

Adverse Childhood Experiences (ACE) / Trauma Informed Resource Guide

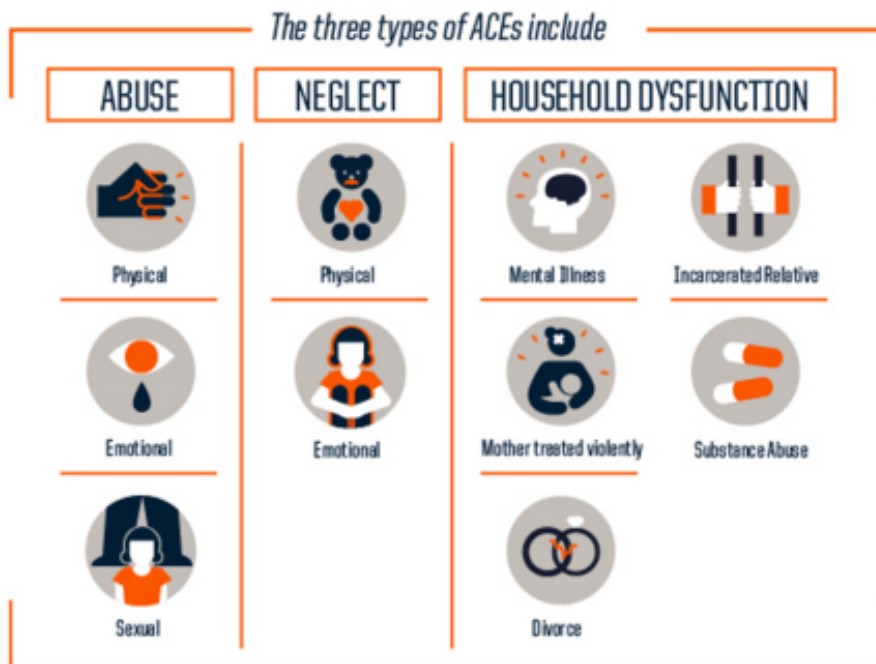
September 2016



EMAIL: ACESatCAAMHPP@albertahealthservices.ca

Background

The original Adverse Childhood Experience (ACE) study (Felitti et al., 1998) was initiated by Drs. Vincent Felitti and Robert Anda specialists in preventive medicine at Kaiser Permanente Health Management Organization in San Diego and the US Centre for Disease Prevention. Felitti and Anda composed a ten (10) item questionnaire, from multiple sources/existing measures, in order to survey members of the Kaiser Permanente health plan. Although there are others researching the area of adverse childhood experiences, such as child abuse/neglect (e.g., Trocme, Finkelhor, Perry), the nature and size of the data-set established by Felitti's group was able to establish a strong association to health and mental health outcomes. This combined with the group's effective health promotion prevention initiatives have brought ACEs into the forefront of health professionals, educators and child welfare specialists.



ACE & Health Outcomes:

Compared to people with 0 ACEs, those with 4 ACEs were:

- 12 times more likely to have attempted suicide
- 460% more likely to be depressed ,
- 7 times more likely to be an alcoholic,
- 10 times more likely to have injected street drugs
- 240 percent greater risk of hepatitis,
- 390 percent more likely to have chronic obstructive pulmonary disease

www.thepermanentejournal.org/files/PDF/Winter2002.pdf

How is the ACE questionnaire and trauma informed care any different from what we are already doing?

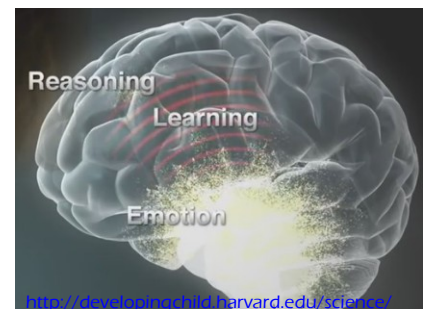
"ACE and trauma informed care is just doing what we've always done – it's a "reframe" not a "new frame" -Anonymous

The ACE questionnaire provides a way to systematically assess for childhood trauma to support clinical practice. The data collected will help direct broader program and system change with regards to the way we understand mental health concerns and develop services to meet the needs.

Why is CAAMHPP investing in ACE?

To align with larger system priorities including:

- * Addiction & Mental Health Review recommendations,
- * CAAMHPP Strategic Plan 2016-2020 and,
- * Research in the developing brain and the impact of toxic stress (Centre on the Developing Child, Harvard University)



Executive Summary

A clear linear relationship exists between the number of Adverse Childhood Experiences (ACEs) an individual reports and many of the different types of problems you may see in your patients and/or their families every day such as early drug use, addictions, promiscuity, teen pregnancy, depression, suicide attempts, life dissatisfaction, school failure and a myriad of social functioning challenges. Research has also shown that it is not unusual for the problems to get worse over the life span. For example, people who report a high number of ACEs are more likely to do poorly in school, be unemployed and live in poverty. They are more likely to be involved in violence and criminal activity and have higher rates of incarceration. ACEs may be linked the adoption of health-risk behaviours, which in turn may be linked to disease, disability, social problems, and even early death. Research shows that ACEs are associated with higher risk for health problems such as liver disease, coronary heart disease, stroke, diabetes, cancer, injuries, HIV and STDs.

