHAPTER 1 – Introduction

A traumatic experience can be described as overwhelming, life-altering or impactful on many facets of one’s life (Satkunanayagam et al., 2010; Trickey et al., 2000). Exposure to trauma, regardless of the severity, can have lifelong impacts over time and chronic exposure to stressors can have devastating results (Trickey et al., 2000). Trauma is experienced by many people, across socioeconomic status, race, culture, and location (Crandall, 2019; Fallot & Harris, 2020). As such, it is vital that individuals who work with people, such as social workers, support workers, healthcare workers and those working in other human services, have knowledge and understanding of trauma and its impacts. One way to ensure trauma sensitivity is to utilize a trauma informed approach (Centre of Excellence for Women's Health, 2021). This in turn can reduce the likelihood of systemic re-traumatization (Fallot & Harris, 2020).

I am a Master of Social Work (MSW) student with the University of Regina. I chose to complete a research practicum as a final degree requirement as I wanted to gain more experience in research while expanding my knowledge of trauma and trauma informed practice. My first experience with research was a graduate qualitative research course. Through the class I gained knowledge of qualitative research, including an introduction to the theory and practice of various qualitative approaches. I also gained hands-on experience by developing and implementing my own course-based qualitative study. It was in this class that I initiated further learning in the area of trauma and specifically vicarious trauma.

My interest in the area of trauma was also influenced by my six years of experience as a child protection worker in Saskatoon, Saskatchewan. While in this role, I encountered many traumatic experiences, including conducting and monitoring child interviews regarding abuse or
other traumatic events, seeing crime scene and autopsy photos, and working with trauma survivors who spoke about abuse and other traumatic events they had experienced.

It was not until several years into my career as a social worker, after attending training on the impacts of working with trauma survivors, that I began to understand what I was experiencing and that there was a name for it: vicarious trauma. It was a light bulb moment for me. I finally accepted that what I was going through was not uncommon. Through this training session, I finally felt that after six years of working in child protection, I was receiving some information about the impacts of working with trauma survivors. This sparked an interest for me in the area of trauma and a passion to learn as much as I could on this topic, which led to my current focus in the area of trauma informed practice. I found the process of understanding trauma to be empowering, which gave me the push I needed to do more research and look into ways of staying healthy while continuing to do difficult work in child welfare. Through reviewing literature as well as personal and professional experience, I also found that there is a gap in education and training related to trauma, vicarious trauma and trauma informed practice for many professionals. As trauma is something experienced by many people, having a good understanding of trauma and its impacts is vital when working with trauma survivors, yet training and education on trauma informed practice is deeply inadequate in many cases as evidenced in the literature and through my personal and professional experiences. A general lack of knowledge and understanding around trauma reduces the accessibility of supports for those suffering from vicarious trauma. This could be detrimental to employers, employees, and the clients they serve due to the negative impacts associated with vicarious trauma.

I am currently employed as an analyst with the Saskatchewan Ministry of Social Services. Although I am removed from working directly with trauma survivors, I am still
exposed to traumatic events on a daily basis while in my role as an analyst. My job includes reviewing files and other information that often document traumatic events and the impact of these events on children, families and communities. My personal and professional awareness in the area of trauma and trauma informed practice has allowed me to practice social work from a trauma informed lens. Trauma awareness is paramount for any helping professional.

Following my interest in trauma and trauma informed practice, I approached Haven Family Connections with my idea for a research project. After several discussions with their management team, the organization supported my research. The research practicum was completed on a part-time basis from September 2020 to April 2021. Haven Family Support, a program area of Haven Family Connections, indicated their desire to increase knowledge and skills on trauma and trauma informed practice and the need for training recommendations for staff in this area. My research investigated how the organization could increase staff knowledge of vicarious trauma and trauma informed practice to enhance their capacity to deliver trauma informed services.

**Haven Family Connections**

Haven Family Connections is a community-based organization that supports parents and families to thrive through difficult times. Programming opportunities offered through Haven Family Connections include temporary housing and caregiving placements for children at Haven Kids House and parenting support through Haven Family Support. Their mission statement is “to keep families together by providing active intervention when support is needed” (Haven Family Connections, 2021). Haven Family Connections chose Haven Family Support as the focus of the agency for the research project. The program area is comprised of approximately 11 family support workers, though this number may fluctuate depending on staff leaves, and a management
team of three including a supervisor, manager and director. The family support workers work one-on-one with parents to provide temporary guidance through in-home parenting support and mentorship. They also work closely with the Ministry of Social Services, working with families who may have children in care and/or are at risk of having their children come into care. The organization also works with families referred from the community, for example, self-referrals (Haven Family Connections, 2021).

This report outlines my research practicum project with Haven Family Support. I begin with a review of the literature on trauma, including intergenerational trauma, the impacts of trauma, systemic trauma, and trauma informed practice. I include an overview of trauma informed assessment tools and discuss the basis of trauma informed practice, reviewing key elements of trauma informed practice. The scholarship reviewed also covers vicarious trauma, secondary trauma, compassion fatigue, and burnout. I will discuss my research approach and how it answers my guiding research question. A discussion on research approach, participant recruitment, data collection, and data analysis follows. I then detail the findings from my research, including a discussion on the limitations, ethical considerations, implications and recommendations. It concludes with a discussion and overall summary. The next section will discuss the purpose and goals of my research practicum.

**Purpose and Goal of the Research Practicum**

The purpose of this practicum was to conduct a research project with the Haven Family Support to assist with meeting their identified need for building staff capacity on vicarious trauma and trauma informed practice. The research practicum was completed on a part-time basis beginning September 2020 through to April 2021. There were two main research goals of the practicum. The first of two main research practicum goals was to assess Haven Family
Support’s organizational knowledge on trauma informed practice and vicarious trauma in order to identify gaps in education and training for the family support workers. This goal was accomplished through reviewing literature on sector-leading practices, developing and implementing the use of a trauma informed practice self-assessment tool, and facilitating two virtual focus groups to gather additional information related to the completed self-assessment tool.

The second goal of this research practicum was to develop a training guide on trauma, trauma informed practice, and vicarious trauma for the family support workers of Haven Family Connections. The results from the self-assessments and focus groups informed the development of training recommendations for the organization and the completion of a trauma informed practice training guide.

**Learning Objectives**

The learning objectives of this practicum were as follows:

- To explore the concept of trauma and its impacts including vicarious trauma and self-care
- To explore the literature on assessment tools
- To gain and demonstrate an increased understanding and knowledge base of trauma informed care/practice
- To gain experience with the use of questionnaire and focus group data collection and quantitative and qualitative data analysis methods
- To understand the services offered by Haven Family Connections, Haven Family Support and evaluate their trauma informed training needs

The following chapter presents the literature on trauma and themes that emerged from the review of the literature. The chapter begins with a discussion of trauma and its impacts and
includes the Adverse Childhood Experience (ACE) study, counter Adverse Childhood Experiences/Advantageous Childhood Experiences, vicarious trauma, secondary trauma, compassion fatigue and self-care/wellness, systemic trauma, intergenerational trauma and trauma informed practice.
CHAPTER Two: Literature Review

In order to conduct a thorough review of the literature numerous search inquiries were needed to access a range of sources. A variety of search engines from the University of Regina Library were used. Key words that were searched included: trauma, vicarious trauma, and trauma informed practice. Data and information were collected via books and journal articles. I also attended in person training on trauma and trauma informed practice to gather further information and insight. Collecting information in these diverse ways allowed me to gain a well-rounded understanding of trauma and trauma informed practice.

The literature on trauma generally, and trauma informed practice specifically, is abundant. My focus was primarily on literature specific to social work and/or helping professions more broadly. I also reviewed newly developing literature on how to conduct research during a pandemic, including online focus groups, and scholarship discussing trauma informed tool kits and self-assessments.

The following literature review is presented in eight key theme areas: trauma and its impacts; vicarious trauma; compassion fatigue; secondary trauma; burnout; adverse childhood experiences (ACEs); counter ACEs; and intergenerational trauma. These themes illustrate the diverse and far-reaching nature of trauma and highlight the importance of research in the area of trauma. They also suggest a need for further research and education in the areas of trauma, the cycle of trauma and its impacts, and trauma informed practice. Although the focus of this research project relates to trauma as experienced by an organization that is interconnected with the child welfare system, much of the literature can be expanded to those working in other systems such as health and justice.
**Trauma and its Impacts**

Trauma has been described as a response that occurs following an overwhelming injury (Centre for Addiction and Mental Health [CAMH], 2000). The injury is not always physical and can also be emotional, sexual, spiritual, and so forth (CAMH, 2000). Long-lasting psychological impacts can occur from even what may be considered minor exposure to trauma (Trickey et al., 2000). Trauma is also often described as a stressor and can be either acute or chronic in nature (Shaw, 2000). Approximately 70-90% of people experience some form of traumatic stress or injury throughout their lives (Shaw, 2000). Of those, approximately ten percent develop Post Traumatic Stress Disorder (PTSD) (Shaw, 2000). These traumatic stressors can include natural disasters and physical injury, but also include physical abuse, sexual abuse or exposure to domestic violence (Shaw, 2000). Females are more likely to experience traumatic stress and are twice as likely to develop PTSD as males (Shaw, 2000). Individuals who have a disability experience trauma at a much higher rate (CAMH, 2000). The effects of chronic exposure to trauma can have lasting social impacts such as difficulty learning in school, lack of trust in adults, and the inability to develop healthy relationships (Centre for Disease Control and Prevention [CDCP], 2015). Many children who have been exposed to trauma develop anxiety, depression, shame, inability to focus and guilt (CDCP, 2015).

