

**MANITOBA PROVINCIAL FORUM ON
TRAUMA RECOVERY**

August 2007

**MANITOBA PROVINCIAL FORUM ON
TRAUMA RECOVERY**

**FINAL REPORT
August 2007**

**Prepared by
Jocelyn Proulx and Maggie R. Nighswander
RESOLVE Manitoba**

TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	5
EXECUTIVE SUMMARY	7
PART I: THE CONTENT	10
GOALS AND OBJECTIVES.....	10
DEFINITION.....	10
OPENING COMMENTS	11
KEYNOTE ADDRESS: Clarissa Chandler.....	11
TRAUMA SURVIVOR'S PRESENTATIONS.....	12
QUESTION AND DISCUSSION RESULTS.....	13
Question 1: What do Trauma Survivors Need to Minimize the Effects of Trauma and/or to Survive?.....	14
Question 2: What Happens to Trauma Survivors When They Try to Enter and Function Within the System?.....	19
Question 3: What Have Been the Challenges and Barriers Within the System That Make it Difficult to Respond to and Acknowledge the Needs of This Population? Please Consider Attitudes, Values, Beliefs, Training etc.	26
Question 4: What Prevents Systems From Working in a More Integrated Way in Manitoba.....	32
Question 5: What Would Need to Change in Order for Systems to Work Together Better in Manitoba?.....	39
Question 6: What Would the Ideal System Look Like?	45
Question 7: What has Worked Well in the Past?.....	53
Question 8: What Recommendations Need to be Made to Government and Other Relevant Provincial Bodies?.....	61
Question 9: What Do You See as Being the Immediate, Intermediate and Long Term Priorities?	71
RECOMMENDATIONS FOR ACTION.....	77
Recommendations for Immediate Goals.....	77
Recommendations for Intermediate Goals.....	78
Recommendations for Long Term Goals.....	79

PART II: THE PROCESS	81
INTRODUCTION	81
THE COMMITTEE	81
THE ATTENDEES.....	81
THE AGENDA.....	82
LIGHTBULB MOMENTS.....	83
EVENT EVALUATION	83
EVALUATION RESULTS	83
RECOMMENDATIONS FOR FUTURE FORUMS.....	91
CONCLUSION.....	92
APPENDIX A: Introductory Comments	96
APPENDIX B: Presentations.....	100
APPENDIX C: Agenda.....	114
APPENDIX D: Light Bulb Moments	116
APPENDIX E: Forum Evaluation Form.....	117
APPENDIX F: Bibliography	118

ACKNOWLEDGEMENTS

There are a number of people that contributed to the success of the forum. The members of the organization committee: David Hutton, Public Health Agency of Canada, Yvonne Block, Manitoba Department of Health, Chez-Roy Birchwood, Winnipeg Regional Health Authority, Tim Wall and Mary-Jo Bolton, Klinik Community Health Centre, Suhad Bisharat, Provincial Addictions Network, Lori Pedden, Native Women's Transition Centre, and Dr. Tracey Peter, Department of Sociology, University of Manitoba, planned the event and worked towards an efficient and productive process. Donna Reid from Klinik Community Health Centre was also involved in organizing the event and her attention to detail during its delivery helped to maintain the forum's schedule. Without the financial support of the Public Health Agency of Canada, the Department of Health, Government of Manitoba, the Winnipeg Regional Health Authority, and Klinik Community Health Centre, the event would not have proceeded. Clarissa Chandler delivered a keynote address that helped to focus participants for the tasks ahead and her skills as a facilitator maintained the event schedule and ensured that all tasks were completed. The courage and dignity of the presenters who told their stories of trauma demonstrated the need for the forum and the actions that will develop from the event. The stories brought home the reality of trauma in the daily lives of the people it effects. A special thanks is due to all of the participants, for the effort they made to attend the event and their hard work and diligence in completing all of the tasks that were assigned. The ideas they have shared form the basis for this report and any subsequent actions resulting from the forum. The gathering, organization, and analysis of the results of the forum was completed by Maggie R. Nighswander and Jocelyn Proulx from RESOLVE Manitoba. It is through their efforts that this report was completed. Opening presentations were video taped by Jennifer Davis, her efforts are much appreciated.

FREEDOM

Freedom, a concept of something greater than what we know or think we know

Where does the yearning of freedom come from?

Does it come from a place of knowing imprisonment of the psychodynamics locked deep?

Does it come from knowing truths of one self, and the truths that surround you?

Does freedom matter to one who knows nothing but the bars that hold the thoughts within its parameters of one's mind?