CAAMHPP is incorporating the use of the ACEs questionnaire into our work because the evidence of its impacts are clear:

1. The score on ACEs provides insight into an individual's possible health risks, inclusive of addiction, mental health, cardiac health, stroke, sexual health, cancer, and other medical conditions
2. It highlights valuable, clinically relevant information in a systematic way (many clinicians ask about these topics already);
3. Individuals who complete the ACEs questionnaire and understand its meaning show less health utilization, even when no other intervention is provided.

We think this will have a significant impact on how we provide care to children and families who access our services and help our system better respond to growing demands.

ACE Mission & Implementation

The mission of the ACE Initiative is to identify, treat and reduce cumulative mental health risks by reviewing available research; applying this research to our clinical practice; capturing and analyzing CAAMHPP ACE data; developing opportunities for knowledge translation and; developing system-wide service provision which targets the reduction in the cumulative risks associated with high ACE scores.

By September 1, 2016

All patients and families seen within CAAMHPP will be asked about Adverse Childhood Experiences and their score will be centrally recorded in RAIS.

By March 31, 2018

This information will be used to clinically inform treatment offered to all patients and families seen within CAAMHPP.

By March 31, 2020

Service provision will be targeted to reduce the cumulative harm associated with high ACE scores.

Trauma is Not Just One More
Thing on Your Plate;
It **IS** the Plate.

Chris Blodgett



Patient/Family Centred Care & Trauma-informed Care

Together **Patient and Family-centred Care** and **Trauma-informed Care**, form the philosophy of care for CAAMPPHs ACEs initiative.

Patient and Family Centred Care (PFCC)

Is an approach to the planning, delivery and evaluation of health care that recognizes the key role that families play in ensuring the health and well-being of young people and family members. This philosophy of care guides the thinking of health care professionals about health care delivery and our way of 'being' with patients and families that informs all aspects of our practice as mental health professionals. Simply stated, PFCC recognizes that how an intervention is being delivered may be as important (and possibly even more important) than what is being delivered. PFCC evolved from a *Patient-centred Care* philosophy to care, which emphasized the patient/client as a key collaborator in the health care team, but failed to include family members, including parents/caregivers and extended family as resources and essential partners. PFCC extended patient/client centred philosophies to make families (as defined by the patient) integral to the care process.



The Institute for Patient and Family-Centred Care (www.ipfcc.org) identify the following as core concepts/values of *Patient and Family-centred Care*:

Respect & Dignity:

Mental health professionals listen to and honor patient/family perspectives and choices. Patient/family knowledge, values beliefs and culture are incorporated in the planning, delivery and evaluation of care.

Information Sharing:

Mental health professionals communicate and share complete and unbiased information with patients/families in a manner that is affirming, accessible and useful. In order to facilitate effective participation in care and decision making patients/families receive timely, complete and accurate information including clinical wisdom and best-evidence from research (consistent with evidence-based practice).

Participation & Collaboration: Patients/families are encouraged and supported to participate in care and decision-making at the level they choose. Mental health professionals at all levels (e.g., support staff, clinicians, physicians, leadership), collaborate with patients/families at all levels of policy, program and facility design, creation/implementation and review/evaluation including educational programming and delivery of care.

Building on PFCC, a group in British Columbia, led by Keli Anderson and Dr. Jana Davidson, focused on mental health/health-care reform and improvement emphasized the importance of moving beyond collaboration towards *empowerment*. The *FamilySmart* framework, extends the PFCC philosophies by inviting the health care system and health-care providers to consider how practice and policy can empower young people families to be primary decision makers in relation to their care.

Trauma-Informed Care

Trauma-informed care (TIC) alternately referred to as Trauma-informed practice (TIP) or Trauma-informed services (TIS) are philosophies of care that are highly congruent with the central values/principles of PFCC. However, TIC are essential to CAAMHPPs ACEs initiative as this philosophy of care recognizes and accounts for the significant role trauma can play in the health and well-being of individuals and families and in how they experience mental health services and professionals: an essential element not explicit within PFCC.

As a philosophy of care TIC is universally applied, meaning that this approach does not require a disclosure of trauma. Rather TIC assumes service users may have, or even likely have, experienced trauma, and would therefore benefit from services that privilege safety (physical, emotional, spiritual), choice and control throughout the spectrum of their engagement with the mental health system. There is an important distinction between TIC and trauma-specific services (see Arthur et al., 2007) in that trauma-specific services (alternately referred to as trauma-focused) are evidence-based intervention services that include a specialized assessment that focus on treating trauma, provided by specialist practitioners (those trained in trauma-focused work with that specific population).