Trauma can have devastating effects on individuals, families, communities, and specifically children. When children are exposed to trauma, their bodies will trigger the fight, flight, or freeze reaction (CDCP, 2015). Individuals who have experienced trauma may turn to drugs and alcohol in an attempt to self-medicate and try to cope; these same individuals often engage in high-risk behaviours (CDCP, 2015). The CDCP (2015) also reports that a combination of unhealthy lifestyle and chronic stressors can lead to numerous health problems and disease.
Further to this, it is reported that females are at a much higher risk than males to not only experience severe stressors and trauma, but in turn are at a higher risk of developing lifelong issues as a result.

**The Adverse Childhood Experiences Study**

The Adverse Childhood Experiences (ACE) Study was the first study of its kind to explore childhood experiences, specifically adverse experiences, and their long-term outcomes. Data was collected between 1995 and 1997 using a questionnaire, following a standardized medical evaluation (Felitti, 1998). The study looked at the relationship between adult diseases such as cancer, heart disease, sexually transmitted infections, and depression, and health risk behaviours such as substance abuse, smoking and obesity, and childhood exposure to adverse childhood experiences or ACEs (Felitti, 1998). The ACEs were broken down into categories including sexual, physical or emotional abuse, and household dysfunction such as domestic violence (against the mother) or household members who abused substances, and experienced mental illness. The questionnaire was originally mailed out to nearly 14,000 adults (Felitti, 1998) with more than 50% reporting one adverse childhood experience and one quarter reported experiencing two or more ACEs (Crandall, 2019). Not only did the study show a relationship between ACEs and health issues/risk factors in adulthood; it also found that the more ACEs one experienced as a child, the more risk factors were present in adulthood (Crandall, 2019).

**Counter-ACEs**

In 2019, a study was conducted that sought to understand how counter-ACEs, or advantageous childhood experiences, such as having a teacher who cares about you, predictability of home life, good friends, or a safe caregiver, impacted adult physical and mental health (Crandall, 2019). The study utilized an online survey to collect data from 246 participants.
ages 19 to 57 (Crandall, 2019). The study found that the presence of reported counter-ACEs not only protected against poor adult health but lead to better wellness in adulthood (Crandall, 2019). The impact of counter-ACEs varied depending on the number of ACEs present; however, the study concluded that counter-ACEs effectively neutralized some of the impacts of ACEs on adult health when ACE scores were moderate (Crandall, 2019).

**Vicarious Trauma, Burnout and Self-Care**

Regular exposure to indirect trauma, such as viewing images, reading file information, or working with trauma survivors, can have long-lasting impacts (Edelmann, 2010; Handran, 2015). These impacts often go unnoticed or do not get the attention required and can lead to vicarious trauma and burnout (Edelmann, 2010). Although they can have a similar presentation, vicarious trauma, secondary trauma, and burnout are all distinct and separate concerns that are experienced by workers who have exposure to indirect trauma (Canfield, 2008; Edelmann, 2010; Handran, 2015). The following section will differentiate between vicarious trauma, secondary trauma, compassion fatigue, and burnout. It will also discuss the impacts experienced by professionals working with trauma survivors and the importance of self-care and wellness.

Horwitz (2008) explores the association of negative workplace events and effects on child welfare workers, noting that similar experiences are shared in many other helping professions, including but not limited to those working in the health and justice systems. Horwitz discusses vicarious traumatization literature, suggesting that trauma can impact individuals not only as a result of direct exposure to negative events, but also through simply hearing about events from clients who have experienced it (Handran, 2015; Horwitz, 2008). Vicarious trauma can be defined by the impacts on one’s mental health that are observable, such as loss of
empathy, difficulty sleeping, withdrawing, hypersensitivity, isolation, conflict, irritability, absenteeism (Horwitz, 2008; Satkunanayagam et al., 2010).

Burnout, although often confused with secondary trauma, vicarious trauma and/or compassion fatigue, can be seen in individuals working with a variety of clients. Canfield (2008) explains that it is not specifically linked to working with individuals who have been abused or have experienced some form of trauma. The causes can be external, with large caseloads and isolation being major contributing factors. Canfield (2008) also identifies that “the key difference between burnout and secondary traumatic stress lies in the cause, since both conditions are characterized by depression, insomnia, loss of intimacy with friends and family, and both are cumulative” (p. 87).

Secondary traumatic stress or secondary trauma has been defined as the impacts on a professional resulting from hearing clients speak of experiences that are emotionally shocking (Canfield, 2008; Satkunanayagam et al., 2010). Canfield (2008) discusses several studies which focus on secondary trauma. A study by Kassam-Adams (1999) looked at the effects of secondary trauma in graduate students who were working with clients who had been sexually abused. The results of the study showed that secondary traumatic stress had many differences from general occupational stress, including symptoms of intrusion and avoidance due to exposure to (sexually) traumatized clients.

Similar to secondary trauma, compassion fatigue has been described as a loss of or reduction in empathy as a result of repeated exposure to individuals who have had traumatic experiences (Horwitz, 2008; Satkunanayagam et al., 2010). The differentiator between the impacts on trauma workers as opposed to that of a trauma victim is that for those working with trauma survivors, the exposure to hearing about traumatic events is repeated often over an
extended period of time and also sometimes by multiple clients (Ayala Malakh-Pines, 1988; Bensinger, 2021; Edelmann, 2010; Satkunanayagam et al., 2010).

The impacts of working with trauma survivors can vary, but they can affect an individual’s physical, mental, behavioural and emotional well-being (Bensinger, 2021; Canfield, 2008; Handran, 2015). These changes can present themselves in many ways, such as headaches, changes in sleep patterns, feeling unsafe, memory issues, difficulty concentrating, anger, irritability and/or withdrawing from others or activities that one used to find enjoyable (Bensinger, 2021; Horwitz, 2008). Many of these changes, if unaddressed, can create challenges and lead to an increase in absenteeism, irritability towards staff or clients, negative thoughts and problematic teamwork issues (Bensinger, 2021; Brigham Women’s Hospital, 2020; Handran, 2015). It is imperative for professionals working with individuals with trauma histories to maintain a level of self-awareness (Brigham Women’s Hospital, 2020). Understanding one’s triggers and having a plan for when they do present themselves can be vital (Brigham Women’s Hospital, 2020). This awareness, coupled with work-life balance, healthy boundaries and a good support system, can go a long way towards combating vicarious trauma, compassion fatigue, secondary trauma and burnout (Bensinger, 2021; Brigham Women’s Hospital, 2020; De Silva, 2009).

**Intergenerational Trauma**

Intergenerational trauma can be described as historical oppression and involves multiple generations experiencing trauma and the impacts that cross generations (Linklater, 2020; Menzies, 2013). Such oppression has been demonstrated in residential schools, the Indian Act, and, many would argue, the child welfare system (both historically and current) (Menzies, 2013).
Residential schools acted as vehicles of assimilation and cultural extinction by removing children from the care of their families and communities and enforcing upon them the values and language of another cultural group (Linklater, 2020; Menzies, 2013). Numerous reports have documented that many children in these institutions were subjected to psychological, emotional, sexual and physical abuse (Linklater, 2020; Menzies, 2013). An estimated 100,000 children attended residential schools in Canada (Menzies, 2013). Of those, according to Statistics Canada, there are approximately 80,000 survivors of residential school still living (Menzies, 2013).

Since the closure of these schools, another disturbing phenomenon has replaced this traumatic systemic practice. A disproportionate number of Indigenous children have been removed from their homes and communities by the child welfare system (Carrière & Strega, 2015; Linklater, 2020; Menzies, 2013). As a result, many more Indigenous people have had their language, traditions and family connections destroyed by the system (Linklater, 2020; Menzies, 2013). Menzies (2013) discusses the changes that need to be made to the child welfare system. He discusses the history of residential schools and that the child welfare system, in many aspects, is mirroring those same traits of acculturation (Menzies, 2013). Menzies argues that “In order to go forward, we must learn from the past” (p. 13). This argument is highlighted in the 94 Truth and Reconciliation Commission (TRC) Calls to Action (Truth and Reconciliation Commission of Canada [TRC], 2015). The Calls to Action were released as part of a report in which more than 6000 residential school survivors’ experiences were taken into account, outlining the wrongdoings against Indigenous peoples both historically and currently (TRC, 2015). The report highlights the impacts colonialism and residential schools have had on individuals, families, communities and Canada as a whole (TRC, 2015). It provides Calls to Action for the child
welfare, education, health, and justice sectors to move forward on a path towards reconciliation (TRC, 2015).

Indigenous people experience an array of social phenomena at disproportionate rates, such as racism, poverty, and unemployment (Carrière & Strega, 2015; Health Canada, 2003; Menzies, 2013). Many suffer from an extremely high rate of addictions and mental health issues, including high suicide rates (Health Canada, 1999, 2003; Menzies, 2013). The frequency in which these issues arise is much higher than in individuals of non-Indigenous descent (Linklater, 2020; Menzies, 2013). One commonly accepted explanation for the disparity in addiction and mental health issues is that many of these issues are understood to be a result of intergenerational trauma (Linklater, 2020; Menzies, 2013).