Does freedom come from within, just knowing one's spirit and our journey's back to the spirit world and our physical going back to the earth and then come back again to the physical world to know again another journey, to the freedom of what one quests for in a lifetime

I know freedom; in a way that I am free to be who I am

I know freedom to think out loud, and to speak my truth

I know freedom to know where I came from, who were my creators,

I know freedom from pain, I know freedom from shame, and I know freedom from a place of never knowing but knowing now, the beauty of being Anishinaabe kwe.

Patented by my DNA of my ancestors who I was meant to be,

My grandparents who did not know *freedom*, who were conditioned and confined in places some never to come back from those horrid places in the mind, to think and believe of ways foreign to us,

As they were the ones' who were the template of my journey to discovering myself and the many ills/self hatred of who I was,

Someone who did not like their skin color, and seeing her people drunk and lying on the streets, begging for one more quarter to drink oneself away, wanting to forget the pain of being

Anishinaabe,

One who hated her parents loathed their existence and the pain that they caused to one another, witnessing the brutality of what residential school did to them, as they were only Acting out what was done to them and then not knowing that was a sickness bestowed upon them, which flowed into the next generation to come, trauma, abuse, hatred, anger.....

They were the ones who started this journey of annihilation to one's self, and impacted my life with colonization and residential school assimilation.

Freeing me was so painful yet so empowering from the many years of colonization and annihilation and letting go of the ills that were put upon me because of my relationship and history to the land and the peoples who skin is brown like mine.

I found a love, the love of knowing one's history, one's truth, and one's love of self, the beauty, strength, the endurance and perseverance to exist.

Journeys of Creators love to know oneself and the honor of being a people who continue to exist despite the holocaust that continues.

Freedom something that my children may see in their time, and my grandchildren, freedom to live freely without man made laws imposed on us,

Freedom to walk the earth and to reclaim our relationship with the lands,

Freedom to live off the lands,

Freedom of loving the spirit, of one human to another without the color's of a person holding one a prisoner.

Freedom of being a human that has a right to exist as any life here on the earth,

Created "Sacred" and Equal.

Being of one life on Mother Earth as her children we are, who she nourishes every day with every breath we take.

"Thunder Rain Woman"-August 5, 2004

EXECUTIVE SUMMARY

The trauma forum was attended by 325 people from all regions of Manitoba and a variety of services and systems including health care, mental health, community agencies, grassroots organizations, consumers, academia, and provincial and federal government. Participants voiced a great deal of appreciation for and satisfaction with the forum. In particular they liked interacting with others and getting direct information from trauma survivors and would have liked more time and opportunity for both. Attendees also reported that they gained greater awareness of trauma effects, existing services and service needs. Many felt motivated towards actions to improve trauma care services.

The definition that guided this trauma forum was: "*Trauma refers to experiences or events that, by definition, are out of the ordinary in terms of their overwhelming nature. They are more than merely stressful – they are also shocking, terrifying, and devastating to the victim, resulting in profoundly upsetting feelings of terror, shame, helplessness, and powerlessness.*" (Courtois, 1999).

All of the objectives of the forum were met and significant work was made towards achieving the goals. Participants discussed existing needs of trauma survivors, barriers to meeting those needs, and systemic changes that have to occur to overcome these barriers. Several themes surfaced in all of the forum discussions. A summary of the 12 most common ones follow.

- 1) The development of an interdisciplinary planning and organization committee to initiate action towards furthering the goals of this forum.
- 2) Increase the amount of information and knowledge about trauma for workers at all levels of service and for clients. Standardized training and opportunities for continued education and professional development of service providers and the development of an extensive resource guide or tool kit on trauma and trauma care are vehicles for this increased education. Education of trauma survivors and of the public were also suggested. Greater awareness would work to reduce the stigmatization of clients presenting with trauma symptoms.
- 3) Increase the amount of communication among systems of service, including community agencies, health care, the justice system, governments and clients. This could be achieved and necessitated by interagency communication for the provision of care to trauma survivors. Networking is an essential part of this communication and engendering understanding and cooperation among all levels of care.
- 4) Integration of services to facilitate clients' movement through the service system. This would require a greater degree of flexibility in the laws about information sharing (PHIA and PHIPA).
- 5) The promotion and application of client centered, strength based, holistic services that would work in collaboration with clients to plan and carry out strategies for recovery. Exploration of a variety of treatment approaches including culturally based practices would be part of the holistic

nature of care, as would case manager positions that would work with clients to develop a treatment plan and help clients navigate the system.

6) The creation of a wellness or trauma recovery centre that would represent a one-stop-shop for treatment. Within this centre clients would only have to go through one intake and one assessment that would be applicable in all services accessed.