These specialty services and specialized clinicians work within a larger TIC environment that embraces the values/principles as outlined in the British Columbia *Trauma-informed Resource Guide* (Arthur et al., 2007):

Trauma awareness: TIC begins with building awareness with staff and consumers regarding the true prevalence of trauma (as is possible via the systematic collection of ACEs throughout CAAMHPPs), the impact of trauma on development and functioning, the subjective and diverse ways people experience & cope with trauma, the association between trauma, substance use, physical and mental health concerns.

Safety & Trustworthiness: Integral to TIC is safety (physical, emotional, spiritual, cultural) for clients. Many clients will have experienced trauma, particularly within relationships with power differentials and/or may be currently in unsafe relationships or environments. Mental health professionals can help facilitate increased safety and trustworthiness through empowerment and relational practices, providing clear information to inform decision, modify and optimize physical spaces to reduce stress factors, and build stability and predictability within services and practices. The professional culture and practice of services must also shift to recognize staff safety needs that mitigate burnout and vicarious trauma, including supervision, educational and self-care opportunities and team-based structures and practices that embody TIC principles.

Choice, Collaboration & Connection: TIC seeks to empower young people and families fostering a sense of personal control, self-efficacy and self-determination throughout their engagement with the health system and beyond. Mental health professionals strive to equalize power-imbalances through open communication and develop genuine collaborations that honour the choices and decisions of young people and their families. Having the opportunity to establish safe connections is considered reparative for those who have experienced trauma.

Strength-based and Skill Building: Empowering young people, families and staff to identify and develop their strengths, coping and resilience.

TIC has facilitated a shift in paradigms among mental health clinicians and services espousing traditional psychiatric models, such as 'What's wrong with you?' towards a new perspective of 'What's happened to you'. However, in tertiary mental health settings, this stance, which at times can privilege case formulations with environmental etiologies for mental health concerns (e.g., abuse and/or adverse experiences) may not always adequately account for biological-based mental health presentations (e.g., Bipolar, Schizophrenia, ADHD), leading to the other perspectives, such as a 'What's happened to you and/or what's happening for you?' approach that merges a *Recovery Approach* with TIC and PFCC.



* Of the ACE scores entered into RAIS, 40% of had an ACE score of 4 or higher

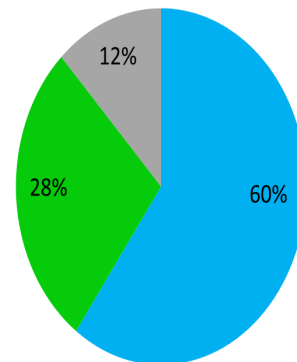
ACE Data Entry in RAIS (Regional Access & Intake System)

- * From the registration information, click the **ACE SCORE** tab to enter all ten questions on the Adverse Childhood Experiences (ACEs) survey.
- * **ACE Outcome** – indicates whether this information has been "Collected", "Not Collected" or the "Client Refused"
- * An outcome of "**Collected**" should be entered if the ACEs has been collected, and all 10 questions must then be entered with pick list options of "Yes", "No", or "Unknown". If some information is missing or the client has refused to answer any individual questions, "Unknown" can be entered as needed.
- * An outcome of "**Not Collected**" can be entered if you are not able to collect the ACEs information and "**Client Refused**" can be entered if you try to collect the ACEs but your client refuses. In either case, the remaining 10 questions can be left blank.
- * The overall "Patient ACE Score" will be automatically generated based on the number of 'Yes' answers entered. Each answer of 'Yes' is scored as a 1.

ACE SCORES ACROSS CAAMHPP

Breakdown of ACE Incidence across CAAMHPP

■ 0 - 3 ACE ■ 4 - 6 ACE ■ 7 - 10 ACE



ACE Report in RAIS

- * A **Patient ACEs Report** has been developed to allow you to print off your ACEs entry if required. There is a button to run this report from the ACEs page.
- * The report includes the patient and clinic information, all ten questions and answers, and the total Patient ACE Score.



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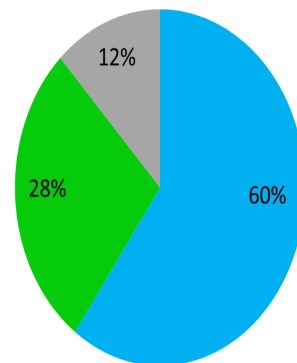
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PRACTICE CONSIDERATIONS

While the information on the survey is now a required part of the record within CAAMHPP, it is really up to the clinician to find the goodness of fit with their practice in regards to how this information is gathered for the record. The remainder of this section of the guide is not to inform you about how to complete the survey, rather the focus is on how you might use the results of the survey to inform the care plan and your intervention strategy.

Am I opening a 'can of worms' that I will not be able to manage?