Societal recognition of the impacts of residential schools is much needed, and specifically recognition that these impacts have not only affected the survivors, but have transferred on through generations (Menzies, 2013). Colonization has imparted trauma onto Indigenous people by way of either lived experience or through trauma being passed on through generations (Linklater, 2020). It is clear that the impacts of residential schools have continued across generations. The suffering of the survivors can be seen in their children, grandchildren and beyond. Although the last residential school closed in 1996, and there has been a lapse in time, the adverse effects of residential schools, including the abuse, neglect and exploitation that Indigenous families have endured, are long lasting (Canada, 2015; Carrière & Strega, 2015; Linklater, 2020; Menzies, 2013; Partridge, 2010; Wilk et al., 2017). Awareness and understanding of this trauma history is crucial when working from a trauma informed lens, as the trauma may be experienced over many generations.
Systemic Trauma

It is imperative to understand that colonialism has had vast and lasting negative impacts on Indigenous culture and its peoples (Linklater, 2020). Government systems enforced their ways through legislation and institutions such as the child welfare system, education system, corrections and healthcare (Linklater, 2020). Trauma resulting from involvement with a system or service can have enormous impact. These “systems” or services are often deemed to be there as a support, but involvement with these “systems” can cause trauma. The way the system is set up, the way services are provided, the qualifications required for services, or even the workers within the system can be trauma-inducing (Brigham Women’s Hospital, 2020). For example, the healthcare system has been described as “inherently flawed” and has been known to “re-traumatize and marginalize” trauma survivors (Brigham Women’s Hospital, 2020).

According to Bernard (2008), when families are dealing with the child welfare system, mothers are often “scapegoated” and made to feel as if they are not adequate parents and that they failed to protect their children from abuse (Bernard, 2008). Bernard also discusses how women frequently are forced to choose between their children and their partners, and they are often expected to put others’ needs before their own. Collings et al. (2003) state that by ensuring the best interests of the child, the mothers’ experiences, viewpoints and well-being are not always taken into consideration. Although child protection workers are trying to ensure children are safe and protected from harm, they can also oppress mothers by scrutinizing the maternal care of the children, which in turn can make mothers feel like they are being told they are not good mothers (Collings et al., 2003). Mothers involved with the child welfare system are often told what they need to do rather than asked what they need and “may see the relationship as controlling and unhelpful” (Collings et al., 2003, p. 158).
Lena Dominelli (2002) discusses the difficulty for feminist social workers to work within the child welfare system as they often prioritize the interests of the children over the mothers’ interests. She goes on to explain that social policies have been based on the white nuclear family and that those who do not fall within this category are deemed as deviant (Dominelli, 2002). Even when men are the ones who caused the issues (such as sexual abuse, physical abuse), mother-blaming occurs as mothers are seen to have not been able to protect their children and are made to feel as though they are bad parents (Dominelli, 2002). Often in cases such as these, mothers are pressured to take parenting classes (Dominelli, 2002). The content of these classes is largely based upon ideologies of white, middle-class families (Dominelli, 2002).

Although there are positive outcomes that can come from involvement with various systems, negative impacts are also common. The child welfare, justice, and healthcare systems can be oppressive (Bruhn, 2003; Carrière & Strega, 2015; Rochman, 2012). Labels are often put on clients and categorization is inherent to service delivery. These labels further oppress clients as they can be seen by both themselves and others as their diagnosis or label as opposed to being treated as a complex being made up of multiple layers and experiences (Shakespeare, 2014). As such, Shakespeare (2014) argues labels devalue individuals and fail to recognize their strengths. There are also many barriers being put up by policies within the system. These barriers deny access to services as judgements are placed on individuals who are deemed ineligible. These negative experiences with systems, which impact individuals’ lives and ability to function, combined with the barriers created by the policies within the systems, can cause further traumatization (Berg, 2015; Carrière & Strega, 2015; Health, 2021).
**Trauma Informed Practice**

Trauma informed practice is both a framework and approach used to examine how an organization or community thinks about and responds to children and adults who have experienced or may be at risk for experiencing trauma (Klinic Community Health Centre, 2020). Using a trauma informed approach an organization, agency or community, centres the prevalence and impact of Adverse Childhood Experiences (ACEs), the role trauma plays in people’s lives, and the complex and varied paths for healing and recovery (Klinic Community Health Centre, 2020). A trauma informed approach asks: “What happened to you?” instead of “What’s wrong with you?” It is designed to avoid re-traumatizing already traumatized people, placing the focus on “safety first” (including emotional safety), and a commitment to do no harm (Klinic Community Health Centre, 2020; Mate, 2011; Perry, 2004).

Trauma is a common theme across all systems, organizations, agencies, and groups (Klinic Community Health Centre, 2020). Whether it is the people served, the staff or stakeholders, trauma can be and is present everywhere (Klinic Community Health Centre, 2020). This prevalence makes the need for trauma informed practice clear. Many of today’s services and systems mirror historically traumatic systems and abusive relationships (Bensinger, 2021). This can further trigger individuals for a variety of reasons (Centre of Excellence for Women's Health, 2021). Since many individuals and families accessing these services have pre-existing traumatic experiences, re-traumatization is often inevitable during or following their interface with various systems or service providers (Klinic Community Health Centre, 2020).

Working from a trauma informed approach takes the focus away from “fixing”, “changing” or “treating” and instead is about offering a welcoming environment, adjusting services to meet the specific needs of individuals (as opposed to using a cookie cutter approach),
building trust, and giving the control back to the client (Klinic Community Health Centre, 2020; Knight 2015). Trauma is often not only overlooked but ignored. Although many times trauma is at the forefront of the difficulties one is facing, it is often left unaddressed (Harris et al., 2001). Many times, the coping mechanisms and adaptations utilized by trauma survivors are not seen as such but instead seen in a negative light (Harris et al., 2001).

A trauma informed approach recognizes that clients may have traumatic experiences throughout their lives and this needs to be taken into account when supporting individuals or providing services (Knight, 2015; Knight, 2009). As a large majority of the population has had one or more traumatic experiences, the prevalence of exposure to trauma increases when working with helping professionals as they are more likely to experience vicarious trauma, secondary trauma, compassion fatigue and burnout (Centre, 2020; Harris et al., 2020; Knight 2015).

**Critiques of Trauma Informed Practice**

Although trauma informed practice is largely accepted and adopted by many professionals, individuals and agencies, specifically those working with vulnerable populations, there are critiques of the approach (Berliner & Kolko, 2016). Some of these critiques have been related to a lack of guidance around the actual practice of the approach, leaving too much uncertainty for service providers (Berliner et al., 2016; Sweeney et al., 2018). There is also concern that a trauma informed approach assumes that all service users have experienced trauma (Sweeney et al., 2018). While this point would be concerning if that assumption is being applied, much of the literature reviewed focuses on a philosophical and values shift that has implications for how services providers think about trauma and provide services to ensure that trauma survivors who do access these services have a more positive experience and avoid re-
traumatization (Harris et al., 2001). Similarly, a common critique of trauma informed practice is that service providers literally ask “what happened to you” rather than using this idea as more of a shift in thinking and an acknowledgement that individuals have a past which contributes to their overall being (Sweeney et al., 2018). Acknowledging the risk of misinterpretation, trauma informed approaches often prioritize training and appropriate supervision which should alleviate most concern that this concept would be taken literally and negatively affect practice.

Summary/Critical Analysis

Upon reflection of the literature and my personal experience, it is evident that working with survivors of trauma, including intergenerational trauma and systemic trauma, is common when working in helping professions such as social work and support work. The literature discusses how service provider self-care and wellness is vital when working with trauma survivors to prevent burnout due to vicarious trauma, secondary trauma and compassion fatigue. Although there are critiques of trauma informed practice, the literature reveals that it is a widely accepted approach utilized in many professions across human services as a client-driven method to avoid re-traumatization and focus on strengths and resilience. This approach fits well with the aims of the research project and can be adapted to meet the needs of the organization, staff and clients. This also is in line with the Canadian Association of Social Workers (CASW) code of ethics values including: “Value 1: Respect for the Inherent Dignity and Worth of Persons,” “Value 3: Service to Humanity,” and “Value 4: Integrity in Professional Practice” (Canadian Association of Social Workers [CASW], 2005).

The following chapter will present the research project methodology. It will discuss the research design and why I chose to utilize a mixed methods approach. It will also outline the
process utilized to recruit participants. Data collection and analysis will also be discussed. I conclude the chapter by presenting the ethical considerations.
CHAPTER Three: Methodology

Research Design

The following section provides an overview of the design of my research project that aimed to answer the following question: “How can Haven Family Connections, Haven Family Support increase staff knowledge of vicarious trauma and trauma informed practice and improve their capacity in delivery of trauma informed services?”

In this chapter I discuss the data collection and analysis methods used in this research. I also provide the rationale for using a mixed methods approach. To collect the data required to complete the research project, I used both quantitative and qualitative data collection tools. Quantitative data was collected through an anonymous participant self-assessment tool. Many trauma informed tools utilize self-assessments (Fallot & Harris, 2020; Harris & Fallot, 2001; Klinic Community Health Centre, 2020). Although the self-assessment provided pertinent quantitative information, I felt that in order to gain depth and breadth in participant responses, it was necessary to hear directly from the family support workers to provide additional context to the self-assessment survey.