7) Accountability was called for in all systems and services, including government, health care, and community agencies. In part this could be achieved by consumer evaluations and service audits. This would ensure quality care and responsible management of resources.

8) Involvement of the provincial and federal government in all actions to improve trauma care and all activities related to the implementation of recommendations from the forum.

9) Increase staffing and staff care to enable agencies to fully meet client needs without jeopardizing the wellbeing of their staff. This would include establishing reasonable workloads and staff care.

10) There is a need for increased resources and services in rural, northern and remote communities and reserves.

11) Meeting basic needs such as food, shelter, and health care and addressing social stressors such as poverty, safe housing, and employment will have a significant impact on individuals. In some cases these will prevent trauma and in other cases they will facilitate recovery.

12) A trauma resource centre of excellence that could help organizations expand their capacity to effectively and appropriately respond to the needs of people affected by trauma would be beneficial. This resource could be involved in developing, updating and maintaining resource information, training, and clinical consultation. Another element of this centre would include a research component and links to a university that would support Manitoba based research initiatives.

Many of these themes have components that could be established as immediate, intermediate, and long term goals. Therefore, actions recommended through this forum would be ongoing. Specific recommendations were made and include:

Recommendations for Immediate Goals

1. Establish An Action Committee to oversee the initiatives that result from this forum.

2. Construct and Distribute a Resource Guide, Manual or Tool Kit comprised of information on trauma, practices and approaches for dealing with trauma, and listings of other trauma related services.

3. Increase Communication and Collaboration among all levels of services and with governments and funders.

4. Gather Information on Trauma including causes, effects, recovery, treatment practices and approaches, existing services in different locations, a bibliography and summary of trauma approaches (including cultural approaches).

Recommendations for Intermediate Goals

- 1. Standardized Trauma Informed Training** for practitioners at all levels of trauma care.
- 2. An Integrated System of Services** including community agencies, health care agencies and governments.
- 3. Funder and Funding Support** and involvement in the plan of action for change.

Recommendations for Long Term Goals

- 1. Establish a Centralized Trauma Care Centre** that would conduct one intake and one assessment that could be accessed and used by all other services the client utilized.
- 2. Client Centered, Strength Based, Holistic System of Services** that involved clients in decisions about treatment, worked to build their strengths and capacity, and addressed physical, emotional, cognitive, and spiritual needs.
- 3. Establish a Resource Centre of Excellence** that would be responsive to the information, education and research needs of the systems of trauma response. Potentially, this could include the development of a provincial research centre on trauma and trauma recovery.
- 4. Additional Programming** for clients on waiting lists, for rural, northern, and remote areas, for immediate trauma response, and to address basic life needs and social stressors such as poverty.

PART I: THE CONTENT

GOALS AND OBJECTIVES

The goals of the forum on trauma recovery was to:

1. Promote and facilitate systemic change in order to
 - a) increase the capacity of organizations and systems to better respond to the needs of people affected by trauma;
 - b) increase the capacity of individuals, families and communities to better respond to future crises, trauma and emergencies.
2. Begin developing a strategic plan and identify priorities and the next steps for facilitating systemic change and capacity building in the area of trauma recovery.

The objectives were to:

1. Provide a venue and format for service providers and individuals with a vested interest in trauma to meet and discuss issues related to addressing the needs people and families affected by trauma in the province of Manitoba.
2. Review current research and practices in the area of trauma with an emphasis on recovery and treatment.
3. Identify and review services currently available for people affected by trauma in Manitoba.
4. Identify gaps in services and current needs of individuals and families affected by trauma.
5. Identify core components for promoting a comprehensive and integrated framework of approaches to trauma recovery.
6. Identify a process for developing a trauma recovery strategy in Manitoba including short term, intermediate and long term goals.
7. Identify opportunities for enhancing service coordination and collaboration.
8. Identify a process for enhancing health care systems and service organizations becoming more trauma informed and thereby increasing their capacity to effectively address the needs of individuals affected by trauma.
9. Identify opportunities and initiatives for promoting professional development and increase the capacity of individual service providers to better respond to the needs of trauma affected individuals and families.
10. Establish a trauma recovery network.

DEFINITION

The following is the definition of trauma that was used within the forum and formed the basis for the discussions of survivor needs, systemic and service response, and required systemic change:

"Trauma refers to experiences or events that, by definition, are out of the ordinary in terms of their overwhelming nature. They are more than merely stressful – they are also shocking,

terrifying, and devastating to the victim, resulting in profoundly upsetting feelings of terror, shame, helplessness, and powerlessness." (Courtois, 1999).