- Screening is therapeutic if done well
- Is a relevant part of individual & family history
- Can open conversations that otherwise would not have taken place
- Don't ask, don't tell is perhaps not the best policy
- Becoming trauma informed and knowing where to refer for trauma focused services may lessen clinician anxiety.
- Not asking prohibits a full understanding of the child's difficulties.
- The information you collect may not inform your clinical practice at the moment but may help inform your colleague's treatment plan down the road.

As with any psychiatric interview, the focus must primarily be on engaging and reassuring the individual being interviewed.

As with any psychiatric assessment, the personal nature of the questions that are asked about a person's presenting problem in history may produce a stress reaction, and clinicians should be aware of this, and, depending on the setting in which they are completing the survey, care provider will need to have access to backup resources in the event of the results of the survey precipitating a crisis for the individual.

In regards to the comfort of patients completing is questionnaire in a waiting room in a primary care setting, recent research reviewed but not yet published indicates that patients do not, on the whole, suffer stress from providing we're discussing the information the adverse childhood experience survey.

Furthermore, in the study patients were apparently comfortable with the information being on their record and used to guide intervention.

Everyone is capable of practicing in a trauma informed way

How Trauma Informed Care Is A Systematic Approach To Ensure All People Receive Care That Is Sensitive To The Impact Of Trauma

<http://insite.albertahealthservices.ca/amh/tms-amh-trauma-informed-practice.pdf>

How do I use the ACE Questionnaire????

It's okay to be flexible! Within CAAMHPP, many programs and staff are adapting the ACE questions to better suit their clients. The process for collecting ACE information also varies from program to program. For example, some programs ask the client to fill out the questionnaire; some programs go through the questionnaire with clients; others ask only select questions to augment information they already have on hand. Talk with your colleagues and manager and determine what works best for you, your program, and your clients.

Some programs have integrated ACEs into their internal program documentation and have developed resources for distribution to, for example, clients/families.

Day-to-Day Practice within CAAMHPP

The ACEs questionnaire has emerged as a key piece of information that, once known and recognized, can be used to better understand and alter health risks and health outcomes.

As a program, CAAMHPP wants to better understand who is at higher risk for developing social and behavioural problems. What is predictable is preventable. Knowing this, we want to pay attention to which children have faced a high number of ACEs. Identifying these children early on will not only help us to reach out with early intervention, it can also help us to prepare for changing demands on our services.

Many clinicians are already asking about the topics covered in the ACEs questionnaire, although perhaps not standardly or inclusive of all factors. The use of the ACEs captures the factors known in the research to influence health outcomes.

The use of the ACEs questionnaire often changes the conversation with a client. It shifts the conversation from "What is wrong with you?" to "What has happened to you?" That shift alone has been shown to free a child, and by extension their family, of the shame and confusion of their experience. It recognizes that the experiences of the past shape current behaviour and the neurodevelopment of the child. It often helps in forming a collaborative partnership with the child with a focus on the child's neurodevelopment and helping him/her to learn the skills needed for change. It moves it away from the child's motivation to change alone.

Using the information to Change a Child's Trajectory

We will not be able to undo the number of ACEs a child has experienced. However, we can work to prevent an increase in their score and build protective factors moving forward. The part of the brain that governs executive functioning doesn't develop properly when exposed to toxic stress. As you probably know, this affects the ability to control impulses, regulate emotions, use reasoning, problem solve, plan, monitor conflict, and be flexible. In other words, children who are exposed to multiple ACEs lack the skill, and not the will, to be good citizens. They need support to develop the skills they are lacking, within a trusting, collaborative relationship. Relationships have been found to buffer the effects of toxic stress. Understanding the adverse experiences a child has been exposed to will help us identify the therapeutic approach needed, so that together we can change the story of the child's life.

Workplace Wellness

Staff who have adopted these practices have reported higher levels of job and life satisfaction.

Overall Goal

For each child to have an ACEs questionnaire completed during their course of treatment when it is best suitable. For each child's parent, when suitable and appropriate, to complete an ACEs questionnaire during their child's course of treatment. To use this information to collaboratively plan the most appropriate treatment with children and their families.

How will CAAMHPP support this?

Knowledge exchange and training will be offered in-house through CAAMHPP Connect Days and Message of the Month (clinical & research articles, podcast and videos).

From an information technology perspective, a field has been created for ACE scores in RAIS which will provide a single repository for the data.

How can we explain what ACEs are to clients/families, other health professionals, schools, etc.?

Programs have found it helpful to provide handouts about ACEs to clients/families and those they partner/ collaborate with.

Early Childhood Handout



ACE Handout ECHC
Jan 2016.doc

School Based Mental Health Handout



ACES Script for
Parent, Caregivers, Y

How the ACE questionnaire informs care?