This approach fits well with my worldview and the importance of participant voices in building understanding. I believe that knowledge is created and co-created through interactions and that it is impossible to completely separate oneself from the research project (Kim, 2010). Interactions with research participants create new knowledge and experiences which construct reality (Kim, 2010). To capture the nuances in the lived experiences and knowledge base of the family support workers from Haven Family Connections, I felt it was important to gather qualitative data using focus groups. The reason for this selection was to highlight the importance
of relationships and personal connection present in qualitative research, even in a virtual setting (Slevitch, 2011).

As a result, I used both quantitative (survey) and qualitative (focus group) data collection and analysis methods in the development of my findings. The self-assessment questionnaire consisted of various questions with predetermined numerical responses. The questionnaire data analysis informed the questions for the focus groups, which added contextual depth from the family support workers to the self-assessment survey. The mixed methods approach allowed me to utilize a data collection tool well-recognized in many trauma informed toolkits, a self-assessment, but also to nuance my understanding of the participants’ lived experiences through the focus groups.

**Recruitment of Participants**

The following section discusses recruitment of participants for the research project. I include the steps taken during recruitment of the participants. I also discuss the methods utilized for participant recruitment. Potential participants were recruited from the family support workers at Haven Family Connections. Following ethics approval from the University of Regina Research Ethics Board, all 11 staff were invited to complete an anonymous self-assessment at a virtual staff meeting. At an earlier staff meeting, employees were informed of the details of the research project and provided the opportunity to ask questions. The consent form was thoroughly explained, highlighting the voluntary nature of participation. Following the staff meeting, a recruitment poster was emailed to Haven Family Connections staff by management inviting them to participate in the survey. A link included in the recruitment poster directed potential participants to the online consent information, and then into the self-assessment. Once the self-assessments were completed, I attended a second virtual staff meeting, at which point staff were
invited to participate in one of two virtual focus groups. During the same virtual staff meeting, a link was provided via Zoom Chat and a follow-up email to the consent form which asked participants to indicate their availability for the focus groups in an email to the researcher. Following completion of the consent form, participants were contacted with focus group log-in information and scheduled dates/times of the focus groups.

The Self-Assessment Tool

This section details the data collection portion of my research project. An overview of the quantitative and qualitative methods of data collection tools that were utilized which included a self-assessment questionnaire and virtual focus groups are discussed.

Through a review of the literature, it became evident that self-assessments were commonly utilized within trauma informed practice. Self-assessments are used to gain understanding of the organizational knowledge base of employees related to current practices and skills. The trauma informed practice toolkits that I reviewed all utilized some type of a self-assessment. I specifically reviewed surveys developed by Klinic in Winnipeg as part of the TIC toolkit (2020); the Trauma Informed Practice Guide by the BC Provincial Mental Health and Substance Use Planning Council; Trauma informed Services: A Self-assessment and Planning Protocol, version 1.4 (2012); and Creating Cultures of Trauma informed Care (CCTIC): A Self-Assessment and Planning Protocol (2009). None of the above-mentioned tools were utilized in their original version in my study, but instead were adapted for use in the development or a new tool specific to this research project. My self-assessment questionnaire was designed to reflect the needs of the agency and the direct purpose of the research practicum project. The self-assessments that informed the development of my project questionnaire were cited within the self-assessment tool. Permission to use these tools was not required as these tools are available
for public use. Staff from Haven Family Support completed the voluntary, anonymous self-assessment. The self-assessment information was then used to develop the focus group questions. Two focus groups followed the self-assessment data collection. The purpose of the focus groups was to gain further insight into the current knowledge and skill base of the staff, as well as uncover areas for future training and development.

The self-assessment tool developed for my project consisted of 23 multiple choice questions. Each question was categorized into one of the six following categories: knowledge and training; support and wellness; leadership and supervision of staff; screening and assessment; safety; service delivery and policy. The development of the categories was based on the literature review, existing self-assessments that were reviewed, the needs of the agency, and the purpose of the research project. The self-assessment was sent to and accessed by participants via a link on the recruitment poster and was completed online using Qualtrics, a web-based survey tool used for data collection. Of the 11 staff members employed by the agency during the data collection period, 91% (n=10) completed the self-assessment. While not all questions were answered by all of the staff who completed the self-assessment, sufficient information was obtained and is reflected in the data below.

The survey utilized numerous question and answer formats. Of the 23 questions, 18 were a four-point Likert-type scale that included response options of achieved, partially achieved/in progress, not achieved and not applicable. One of the 23 questions was more specific and included areas of previous education and/or training.

The self-assessment was accessed using a link that was emailed to all staff. Staff were made aware that the survey was voluntary, confidential and anonymous. Staff were initially given a two-week window to complete the self-assessment; however, an additional two-week
extension was requested and approved by the University of Regina Ethics Board to allow staff returning from leaves to complete the self-assessment.

**Focus Groups**

Qualitative data collection was completed through two focus groups. A semi-structured interview guide was used, informed by the literature review and the results of the survey self-assessment. The focus groups were conducted virtually due to the COVID-19 global pandemic. To gain additional contextual understanding of the findings of the self-assessment, any areas that required further exploration were included as questions in the focus groups. In particular, the self-assessment questions about current knowledge, skills and practices were further explored in the focus groups in order to get a deeper understanding of the levels of knowledge and more specifics about practice.

Focus group participants were contacted by email following completion of the online consent form. Of the 11 family support workers at Haven Family Support, eight consented to participate in the focus groups; however, only six staff attended the actual focus group sessions. Due to the COVID-19 global pandemic both focus groups were facilitated virtually by Zoom. The focus groups were both audio and video recorded for transcription purposes only; the recordings were deleted immediately following transcription. The limits of confidentiality were explained in both the consent form and verbally prior to starting focus group questions. Participants’ names were not included in the transcripts or this report through the use of pseudonyms.

**Data Analysis**

Data from the self-assessment was analyzed using Qualtrics reports. Each of the 23 questions were analyzed independently and within the six categories outlined. Graphs were
utilized to display the responses to each of the questions, and descriptive statistics were used to report the outcomes in each category.

Following transcription, I coded and analyzed the data using thematic analysis in NVivo by creating nodes within the program. Thematic analysis is a process in which data is analyzed by surfacing commonalities or patterns in the data which are then categorized into themes (Creswell, 2013). To code the data, I identified key words, phrases, and ideas that the participants used to express their experiences in response to the focus group questions (O'Connor, 2003). These particular statements stood out in the data and provided understanding about the participants’ experience with or perspectives on trauma informed practice and will be discussed in detail in the following section. For example, specific feelings, responses, or experiences that repeated throughout or were common across the data were grouped. In the initial stages of data analysis, the significant statements and ideas that answered my research question or provided further understanding were highlighted. Following the initial coding process, the identified key statements and ideas were then organized into themes using NVivo. Each theme represented a specific idea that encompassed the overall meaning of the data (O'Connor, 2003). The data analysis provided pertinent understanding on the current knowledge, practices, and prior training of the participants. Four main themes emerged from the focus group data: trauma is…, a weight, self-care/the importance of support, and learning what is needed to become trauma informed.

**Ethical Considerations**

An ethics application was completed in consultation with my supervisors Dr. Amanda Gebhard and Dr. Darlene Chalmers. I also read and adhered to chapter nine of the Tri-Council Policy Statement and the Canadian Association of Social Workers (2005) Code of Ethics and
Guidelines for Ethical Practice. The ethics application was then submitted to the University of Regina Research Ethics Board (REB) and received approval. Both the self-assessment and focus groups posed minimal risk to participants. A list of resource contacts was provided to the participants if difficult topics arose and if they required support. A consent form was reviewed with all potential participants prior to the start of the data collection, and informed consent was gained prior to the focus groups taking place. As all research participants were employees of Haven Family Connections, confidentiality was explained and participants all agreed to confidentiality prior to participation. Participants were reminded of confidentiality before the focus group commenced. The self-assessments were completed anonymously. Both focus groups were audio and video recorded and these recordings were destroyed immediately after transcription of the data was completed. Pseudonyms were used in the transcription process to ensure participants could not be identified by name. All the above precautions were undertaken in order to attempt to avoid any negative repercussions or stigma for those employees who chose to participate and voice their opinions.
CHAPTER Four: Findings

Quantitative Self-Assessment

The following section will discuss the findings from the quantitative self-assessment data collection tool. The participant responses from each question were analyzed individually but also within the themes listed below. The results of each section are summarized, and graphs are presented showing the results of the findings. An overall summary of the findings from the self-assessment is presented at the end of this section.