OPENING COMMENTS

1. Tim Wall

Tim Wall, Director of Counselling Services at Klinik Community Health Centre, welcomed attendees and talked about the commonality of direct or indirect trauma in people's lives. He expressed concern that the focus of services is often on addressing the symptoms rather than the causes of trauma. Further, many who seek therapeutic support experience barriers and are challenged in finding and accessing that support, especially in remote and rural communities. There is often a reluctance on the part of service providers to deal with trauma due to misconceptions, fears and the long and turbulent journey to recovery. He further stressed the importance of services being driven by the needs of the client rather than the needs of the system. The forum is intended to examine how the systems currently respond to the needs of people affected by trauma and how the capacity to respond effectively and appropriately can be enhanced. For a complete copy of Tim Wall's speech, please see Appendix A.

2. Minister for Healthy Living

The Honorable Kerri Irvin-Ross, Minister for Healthy Living, brought greetings from the Premier and Government of Manitoba. Please see Appendix A for a transcript of these greetings.

3. Public Health Agency of Canada

David Hutton brought greetings from the Public Health Agency of Canada. Please see Appendix A for a transcript of these greetings.

KEYNOTE ADDRESS: Clarissa Chandler

Introduction by Tim Wall

I first had the opportunity to meet Clarissa a little over a year ago when she presented at a trauma conference here in Winnipeg. We are fortunate to have Clarissa in Winnipeg once more this time as our keynote speaker and forum moderator. Clarissa has been the primary consultant with LCC Consulting in Toronto, Ontario since 1994. Educated in the U.S. and a graduate of the University of California, she has consulted in the non profit sector with a specific focus on women, trauma, domestic violence, addiction, recovery, community responses to co occurring substance abuse, trauma and mental health issues, women in conflict with the law, anti racism, and culturally relevant services.

The Importance of the Collaborative Approach

Clarissa Chandler stated that gatherings such as these are important to share experiences and to discuss the system's response to trauma and if change is necessary. Working with issues of trauma cannot be done in isolation, rather a collaborative process is necessary. Trauma experiences are greatly varied and this in part determines why people react differently to their experiences. The effects of trauma depend on its severity, duration, age of the victim, and the agent of trauma. The pain of trauma is increased when the people around the victim are not able to respond effectively. In some cases the reaction of these people re-traumatize the victim, as when people display racism. One of the problems is that trauma services are often for those who are the least traumatized and are able to retell their story. Services have to find a way to help all trauma survivors and to do so in an integrated way, dealing with people as a whole rather than separate issues. There is also a need to educate people in trauma so that everyone shares the same perspective upon which to base care. Further, services have to be survivor informed and work on individual and community strengths. A full copy of the presentation can be found in Appendix B.

TRAUMA SURVIVOR'S PRESENTATIONS

1. Panel Presentations

A panel of trauma survivors spoke of their experiences of trauma and within the system. Their stories revealed how trauma comes to affect all parts of a person's life and the inadequacy of the systemic response to these experiences. Their experiences exemplify how people are re-traumatized by the system that was intended to help them as well as the need for change to more fully meet the healing needs of those affected by trauma. A copy of the panel presentation is available on DVD from Klinik Community Health Centre.

2. Tracey Peter and Mary-Jo Bolton

The goal of the presentation was to build a case for why community agencies, psychiatrists, doctors, friends and family should work together to help trauma survivors. Tracey Peter talked about her experiences with childhood sexual abuse trauma and the subsequent effects. She also spoke about her experiences in the psychiatric ward where she was hospitalized after suicide attempts. There was a lack of sensitivity for what she had experienced and a lack of respect for her as a person who was traumatized and fearful of this new environment. She had to undergo a two hour assessment alone because the psychiatrist would not allow her community therapist (Mary-Jo) to be with her. She was treated as a case rather than a person. She and Mary-Jo stated that many responses that are re-traumatizing to clients, as with Tracey's experience, is due to a lack of understanding of the dynamics of trauma. They suggested that hospitals must place a high value on collaboration with community based service providers, treatment needs to be innovative and consistent, assessment and treatment must be combined, and the hierarchy of expertise within the health care and social services systems must be removed. A full copy of the presentation can be found in Appendix B.

QUESTION AND DISCUSSION RESULTS

Each of approximately 30 tables of participants responded to the following questions. The responses given were analyzed for common themes. It is these themes that are presented below. A brief summary of the comments follow each question. Tables that present the response themes along with the number of comments that represent each category are then displayed. Themes are presented in descending order. More detailed descriptions of responses within these categories follow. These different modalities for presenting the data gathered will allow readers to select the one that is most appropriate to their needs or preference.

Question 1: What do Trauma Survivors Need to Minimize the Effects of Trauma and/or to Survive?