Completion of the survey provides a critically important clinical turnstile which is easily illustrated with the following example:

13-year-old child presenting with attention deficit hyperactivity disorder

Symptom Focused Care:

Examine and treat psychiatric symptom and presenting complaint.

Trauma history may or may not be applied to case / diagnostic formulation.

Trauma Informed Care:

Examine and treat psychiatric symptom and presenting concerns from a trauma informed lens.

ACE Score was assessed (0 or any score that was higher) but was assessed to have no direct bearing on the focus of treatment or the presenting complaint.

Trauma Focused Care:

ACE Score was assessed and treating the trauma would be the focus of treatment, and indeed the symptoms of ADHD may, in fact, be comorbid to the trauma rather than a diagnostic entity in and of themselves.

Presently, every child should have on their record a treatment care plan based on the completion of gathering registration, triage, and admission information. For example, depending on the level of service you're providing and your role, you may also complete a Western Canada waiting list screen (designed to measure cross-sectional urgency at the time of referral), a health of the nation scale Child and adolescent form (designed as a repeated measure of symptom severity and function at least on admission and discharge).

The summary care plan, known as the measurable treatment plan (MTP) has three embedded scales, which take at most a few minutes to record on admission and discharge. The scales embedded in the measurable treatment plan include a measure of function (Child global assessment scale), a strength/concern rating and a goal achievement rating together with associated dates. While the minimum requirement is one per admission, an individual may have as many measurable treatment plans as required or deemed necessary to provide adequate service. The contents of the plan are absolutely required to orientate all care providers to the main focus of the admission, whereas the scales provide us with a basis for measuring the effect of treatment. The fact that the strength/concern scale can measure both a strength and a concern or symptom, introduces the concept of resilience and provides a location for the care provider to make note of any strengths that emerge. Strengths should be recorded on a separate measurable treatment plan form for that particular child.

Together with the adverse childhood experience scale, the surveys provide a comprehensive assessment resource that may serve to guide strategies for interventions related to a particular child's treatment.

The constellation of scores, particularly in the adverse childhood experience scale can be used on an item per item basis to orientate the care provider to the areas of concern in the clinical profile can be reviewed with the child's parents for the purpose of orientation to treatment and for the purpose of validation.

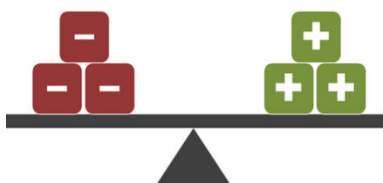
Responses on each of the adverse childhood experience scale items need to be interpreted in the context of why the child is presenting at this time for psychiatric services, hence the report of any impropriety on the part of a parent or significant other needs to be responded to by the clinician in the way that one would record and respond to the report of that information in any clinical context.

Individual cases do not tend to change, hence over the course of treatment where a positive response is being recorded, one is able to focus on the particular issue that has been reported, and through intervention, attempt to mitigate the effects of that experience on the child's developmental trajectory. There is not anything additional or special that one would do, other than to use the information from each of the surveys that give rise to a comprehensive clinical profile for that particular child to inform the contents of the clinical care plan.

As an addition to this battery, which gives rise to comprehensive clinical assessment and an empirical basis on which to evaluate the effect of treatment (data collected on admission predicts 60% of the variance in the MTP on discharge), the adverse childhood experience survey provides a gateway turnstile that can direct intervention strategy that has not yet been formally implemented within our services at the very least, to formally identify and record adverse childhood experiences will in and of itself inform the approach to treatment. As a result, your intervention work will by definition be trauma informed and represent the first evidenced-base step that an organization may take to lay the groundwork to become trauma focussed.

ACEs and Resiliency: Two Sides of the Same Coin

Adversity is only one part of the equation. Exploring resiliency aligns with strength based approaches that can tip the scale towards promoting positive outcomes for a young person faced with toxic stress or adversity. A strength based approach offers a foundation for addressing the intentions behind community and mental health services in supporting people to take control of their own lives in meaningful and sustainable ways (Hammond, 2010).



Exploring resilience can also be seen as a way to offer a strength based balance to uncover a child's ACEs.

The cumulative effect of positive life experiences and coping skills on building resilience can shift the fulcrum's position, making it easier to achieve positive outcomes, such as school performance and education level (Longhi & Barila, 2015).

Definitions:

Early conceptualizations of resilience identified mainly individual factors that were responsible for promoting positive outcomes in the face of adversity. However, there is a growing research and knowledge base that reveals a variety of contextually related extrinsic variables associated with childhood resilience (Donnon & Hammond, 2007). Current frameworks and measures to understand and assess the construct of resilience aim to encompass both extrinsic and intrinsic protective factors (Donnon & Hammond, 2007). There is evidence that resilience is more related to the quality of a child's social and physical ecology as opposed to an individual trait (Ungar, 2011). Children may not necessarily change because of what they do, but change as a result of what their environment provides (Donnon & Hammond, 2007; Ungar, 2011). The concept of resilience includes the presence of serious threats to child development (Armstrong, Burbue-Lefcovitch, Ungar, 2005). Resilience can be conceptualized as unique patterns of positive development when experiencing stress (Coimbra Liborio & Ungar, 2010).