Section 1: Knowledge and Training

All staff identified that they knew what the word trauma meant (see Figure 1). Eighty percent or 8/10 staff answered yes to having knowledge of trauma informed practice with 10% indicating they did not and another 10% were unsure (see Figure 2). Of the 10 staff who completed the self-assessment, 100% advised that they had knowledge and/or experience with vicarious trauma, secondary trauma and/or compassion fatigue (see Figure 3). Of the nine responses to question four nearly 78% of respondents believed that Haven Family Support was currently or at least partially trauma informed (see Figure 4). Of the nine staff who responded to question five, the majority of staff (88.89%) already had some prior education or training in at least one topic related to trauma informed practice, with many of them reporting prior education or training related to trauma (see Figure 5).
Figure 1

*Trauma*

- **Number of Participants**

Figure 2

*Trauma Informed Practice*

- **Number of Participants**

Figure 3

*Vicarious Trauma, Secondary Trauma and/or Compassion Fatigue*

- **Number of Participants**
Figure 4

*Trauma Informed Practice (TIP) at Haven Family Support*

<table>
<thead>
<tr>
<th>Achieved</th>
<th>Partially Achieved/In Progress</th>
<th>Not Achieved</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>4</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Number of Participants

Figure 5

*Education or Training*

- Discriminatory and stigmatizing language, practices, and biases, as well as inclusive and non-stigmatizing alternatives
- Self-awareness around assumptions, values, and beliefs about marginalized groups
- Residential schools, the 60’s scoop, and other colonial policies
- Domestic Violence
- Gender diversity training
- Anti-racism education
- Strength based, person focused practice
- Cultural Competency – including cultural practices, beliefs, differing cultural responses to trauma

Number of Participants
Figure 6

*Trauma Training*

![Bar chart showing the number of participants in trauma training categories: Achieved, Partially Achieved/In Progress, Not Achieved.](image1)

Figure 7

*Mental Health Services*

![Bar chart showing the number of participants in mental health services categories: Achieved, Partially Achieved/In Progress, Not Achieved.](image2)

Figure 8

*Trauma Informed Support Services*

![Bar chart showing the number of participants in trauma informed support services categories: Achieved, Partially Achieved/In Progress, Not Achieved.](image3)
Section 2: Support and Wellness

Of the 10 staff who responded to question nine, 9/10 (90%) agreed fully or in part, that Haven Family Connections, Haven Family Support encouraged wellness/self-care among staff (see Figure 9). 100% of respondents to this same question utilized at least some form of self-care/wellness practices or techniques (see Figure 10). Ninety percent (9/10) of the participants agreed at least in part that Haven Family Support had mechanisms to provide support to staff exposed to trauma or experiencing vicarious trauma, secondary trauma or compassion fatigue (see Figure 11).

Figure 9
Wellness/Self-care

![Wellness/Self-care Chart]

Figure 10
Self-care/Wellness Practices and/or Techniques

![Self-care Chart]
Section 3: Leadership and Supervision of Staff

Only two of the respondents (20%) identified that they felt Haven Family Support did not provide regular supervision with a supervisor who has an understanding of trauma and its impacts (see Figure 12). Nearly 80% of staff identified that during supervision, Haven Family Support supervisors included discussions that assisted staff in understanding their own feelings and responses to their work with clients (see Figure 13). Regular staff meetings including group supervision and knowledge exchange opportunities were something that almost 40% of staff felt were not occurring; however, half of the staff identified that this area was partially achieved by Haven Family Support (see Figure 14). Almost 45% of staff agreed that debriefing and/or discussion of ethical issues regarding personal and professional boundaries was encouraged and nearly 35% felt this was occurring some of the time (see Figure 15). Question 16 on trauma informed supports yielded mixed results; of the eight staff who answered the question, 25% believed that leadership was not allowing staff time and resources to focus on implementing trauma informed services, 50% identified this area was partially achieved or still in progress, and another 25% believed it had been achieved and was occurring (see Figure 16).
Figure 12

Trauma Informed Support

Figure 13

Supervision

Figure 14

Group Supervision
**Figure 15**

*Debriefing*

![Debriefing bar chart]

**Figure 16**

*Implementing Trauma Informed Services*

![Implementing Trauma Informed Services bar chart]

**Section 4: Screening and Assessment**

Of the 10 staff that completed the self-assessment, only seven chose to answer question 17. Of those that responded, 100% agreed that Haven Family Support is not currently using a trauma screening tool with the families they work with. Just under 30% indicated that this area was in progress/partially achieved (see Figure 17).
Eight out of 10 staff who completed the self-assessment answered the question in the safety category. Of those who responded, over half (62.5%) indicated that safety plans, including a list of safe people, strategies that were and were not helpful, and a list of stressors/triggers were being utilized with their clients at least some of the time (see Figure 18). Over 30% felt that these safety plans were not being utilized with clients (see Figure 18).

**Figure 18**

*Client Safety*
Section 5: Service Delivery and Policy

On average only eight staff answered the questions in the section pertaining to service delivery and policy. One hundred percent of respondents indicated that for the most part, the first contact between staff and the families that they work with is warm, respectful, engaging, and welcoming (see Figure 19). All respondents also agreed that Haven Family Support was utilizing a model of doing “with” rather than “to” or “for”, with 75% indicating this area had already been achieved and 25% indicating it was partially achieved or in progress (see Figure 20). The majority of staff also agreed that there are clear expectations about the process, roles and responsibilities, and next steps for clients when working with a family support worker, with 87.5% indicating this area was at least partially achieved or more (see figure 21). Half of respondents indicated that clients were informed, given choices and decision-making power over their level of participation and pacing of services and the other 50% believed this area to the partially achieved or still in progress (see Figure 22). Of the seven responses received for Question 23, less than 30% did not believe that the services provided by the family support workers at Haven Family Support were based on an evidence-informed, trauma informed model; however, more than half of all respondents felt this area was partially achieved/in progress and only 15% indicated this was achieved (see Figure 23).
Figure 19

_Figure Contact_

**Figure 20**

_“With” Rather Than “To” or “For”_
Figure 21

Clear Expectations and Process

Number of Participants

Figure 22

Choices

Number of Participants
**Overall Summary of Self-Assessment Results**

Of the 23 self-assessment questions, 70% of participants answered all questions. The findings of the survey suggest that many participants believe that Haven Family Support had already achieved the identified goals in many of the areas or was working towards the desired outcome. There were several areas where participants felt that more work was required by Haven Family Support, specifically around current training, support and trauma screening tools, and safety plans around triggers. Literature on trauma informed practice and becoming trauma informed speaks to the importance of adequate training and support for staff in order to best serve clients and avoid burnout (Canfield, 2008; Centre of Excellence for Women's Health, 2021; De Silva, 2009; Handran, 2015; Klinic Community Health Centre, 2020; Levenson, 2017). The results are also supported by the literature around the importance of trauma screening and safety plans (Centre of Excellence for Women's Health, 2021; Fallot & Harris, 2020; Klinic Community Health Centre, 2020). To gather further insight, the data obtained from the self-
assessment as well as the literature around trauma informed practice were utilized in the
development of the focus group questions.

**Qualitative Focus Group Findings**

Through the process of thematic analysis, four main themes emerged from the key ideas and statements that were identified from the participant focus group transcriptions. The four themes are: “a weight”; self-care/the importance of support; and learning - what is needed to become trauma informed; trauma is. A discussion of the four themes follows.

**Theme One: “A Weight”**

The feeling of being overwhelmed was prevalent in the data. One participant stated, “you kind of put yourself in that situation, how would you feel, what would you do and then take on all that responsibility like it's a weight on your shoulders” (Jasmine). This feeling was described multiple times by participants as “a weight” and many described it as something they carried around with them. These feelings seemed to stem not only from the type of work, but also the intensity of the job demands and perceived lack of supports, including lack of opportunities to debrief as well as lack of effective self-care. Many of the participants discussed the workload and demands of the job, and how they were not always encouraged to share experiences or debrief with co-workers. Participants stated that they often quickly moved from one client or family to the next without downtime in between, thereby getting stuck in a cycle that led to exhaustion. For example, Jasmine stated: “If someone needs to talk, like supporting other people, I find it just like so exhausting and that I can't help, but I want to, and then you just like carry that with you even more. It's kind of like a cycle.”

Participants’ discussion of not having the capacity to do enough was reflected by another participant who stated: “I just don't have the energy to help or to listen” (Jasmine). Participants
also shared the impacts of their work on their personal lives. “It just wears on you” (Ellen). One participant noted, “Especially with COVID now, there's nowhere to be together to talk about it so sometimes it then builds up and then you're carrying it home with you” (Ellen). It was also mentioned that “You start feeling bad that you can't help your own people that you love” (Deb). Another participant stated, “I feel like when I do feel that like burnout or compassion fatigue it's hard to like go through things in my personal life” (Lisa).

One focus group participant mentioned that “there's quite a few stories that I have heard that's affected me and how do you deal with all that” (Deb). Yet another stated, “it still comes back: you still think of it” (Lisa). Further to this, one participant mentioned, “We see a lot, we hear a lot” and “It's not something that you walk away where it's not impacting you. It's something that stays with you” (Ellen).

Theme Two: Self-Care/The Importance of Support

Another theme that emerged in participants’ responses was an emphasis on the importance of support and self-care. There was no discussion around one form of support being more beneficial than the other; support in general was viewed as beneficial. Forms of support ranged from informal, such as talking with a co-worker or taking time for themselves to having a bath or exercising, to more formal support, such as supervision and debriefing with supervisors and seeing a counselor. One participant stated that “the opportunity to expel what's building up within you and gather ideas and information, so I mean having breakout time like that, would be so powerful” (Lisa). Another focus group participant wondered “how to find that balance and sustain it without becoming burnt out” (Jasmine). For another, they found comfort in “being able to talk it out and let go of the feelings” (Ellen).
One common reflection when it came to the topic of support was the lack of opportunity for formal and informal support and debriefing. Participants highlighted that in-person debriefing was lacking even more due to COVID-19. Examples of what participants suggested would be helpful included: “Going to each other, because we all have that that common base of experience” (Ellen). “Have a time where we can show each other different ideas with other coworkers” (Deb). “Talk about some things and even laugh about it” (Lisa). “Being able to share like common themes and common feelings, it makes it feel better” (Deb). “That ability to just kind of debrief or vent” (Lisa). “Not everyone needs someone to give an answer, like we don't need an answer I just sometimes just need you to listen” (Robin).

Despite participants discussing a need for more support and additional opportunities for self-care/wellness, many identified current practices they engage in that work well and they find supportive. One participant stated, “When I talk about it, then I actually think about it differently, and I can break it down” (Robin). Another described their supportive co-workers by saying, “We have an amazing group of women and just about every one of them will give you a hug” (Ellen).

**Theme Three: Learning/ What is Needed to Become Trauma Informed**

Early in the focus groups, it became evident that participants had more knowledge and skills in trauma informed practice than they gave themselves credit. Haven Family Support employees used the following words to describe the knowledge and skills that were already present: “We need to be taking the time to develop a trust relationship” (Ellen); “Working alongside them and meeting them where they're at” (Lisa); “Looking back into that person's history” (Ellen). There was also a sense of eagerness to learn more in order to work more effectively with the families and build upon their lack of confidence in their current knowledge and abilities.
A lack of training opportunities, both initial and continuing education, was noted several times by multiple participants. Participants expressed that more opportunities for training would be welcomed and appreciated. Most, if not all, of the participants appeared to have an understanding of what they believed they needed in terms of training and education to work from a trauma informed lens. Participants expressed a desire for more training and education in areas related to triggers, trauma screening questions and tools, trauma informed practice techniques to avoid re-traumatization, the impacts of trauma, and available trauma informed supports in the community. Participants’ responses regarding additional training opportunities included: “Recognizing their triggers and helping them recognize their triggers” (Robin). “Realizing that sometimes like it affects your brain, so they maybe can't see things in a way that someone that hasn't had a lot of trauma can see it” (Lisa). “When working with someone, to be able to help them cope with their trauma and understand it” (Lisa).

**Theme Four: Trauma is…**

Trauma is an area in which all participants held knowledge and experience. They recognized many of the signs and symptoms of someone who has been exposed to trauma, and presented a good understanding of the various facets of trauma. For example, they described trauma as being “An experience” (Jasmine) that “[is] different for each person” (Ellen), and as “An experience, that it could be anything like either abuse or even just getting in a car accident” (Jasmine). Participants understood trauma to be perspective-altering: “Something that changes the way you look at things and it changes your brain” (Jasmine); “Something that someone has had that's changed their overall well-being and mental health” (Deb); “You look at things differently” (Lisa); “Something that affects more than just our thoughts, it affects our bodies” (Robin); “Trauma-impacted people don't allow a lot of people into a deeper level” (Robin).
**Summary**

Although it was apparent that there was a solid knowledge base of trauma among the team, to become trauma informed on a deeper practice level requires further training. Specific education on trauma informed tools, trauma informed services within the community, self-care, and ways in which to prevent and/or recognize and manage vicarious trauma and burnout, would provide insight and increase the team’s knowledge base to positively impact those who work at, interact with, and support Haven Family Support.

The results from the quantitative self-assessment provided insight into the current knowledge, practices and training of Haven Family Support staff. The findings from the qualitative focus groups provided a deeper level of understanding into the current knowledge base and current practices of the participants. It also provided insight into current feelings of being overwhelmed and experiences of vicarious trauma, which could lead to burnout. Overall, both the self-assessment and focus group data showed that staff currently have some experience and knowledge in many areas of trauma informed practice; however, they lack definition of their current abilities and confidence in trauma informed practice. From the findings, it was also apparent that although many of the staff are self-aware, there is a desire to do and know more.

The following chapter will include a discussion of the findings, the limitations of the research project, the implications for practice, and conclude with future recommendations for the agency and human service providers.
CHAPTER Five: Discussion

Although the experiences of the participants were unique, they shared many commonalities. Many significant stories and statements emerged from the focus groups with participants that were in line with the literature. One particular statement shared by a focus group participant stood out for me. I feel their words encompass, in a very broad but also descriptive manner, the overall experience of trauma, working with trauma survivors and why trauma informed practice is so vital. Trauma was described by this participant as “a weight.” Many other participants nodded their heads and verbally agreed with this description of trauma. That moment and description really encompassed a lot of the feelings for both the participants and myself.

The statement of trauma being “a weight” best described the overall feeling of the participants’ experiences in the work they do each day. It not only described how trauma can feel for those they are working with, but also how work with trauma survivors parallels how it is described in the literature (Ayala Malakh-Pines, 1988; Canfield, 2008; De Silva, 2009). Theme one “a weight,” resonates with research conducted by Horwitz (2008). Horwitz discussed caseload size as a common theme with those experiencing vicarious trauma. Horwitz (2008) also discussed vicarious trauma effects on professionals who were “unable to do enough for a specific client, [or] unable to do enough for clients generally” (p. 6). Theme four, “trauma is,” identified that participants were able to identify many impacts of trauma noted in the literature (Crandall, 2019; Felitti, 1998; Shaw, 2000). Participants talked about both positive and negative experiences. They discussed how it felt when they both were and were not feeling supported, and how great it could be when they were. They also talked about the strengths of the team they work with, and identified that some of the areas needed improvement. They shared stories of connections they had with families, and also identified feeling unable to do the work required
due to burnout or “taking it home.” The words “too much,” “overwhelmed,” and “burnout” were repeated, as were the words “talking,” “caring,” “support.” These findings also mirror what the literature says around vicarious trauma, secondary trauma, compassion fatigue and burnout (Ayala Malakh-Pines, 1988; Canfield, 2008; De Silva, 2009). The participants not only had vast knowledge and lived experiences of both personal and professional trauma, but also had a desire to learn and know more in order to better serve the families they work with. There was a clear desire to do better, including avoiding burnout and creating a support system in order to stay healthy and positive in their role. Much of the literature around trauma informed practice emphasizes the importance of these things both as individual staff members and an agency or organization as a whole (Centre, 2020; Fallot & Harris, 2020; Handran, 2015). Participants expressed an openness to doing things differently and expanding their tools and skills in order to work from a trauma informed lens.

The implications of this research could positively impact educators, policy makers, and professionals working in the helping professions, which in turn assists the clients served. The data collection revealed the need for further education and training for professional agencies and students in the field of social work and other professions who work with vulnerable populations. Enhanced knowledge in the areas of vicarious trauma, secondary trauma, compassion fatigue and burnout could be obtained through more training for those working in helping professions. In turn, this could lead to increased support and understanding for individuals working with trauma survivors by supervisors, management, family members, and friends. Workplaces could improve access to more formal supports such as counselling or debriefing sessions for professionals, making self-care a priority. Policies could be developed making continued education around
vicarious trauma and forms of self-care not only recommended, but mandatory, for those working in environments where vicarious trauma is common.

As identified in the literature, becoming trauma informed requires that organizations include trauma informed policies and practices not only for practice with clients but also for employees, including responding to vicarious trauma and burnout (Centre, 2020; Fallot & Harris, 2020). Through my review of the literature, the data from the self-assessments, and virtual focus groups, the need for more research in this area has become evident. This research could provide guidance for agencies and organizations around the necessity of increased support. It could also assist to reduce the impacts of the work on those working in the helping professions and the clients they serve. In turn, the research results could improve outcomes for clients when a trauma informed approach is utilized on both macro and micro levels.

Recommendations

Based on my review of the literature and the findings from the survey and focus groups, I present several recommendations at the micro and macro levels. As the focus of this research project was specific to trauma-focused knowledge and training, the following recommendations, for both the agency and individual staff, concentrate on the same areas. The recommendations are categorized into micro and macro: micro being recommendations for employees, and macro being recommendations for the organization.

Bloom (2015) discusses the impacts of chronic stress on an organization. Like individuals who have experienced trauma, organizations who work with clients impacted by trauma without the proper supports, policies, and practices in place, can slide into dysfunction and become deficient of adequate service delivery (Bloom, 2015). Bloom (2015) discusses how chronic stress in an organization can lead to a loss of safety and trust, which are paramount to trauma informed
practice. Similarly, Richardson (2001) discusses how working with individuals and families with trauma histories can lead to vicarious trauma, compassion fatigue and burnout. When an organization is struggling with traumatization, Bloom (2015) describes it as being a “parallel process.” Therefore, not only does the organization and staff suffer the negative outcomes of trauma; the impacts are felt by those they serve and support (Bloom, 2015). It is crucial that when an agency is becoming trauma informed, all areas are considered, including employees, hiring, practices and policies, and that necessary changes are implemented at all levels.