To encompass both the individual and socioecological aspects of resilience, the following "definition" has been posited:

"In the context of exposure to significant adversity, resilience is both the capacity of individuals to navigate their way to the psychological, social, cultural, and physical resources that sustain their well-being, and their capacity individually and collectively to negotiate for these resources to be provided and experienced in culturally meaningful ways" (Ungar, 2008).

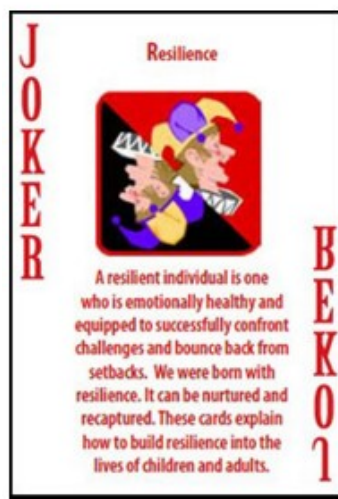
Assessing Resiliency

“Diagnostic Criteria” for Resilience:

- **Domain: Assess Adversity**
 - ⇒ Consider dimensions including severity, chronicity, ecological level of the risk factors, and attributions of causality
- **Domain: Assess Resilience**
 - ⇒ Examine dimensions of coping such as temperament, personality, cognitions, locus of control, and self-regulation
- **Domain: Multidimensional Considerations**
 - ⇒ Temporal dimensions such as a child’s physical and cognitive development that makes coping strategies more or less viable
 - ⇒ Consider how context and culture influence a child’s expression of resilience

RESILIENCE TRUMPS ACES

Ungar, 2015



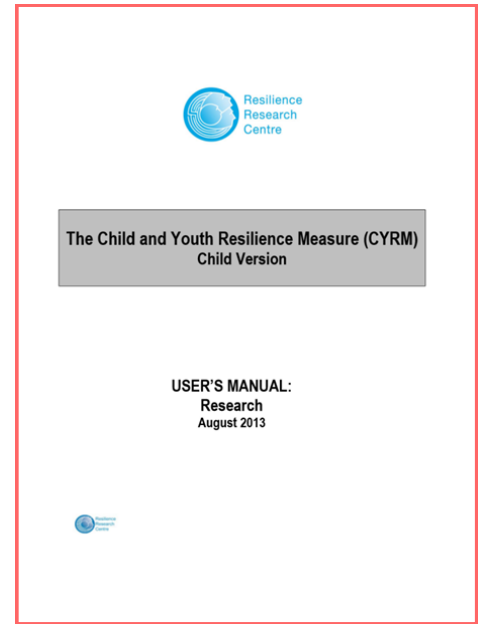
Risk and resilience can be conceptualized as occurring on a continuum, where both addressing both sides are complementary and necessary. Environments may contribute to a person’s risk of various problems, but can also provide protection, enhancing the likelihood of positive outcomes (Brooks, 2006). As resilience can be considered an ecological phenomenon, it is important for assessment tools to encompass this influence.

Resilience Assessment Tools

Based on the literature and the work of the Resilience Research Centre, resilience can be understood as a social ecological construct.

The Child and Youth Resilience Measure (CYRM) is a measure of the resources (individual, relational, communal and cultural) available to individuals that may bolster their resilience.

The CYRM is available for clinical use in both child and youth versions.



OPTION 1: SECTION C

To what extent do the sentences below describe you? Circle one answer for each statement.

	Not at All	A Little	Some -what	Quite a Bit	A Lot
1. I have people I look up to	1	2	3	4	5
2. I cooperate with people around me	1	2	3	4	5
3. Getting an education is important to me	1	2	3	4	5
4. I know how to behave in different social situations	1	2	3	4	5
5. My parent(s)/caregiver(s) watch me closely	1	2	3	4	5
6. My parent(s)/caregiver(s) know a lot about me	1	2	3	4	5
7. If I am hungry, there is enough to eat	1	2	3	4	5
8. I try to finish what I start	1	2	3	4	5
9. Spiritual beliefs are a source of strength for me	1	2	3	4	5
10. I am proud of my ethnic background	1	2	3	4	5
11. People think that I am fun to be with	1	2	3	4	5
12. I talk to my family/caregiver(s) about how I feel	1	2	3	4	5
13. I am able to solve problems without harming myself or others (for example by using drugs and/or being violent)	1	2	3	4	5
14. I feel supported by my friends	1	2	3	4	5
15. I know where to go in my community to get help	1	2	3	4	5
16. I feel I belong at my school	1	2	3	4	5
17. My family stands by me during difficult times	1	2	3	4	5
18. My friends stand by me during difficult times	1	2	3	4	5
19. I am treated fairly in my community	1	2	3	4	5
20. I have opportunities to show others that I am becoming an adult and can act responsibly	1	2	3	4	5
21. I am aware of my own strengths	1	2	3	4	5
22. I participate in organized religious activities	1	2	3	4	5
23. I think it is important to serve my community	1	2	3	4	5
24. I feel safe when I am with my family/caregiver(s)	1	2	3	4	5
25. I have opportunities to develop skills that will be useful later in life (like job skills and skills to care for others)	1	2	3	4	5
26. I enjoy my family's/caregiver's cultural and family traditions	1	2	3	4	5
27. I enjoy my community's traditions	1	2	3	4	5
28. I am proud to be a citizen of _____ (insert country)	1	2	3	4	5