**Macro: Recommended Changes at the Agency Level**

*Recommendation One: Increase training in trauma informed practice*

It is pertinent that an agency wishing to become trauma informed ensures staff understand and embrace the foundations of trauma informed practice. Based on the findings in this study, many staff identified they did not have adequate training on trauma informed practice and felt they could benefit from both further training and updates. It is recommended to provide training to staff upon hire as a part of orientation as well as regular updates during training days or in-services to ensure the agency’s dedication to offering services that are trauma informed flows through to staff (Accessing Safety and Recovery Initiative and National Center on Domestic Violence, Trauma & Mental Health, 2020). It is imperative that this training includes information on the provision of trauma informed services, culture, accessibility and violence (Accessing Safety and Recovery Initiative and National Center on Domestic Violence, Trauma & Mental Health, 2020).
**Recommendation Two: Increase training on and implementation of trauma screening questions or a separate trauma screening tool at intake**

Staff identified that currently no such tool or questions are being used in the organization. This can be either a formal screening tool or informal questions that are included as a part of the intake process. This may aid in the assignment process, ensuring that a parent or family is matched well with a family support worker that will best meet their needs based on past experience, skill and knowledge base (Accessing Safety and Recovery Initiative and National Center on Domestic Violence, Trauma & Mental Health, 2020). Clients should always be given the option of whether or not to respond to questions; however, questions about any safety concerns, history or patterns of abuse, mental health or substance misuse should be included (Accessing Safety and Recovery Initiative and National Center on Domestic Violence, Trauma & Mental Health, 2020). It is also essential to include questions related to barriers to safety, current coping strategies and supports and what the client’s goals are for the interaction with the agency (Accessing Safety and Recovery Initiative and National Center on Domestic Violence, Trauma & Mental Health, 2020). Furthermore, staff need to be trained to be able to respond appropriately to disclosure and ensure questions are asked with sensitivity to ensure clients are not re-traumatized (Accessing Safety and Recovery Initiative and National Center on Domestic Violence, Trauma & Mental Health, 2020).

**Recommendation Three: Enhance supervision of staff, including group supervision, debriefing sessions specifically after traumatic events or experiences, and also as requested**

Participants identified that supervision was already occurring in their work. However, participants indicated that additional group supervision and debriefing sessions would be beneficial and helpful to staff. It is crucial that an agency provide the necessary support to staff,
especially when those staff are regularly working with individuals and families who have experienced significant trauma (Accessing Safety and Recovery Initiative and National Center on Domestic Violence, Trauma & Mental Health, 2020). Staff and those in supervisory or management roles that support them need adequate training around vicarious trauma, burnout, and self-care, including how to be supportive of individuals experiencing these phenomena (Accessing Safety and Recovery Initiative and National Center on Domestic Violence, Trauma & Mental Health, 2020). Part of this is having the knowledge of and ability to refer to outside supports within the community when necessary (Accessing Safety and Recovery Initiative and National Center on Domestic Violence, Trauma & Mental Health, 2020). Support does not always come from the top down and as mentioned multiple times in the focus groups, co-workers play a large role in staff support networks. Not only is it essential to provide regular supervision of staff and ensure the one providing the support is thoroughly trained and knowledgeable in trauma, vicarious trauma and trauma informed practice, it is also extremely beneficial to utilize co-workers in group supervision and peer support or consultation. Co-workers not only often have had similar experiences but also are on the same level within the agency, creating a different support dynamic (Accessing Safety and Recovery Initiative and National Center on Domestic Violence, Trauma & Mental Health, 2020).

**Micro: Recommended Changes at the Individual Level**

*Recommendation One: Incorporate the use of trauma informed tools, such as safety plans and trauma screening questions, and increase understanding and knowledge of various community supports including trauma informed support services*

Staff identified that no trauma informed tools such as trauma screening tools were currently utilized. Although some staff identified that they are utilizing safety plans, this was not
the case for all staff, with no formal or consistent tools in place. It is important that staff understand and utilize trauma informed tools but also have the ability to respond when disclosures of past or current traumas are made (Accessing Safety and Recovery Initiative and National Center on Domestic Violence, Trauma & Mental Health, 2020). Part of this includes having the knowledge of what trauma informed support services are in the community to be able to make necessary referrals (Accessing Safety and Recovery Initiative and National Center on Domestic Violence, Trauma & Mental Health, 2020). Additionally, it is imperative that staff discuss with their clients possible triggers and a safety plan to ensure that the clients have a safe place or person to access if they are triggered or feel unsafe (Accessing Safety and Recovery Initiative and National Center on Domestic Violence, Trauma & Mental Health, 2020). Part of the discussion around safety plans should include current coping strategies and supports and utilize a strength-based, client-centred approach to empower the client and ensure the process avoids re-traumatization (Accessing Safety and Recovery Initiative and National Center on Domestic Violence, Trauma & Mental Health, 2020). Trauma screening questions do not need to be part of a formal process; however, it is important they are utilized at the beginning of the support/client relationship to establish any safety concerns, boundaries and impacts (Accessing Safety and Recovery Initiative and National Center on Domestic Violence, Trauma & Mental Health, 2020). Part of this process includes listening, normalizing trauma responses and ensuring a safe space for meetings (Accessing Safety and Recovery Initiative and National Center on Domestic Violence, Trauma & Mental Health, 2020).
**Recommendation Two: Ensure that clients have choices regarding service delivery and input wherever possible**

When working from a trauma informed lens, clients must have a sense of control over their situation (Accessing Safety and Recovery Initiative and National Center on Domestic Violence, Trauma & Mental Health, 2020). Although participants indicated that clients were involved in case planning, it was acknowledged that this area could be improved upon to ensure it is being done consistently. Staff should be empowering the parents they are working with and giving them choices whenever possible such as meeting days/times and topics of discussion (Accessing Safety and Recovery Initiative and National Center on Domestic Violence, Trauma & Mental Health, 2020). It is also imperative that clients are fully informed of the process including as much detail as possible without overwhelming them, while taking into consideration that the process may be intimidating or triggering (Accessing Safety and Recovery Initiative and National Center on Domestic Violence, Trauma & Mental Health, 2020).

**Recommendation Three: Work towards self-wellness to prevent burn-out, including seeking support as required, making time for self-care, and understanding the importance of personal and professional boundaries**

The majority of participants discussed dealing with vicarious trauma and compassion fatigue. Many also shared struggles with self-care and burnout prevention. It is important that not only the agency provides adequate supports for staff around vicarious trauma, compassion fatigue and burnout to ensure staff have the capacity to provide trauma informed services but also that staff seek the necessary supports for themselves and have adequate self-care/wellness practices (Accessing Safety and Recovery Initiative and National Center on Domestic Violence, Trauma & Mental Health, 2020). Part of this is being self-aware, having boundaries with clients...
and co-workers, and addressing their own responses and triggers when they come up (Accessing Safety and Recovery Initiative and National Center on Domestic Violence, Trauma & Mental Health, 2020). For some, further training and referrals to outside supports may be necessary to accomplish this (Accessing Safety and Recovery Initiative and National Center on Domestic Violence, Trauma & Mental Health, 2020). It is also important for staff to have opportunities for further education and learning in these areas, as well as the opportunity to debrief, seek peer support and supervision, and lean on supportive relationships with supervisors and managers (Accessing Safety and Recovery Initiative and National Center on Domestic Violence, Trauma & Mental Health, 2020).

**Limitations and Strengths**

This research is not without limitations. Due to my own history of employment as a child protection worker who has worked closely with Haven Family Support in the past, my personal biases would have been present in my interview questions and data analysis. Although I aimed to remain aware of my own personal biases, opinions, and values throughout the research project, they naturally impacted this study. Creswell (2013) discusses a term called “bracketing” in which the researcher identifies their experiences with the phenomena in their discussions. I believe it to be impossible to completely “bracket” or set aside all prior knowledge or experiences. Initially, I intended to keep a reflective journal; however, I abandoned this approach as I was finding it overwhelming and instead practiced reflective thought and meditation throughout my research project. I also had discussions and debriefed with my supervisor throughout the work. As discussed previously, I believe that knowledge is co-created and all knowledge builds upon previous knowledge; therefore, it impossible to completely separate the researcher’s biases from the research.
The COVID-19 global pandemic presented several limitations. All components of the research project had to be conducted virtually. Not everyone is comfortable with this format of research, which may have impacted the study and its findings. Further, due to a variety of reasons including the pandemic, some employees were on leave and therefore unable to participate, which left the research project with a smaller sample size. Despite limitations in the research study and the critiques of the trauma informed practices, the data revealed important understandings for me in the practicum and, importantly, for the agency. The findings informed the recommendations which were made on both a micro and macro scale and are presented in the following section.

Conclusion

The purpose of this research practicum was to assist Haven Family Connections, Haven Family Support with building staff capacity on vicarious trauma and trauma informed practice. This was attained by first assessing the organizational knowledge of trauma informed practice and vicarious trauma and identifying gaps in education and training for the Haven Family Connections family support workers. The literature review revealed that trauma informed self-assessments are often utilized with agencies and organizations wanting to gain further understanding of their needs in next steps to becoming trauma informed. As such, the literature review informed the development of a trauma informed practice self-assessment tool, adapted from current trauma informed self-assessment tools. The newly created trauma informed self-assessment, which was completed by 10 Haven family support workers, provide this starting point for Haven’s work in trauma informed practice, alongside qualitative data collected through virtual focus groups.
Findings revealed that the family support workers at Haven Family Connections, Haven Family Support had some level of knowledge and training around trauma, vicarious trauma and trauma informed practice. The findings also revealed that the agency was, to some extent, already practicing a number of key elements of trauma informed practice. Study participants identified safety plans already in use, a warm, respectful and engaging first contact approach, and working from a model of “doing with” rather than “doing for or to.”

Alongside this wealth of organizational knowledge and experience among staff, the findings identified areas needing further development. The family support workers had varying levels of knowledge and experience with regards to trauma, trauma informed practice and trauma informed support services within the community. Although it was evident staff had some training in these areas, further understanding and development will be required in order for the family support workers to fully incorporate a trauma informed lens into their practice. Many of the participants discussed lived experiences of dealing with trauma and trauma survivors. Common themes emerged around the “weight” some participants felt they carried due to working with families who have experienced trauma. The need for further support and self-care was identified. Participants also discussed burnout and feeling like there were times they could not give what was needed in their personal lives. At the same time, many of the participants discussed various self-care or wellness strategies that they utilized when feeling this way.