1. Ungar, M., and Liebenberg, L. (2011). Assessing resilience across cultures using mixed-methods: Construction of the Child and Youth Resilience Measure-28. *Journal of Mixed Methods Research*, 5(2), 126-149.

2. Liebenberg, L., Ungar, M., and Van de Vijver, F. R. R. (2012). Validation of the Child and Youth Resilience Measure-28 (CYRM-28) Among Canadian Youth with Complex Needs. *Research on Social Work Practice*, 22(2), 219-226.

Subscales and Question Clusters on the CYRM-28:

Individual

Personal Skills
Peer Support
Social Skills

Caregiver

Physical Caregiving
Psychological Caregiving

Context

Spiritual
Education
Cultural

APPENDIX I — ACE/TRAUMA INFORMED CARE RESOURCE LIST

Alberta Family Wellness Initiative (AFWI) - The AFWI began with the Building Blocks for a Healthy Future conference in 2007, which brought policy makers together with leading experts in brain and child development to talk about the implications of this knowledge for negative health outcomes like addiction. The AFWI has since added further projects and events to its agenda and, in co-ordination with partnership organizations, broadened its mandate to include knowledge translation and mobilization.

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

How Trauma Informed Care Is A Systematic Approach To Ensure All People Receive Care That Is Sensitive To The Impact Of Trauma

<http://insite.albertahealthservices.ca/amh/tms-amh-trauma-informed-practice.pdf>

TIC E-Learning Module: What is Trauma Informed Care?

This is the first learning module in the Trauma Informed Care online learning series. In this module, learners will be introduced to key concepts and practices of Trauma Informed Care. The purpose of this module is to increase knowledge about psychological trauma and improve practice to be more trauma informed and patient centered. Mylearning Link: What is Trauma Informed Care? <http://mylearninglink.albertahealthservices.ca/elearning/bins/index.asp>

**Overview of Substance Abuse and Mental Health Services Administration (SAMHSA)
Six Key Principles Of A Trauma-Informed Approach And Trauma-Specific Interventions**

Following are some well-known trauma-specific interventions based on psychosocial educational empowerment principles that have been used extensively in public system settings.

<http://www.samhsa.gov/nctic/trauma-interventions>

The Trauma-informed Toolkit: A Resource For Service Organizations And Providers To Deliver Services That Are Trauma-Informed

<http://insite.albertahealthservices.ca/hpsp/tms-hpsp-trauma-informed-kit.pdf>

Trauma-Informed Care - Best Practices and Protocols Domestic Violence

http://www.ncdsv.org/images/ODVN_Trauma-InformedCareBestPracticesAndProtocols.pdf

Trauma-Informed Care Toolkit: Canadian Centre on Substance Abuse

<http://www.ccsa.ca/Resource%20Library/CCSA-Trauma-informed-Care-Toolkit-2014-en.pdf>

Trauma-Informed Practice (TIP) Guide and TIP Organizational Checklist

Translation of Trauma-Informed Principles into Practice (BC Provincial Mental Health and Substance Use Planning Council) http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

Mental Health Coordinating Council (MHCC) Australian Reference: Trauma-Informed Care And Practice (TICP)

<http://www.mhcc.org.au/sector-development/recovery-and-practice-approaches/trauma-informed-care-and-practice.aspx>

The COLEVA PROJECT: Consequences of Lifetime Exposure to Violence and Abuse (David McCollum, MD)
Demonstrating the wide-ranging impact that violence and abuse has on the health and well-being of all people. <http://coleva.net/COLEVA-Main-2-2-2011-v2.html>

The Child and Youth Resilience Measure (CYRM) is a measure of the resources (individual, relational, communal and cultural) available to individuals that may bolster their resilience. The measure was developed as part of the International Resilience Project (IRP) at the Resilience Research Centre (RRC) in 14 communities around the world. Dr. Michael Ungar at the School of Social Work, Dalhousie University.



Youth - CYRM
Manual.pdf



Child - CYRM
Manual.pdf

CAAMHPP staff may optionally use this resource to contextualize a strengths-based approach to care.