The themes revealed within the data reflected themes in the literature. Vicarious trauma, compassion fatigue, and burnout are common amongst those working in helping professions, and the need for self-care is apparent. Further training to expand on already-developed knowledge and skills in the areas of trauma and trauma informed practice would greatly aid workers to
better support those they serve. This would enhance workers’ already deep levels of compassion and empathy, understanding and respect for the lived experiences of their clients.

The final goal of this research practicum was to develop a training guide on trauma, trauma informed practice and vicarious trauma for Haven Family Connections, Family Support Workers. The completion of this goal was attained in three parts: 1) collecting both survey and focus group data through a self-assessment and two online focus groups; 2) completing data analysis using descriptive statistics and thematic analysis; 3) summarizing the results through the development of trauma informed practice recommendations to guide the agency in future development in their work towards becoming trauma informed. The recommendations were delivered as a virtual presentation on June 22, 2021.

This research practicum enabled me to meet all of my learning objectives that were detailed in the initial research proposal. While I was unable to spend any time in person at the agency due to the COVID-19 pandemic, I was able to routinely connect virtually with my supervisor, agency management, and the family support workers through scheduled Zoom meetings, virtual staff meetings, and the two virtual focus groups. This allowed me to work closely with Haven Family Connections to develop a suitable self-assessment tool and create applicable and appropriate focus group questions. Their guidance helped ensure that the data collection would meet the needs of the agency and my research practicum outcomes. Through the data collection and analysis, I was able to gain an in-depth understanding of the family support workers’ current knowledge and skill base around trauma and trauma informed practice. This allowed me to provide recommendations which will contribute to the future goal of increasing knowledge and understanding of trauma informed practice in order to become a trauma informed agency.
The family support workers with Haven Family Connections collectively have a tremendous amount of knowledge, experience and passion for what they do. They have many skills and abilities that they are already utilizing which are in-line with taking a trauma informed approach. By implementing the recommendations outlined within this report, I believe the agency will gain new and useful tools to enhance their work with trauma survivors. The staff will gain confidence through further knowledge in utilizing a trauma informed approach. This will in turn work towards the collective goal of ensuring clients are not re-traumatized while accessing services. This combination will assist the agency in working towards becoming trauma informed for the benefit of the agency, the employees and the individuals they serve.
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Appendix A

Trauma Informed Care Assessment

Haven Family Connections, Haven Family Support 2020/2021

The purpose of this assessment is to gain understanding of the policies, current environment and practice implementation, as well as current knowledge of, if and how the parent aides are implementing the guiding principles of trauma informed practice. This study and assessment have been reviewed and approved by the University of Regina Research Ethics Board. Please answer the questions below to the best of your ability. This data will be used to inform findings and recommendations as well as to develop a training guide around trauma informed service delivery within the Parent Aide Program. This assessment is anonymous and confidential. The completion of this assessment is voluntary and consent is implied by completion. Once completed there is no longer an option to withdraw as a participant due to the anonymity and confidentiality mentioned above.

For all questions below with the answer options of “achieved, partially achieved/in progress, not achieved, not applicable”, please answer based on your assessment of the Parent Aide Programs currently implemented practice, policies and mandate.

Knowledge and Training:

-Do you know what trauma is?
  - Yes
  - No
  - Unsure

-Do you have knowledge of and/or experience with trauma informed practice is (TIP)?
  - Yes
  - No
  - Unsure

-Do you have knowledge of and/or experience with vicarious trauma, secondary trauma and/or compassion fatigue?
  - Yes
  - No
  - Unsure

-The Parent Aide program is currently trauma informed?
  - Achieved
  - Partially Achieved/In Progress
-Do you have education or training on any of the areas listed below? If yes, please check those that apply to you or check no if you have not received education or training in any of the areas.

- Trauma
  - Vicarious Trauma, Secondary Trauma, Compassion fatigue, Burn Out
  - Trauma Informed Practice
  - The links between mental health, addictions and trauma
  - Systemic trauma
  - Re-traumatization
  - Intergenerational Trauma
  - Cultural Competency – including cultural practices, beliefs, differing cultural responses to trauma
  - Strength based, person focused practice
  - Anti-racism education
  - Gender diversity training
  - Domestic violence
  - Residential schools, the 60’s scoop, and other colonial policies
  - Self-awareness around assumptions, values, and beliefs about marginalized groups
  - Discriminatory and stigmatizing language, practices, and biases, as well as inclusive and non-stigmatizing alternatives
  - No

-All staff receive training specific to trauma, both initially upon employment and updated as needed.

- Staff receive training and are made aware of trauma-specific mental health services in the community in which they work.

- Staff receive training and are made aware of specialized trauma informed support services in the community in which they work (ie. Services specific to LGTBQ, Indigenous, newcomers, or those experiencing domestic violence).
- Wellness/Self-care is encouraged among staff.
  - Achieved
  - Partially Achieved/In Progress
  - Not Achieved
  - Not Applicable

- Do you utilize any Self-care/Wellness practices and/or techniques?
  - Yes
  - No

-Haven Family Support has a mechanism to provide supports to staff who have been exposed to trauma or experienced vicarious trauma, secondary trauma or compassion fatigue
  - Achieved
  - Partially Achieved/In Progress
  - Not Achieved
  - Not Applicable

Leadership and supervision of Staff:

- Staff who have contact with survivors of trauma have regular supervision from someone who has an understanding of trauma and its impacts.
  - Achieved
  - Partially Achieved/In Progress
  - Not Achieved
  - Not Applicable

- During supervision discussion occurs to assist staff in understanding their own feelings and responses to their work with clients.
  - Achieved
  - Partially Achieved/In Progress
  - Not Achieved
  - Not Applicable
- Staff have regular staff meetings in which there is an opportunity to utilize group supervision and exchange knowledge on working with individuals who have experiences of trauma and trauma informed service delivery.
  
  - Achieved
  - Partially Achieved/In Progress
  - Not Achieved
  - Not Applicable

- Debriefing and/or discussion of ethical issues regarding personal and professional boundaries is encouraged.
  
  - Achieved
  - Partially Achieved/In Progress
  - Not Achieved
  - Not Applicable

- Leadership allows staff time and resources to focus on implementing trauma informed services.
  
  - Achieved
  - Partially Achieved/In Progress
  - Not Achieved
  - Not Applicable

**Screening and Assessment:**

- Haven Family Support currently utilizes trauma screening tools?
  
  - Achieved
  - Partially Achieved/In Progress
  - Not Achieved
  - Not Applicable

**Safety:**

- Clients have individual safety plans including a list of stressors/triggers, helpful and non-helpful strategies and a list of safe people.
  
  - Achieved
  - Partially Achieved/In Progress
  - Not Achieved
  - Not Applicable

**Service Delivery and Policy:**

- The first contacts with clients is warm, respectful, engaging and welcoming?
- Haven Family Support utilizes a model of doing “with” rather than “to” or “for” clients?
  
  o Achieved
  o Partially Achieved/In Progress
  o Not Achieved
  o Not Applicable

- There are clear explanations for the clients about the process, roles and responsibilities and next steps in working with each parent aide.

  o Achieved
  o Partially Achieved/In Progress
  o Not Achieved
  o Not Applicable

- Clients are informed about and given choices and decision making over their level of participation and pacing of services wherever possible.

  o Achieved
  o Partially Achieved/In Progress
  o Not Achieved
  o Not Applicable

- Services are based on an evidence-informed, trauma informed model.

  o Achieved
  o Partially Achieved/In Progress
  o Not Achieved
  o Not Applicable

'This survey was adapted from the Klinic in Winnipeg – TIC toolkit, Trauma informed practice guide BC Provincial mental health and substance use planning council. May 2013, Trauma informed services: A self-assessment and planning protocol, version 1.4 and Creating Cultures of Trauma informed Care (CCTIC): A Self-Assessment and Planning Protocol
Appendix B

Virtual Focus Group Discussion Guide

Duration: 60-90 minutes
Approximate number of participants: 6
Researcher/Facilitator Name: Erin Gagne

Internet users: Zoom link and password to be provided.
Non-internet users: a telephone number will be provided for participants to call into the Zoom video call

Meeting Agenda:

Part 1. Preliminaries (15 minutes). Facilitator will:
   a) Conduct brief introduction and overview of the project. Explain the purpose of the project and the focus group.
   b) Explain privacy, confidentiality, and consent forms.
   c) Remind participants they do not have to answer any questions that make them uncomfortable and that they are free to leave the focus group at any time.
   d) Explain online focus group process, including procedures using Zoom technology effectively during interaction and discussion.
   e) Begin recording.

Part 2: Focus Group Discussion

Questions:
How would you describe or define trauma in general?
How would you describe trauma informed practice?
Tell me about how you utilize trauma informed practice in your work?
What training topics would enhance your confidence in utilizing trauma informed practice?
How would you describe vicarious trauma, secondary trauma or compassion fatigue?
What wellness, self-care or coping strategies have you utilized or found helpful in your experiences (if any) of vicarious trauma, secondary trauma or compassion fatigue?

Part 3: Conclusion and De-briefing (15 minutes).

a) Ask participants if they have anything further to add to the discussion.
b) Conclude by reminding participants of confidentiality and thanking the participants for their time, energy, and ideas.
c) Stop recording.

__________________________