ACESTooHigh is a news site that reports on research about adverse childhood experiences, including developments in epidemiology, neurobiology, and the biomedical and epigenetic consequences of toxic stress. <https://acestoohigh.com/>

The Center on the Developing Child at Harvard University was established in 2006 by director Jack P. Shonkoff, M.D. Our founding mission was to generate, translate, and apply scientific knowledge that would close the gap between what we know and what we do to improve the lives of children facing adversity. <http://developingchild.harvard.edu/>

Resilience Trumps ACEs is mobilizing the community through dialogue to radically reduce the number of adverse childhood experiences while building resilience and a more effective service delivery system. <http://resiliencetrumpsaces.org/>

Community Resilience Cookbook - Resilience has been shown to buffer the impact of suffering or stress. Resilience isn't just a gift of nature or an exercise of will; resilience grows through positive experiences, supportive environments and the caring intervention of others. <http://communityresiliencecookbook.org/>

CBC IDEAS producer Mary O'Connell explores the ACE study; explores what happened at one high school when suspensions and punishments were replaced with new "trauma-informed" approaches and looks at case studies that provide insights they may contain for deepening our understanding of the causes and consequences of trauma.

<http://www.cbc.ca/radio/ideas/all-in-the-family-part-1-1.3523111>

<http://www.cbc.ca/radio/ideas/all-in-the-family-part-2-1.3532422>

<http://www.cbc.ca/radio/ideas/all-in-the-family-part-3-1.3545271>

Resources for Training and Education - Trauma Informed Oregon is a statewide collaborative aimed at preventing and ameliorating the impact of adverse experiences on children, adults and families. We work in partnership to promote and sustain trauma informed policies and practices across physical, mental, and behavioral health systems and to disseminate promising strategies to support wellness and resilience.

<http://traumainformedoregon.org/>



Trauma-Informed-Care-101-Portland-State

The Resilience Research Centre

<http://resilienceresearch.org/>

Resilience Initiatives

<http://www.resil.ca/>

Patient and Family Centred Care

<http://www.ipfcc.org>

Family-Centred Care in Practice

http://www.camh.ca/en/hospital/Documents/www.camh.net/Care_Treatment/Community_and_social_supports/Social_Support/FCCI/FCC_Better_Practices_PDF.pdf

Importance of Family Centred Care

<http://www.familysmart.ca/sites/default/files/Family%20Centered%20Practice%20-%20GFSE.pdf>

Family Smart

<http://www.familysmart.ca/familysmart>

Trauma-informed Care TIC AHS

<http://www.addictioncentre.ca/wp-content/uploads/2011/11/Trauma-Informed-Practice1.pdf>
<http://www.addictioncentre.ca/wp-content/uploads/2011/11/Trauma-Informed-Practice1.pdf>

TIC Practice Guide-BC

http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

TIP Practice Guide-SAMHSA

<http://store.samhsa.gov/shin/content/SMA14-4816/SMA14-4816.pdf>

TIP Quick Guide for clinicians-SAMHSA

<http://store.samhsa.gov/shin/content/SMA15-4912/SMA15-4912.pdf>

Child Abuse:

<http://www.unh.edu/ccrc/researchers/finkelhor-david.html>

APPENDIX II — KEY REFERENCES

Aurthur, E., Seymor, A., Dartnall, M., Beltgens, P. Poole, N. and the TIP Project Team (2012). **Trauma-informed practice guide**. Vancouver: BC Provincial Mental Health & Substance Use Planning Council. Accessed on March 28, 2016 from www.bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

MacKean, G., Spragins, W., L'Heureux, L., Popp, J., Wilkes, C. & Lipton, H. (2012). **Advancing family-centred care in child and adolescent mental health: a critical review of the literature**. *Healthcare Quarterly*, 15(4), 64-75.

SAMHSA (nd). *Trauma-informed care in behavioral health services: treatment improvement protocol (TIP) series 57. Part 3: A review of the literature*. Rockville, MD: US Department of Health and Human Services, SAMHSA. Available from www. http://store.samhsa.gov/shin/content/SMA14-4816/SMA14-4816_LitReview.pdf

Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A., Edwards, V....Marks, J.S. (1998). **Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the adverse childhood experiences (ACE) study**. *American Journal of Preventive Medicine*, 14(4), 245-258.

You got this! CAAMHPP clinicians are skilled practitioners... including you! Further, you know your clients best. Don't hesitate to use your clinical judgement! **Just do it!** Research suggests that just by asking the questions, future health outcomes can be influenced.

Challenges

- Often it is difficult to manage the ACE information of parents - staff have identified challenges with sending referrals to adult programs, and also sending referrals within CAAMHPP itself.
- Some clinicians have found challenges with the tool – for example, the age appropriateness of some of the wording, the ambiguity of some of the wording, and the reference period of some questions.



We would love to hear about any challenges and solutions that you have found with using ACE, please contact us at ACESatCAAMHPP@ahs.ca