Summary

A number of different needs were identified, with the need for service providers to be respectful, to listen to survivors, to be empathic, and to develop a good relationship with survivors being the most frequently mentioned. Respondents felt the focus needed to be on the individual, with client driven services and the development of individual informal support networks. There was general consensus on the need for an integrated system of services and resources that are accessible and easy to navigate. These should include options for alternative and culturally sensitive approaches to service. Greater education and awareness about trauma for both survivors and service providers was believed to bring about empowerment through knowledge and greater capacity for effective service responses. Immediate response in the nature of safety and support was identified as necessary. Finally, larger systemic involvement in terms of funding and provincial and national directives would indicate their commitment to respond to the needs of trauma survivors.

Table 1: Trauma Survivor Needs

Themes identified	Number of comments made
Respect and compassion from service providers	118
Supportive therapeutic processes	78
Client-driven services	62
Resources	55
A cohesive, integrated and flexible structure within the help system	43
Education of the helping community about how to respond appropriately	43
A healthy trauma survivor/ primary service provider relationship	35
Education provided to trauma survivors	34
Immediate supports (food, clothing, shelter, access to “safe houses”)	28
Alternative/culturally based therapeutic approaches	25
Safety (emotional, physical, psychological, self and others)	15
Strong/strengthened informal supports	15
Other (broad system needs)	8

Detailed Descriptions

1. Respect and Compassion from Service Providers

Overwhelmingly participants recognized trauma survivors' need for services that provide an atmosphere that is conducive to their disclosure and processing of their trauma and healing from the experience. Specifically mentioned were the need:

- For respectful, nonjudgmental service providers who maintained the dignity of survivors.
- For empathy, compassion, support, and care to not re-traumatize individuals.

- To be heard, believed, and understood.
- For primary service providers to be approachable, knowledgeable, and culturally sensitive.
- To be validated, and not have their concerns minimized.
- For trust from service providers.

2. Supportive Therapeutic Process

There were components of the therapeutic process itself that were identified as being important for survivors' healing from their trauma. Among these were:

- Individualized care and attention, allowing them to speak about their experiences at their own pace, and acknowledging each person's multidimensionality and the many aspects of their identity. This includes not making assumptions and not adhering to or promoting stereotypes or racism.
- Affirmation of individuals' identity, resilience, coping skills, and strengths. This includes normalizing their feelings around the trauma.
- Hope and a focus on the present and the future. These are important to building a new life, finding meaning and purpose and not letting the past dominate future aspirations.
- Consideration for regaining a positive perspective of life such as having a sense of personal control in their lives, laughing, playing and enjoy life, and healing.
- The skills of the services including: their ability to communicate effectively; their use of evidence based practices; their teaching of healthy coping skills; their maintaining a balanced sense of power between themselves and the survivors; having confidence in their own expertise, and self care to maintain their own health.
- Confidentiality, which would work to build the trust and security needed to deal with the trauma in their lives.

3. Client Driven Services

The focus on individualized care also came through in the recognition of the need for services to take their lead from survivors' needs. Specifically respondents suggested that:

- Clients need to have choice in the form of treatment and the staff that will be working with them, giving them control in their own healing process.
- The person should be treated as a whole person. Thus, a holistic approach was seen as preferable.
- Continuity of care, long term services and follow-up with clients would allow them to meet their needs as they arise. These types of opportunities to 'touch base', reconnect, and obtain assistance beyond immediate treatment is more conducive to healing rather than just survival. Helping clients build their support systems would be part of establishing the mechanisms for long term healing.

4. Resources

The identification of the need for resources referred to the need for a sufficient number and variety of services to meet the multiplicity of needs of trauma survivors. Included in the suggestions were:

- Services that were available and accessible when they were needed.
- Resources in rural and remote communities.
- A sufficient number and variety of resources to offer client the opportunity to find services that fit for them in terms of language, culture, age, gender and other aspects that are important to them. Among the variety of services mentioned were:
 - Services for men, for children, for parents and children, and for Child and Family Services involved parents.
 - Outreach, crisis stabilization, practical support, and safety planning.
 - Peer supports.
 - Walk in services, group services, individualized service.

5. A Cohesive, Integrated and Flexible Structure Within the Help System

Forum participants identified the need to have a service system that was easy for trauma survivors to utilize. This type of system would need to have services that worked cooperatively, collaboratively, and were flexible enough to accommodate the needs of the clients. Elements of these services consisted of the following:

- Information sharing among different services about services and about clients. It was felt that the culture of privacy governed by acts such as PHIA are barriers ease of service use.
- Networking, coordinated services and good communication between services.
- Collaboration among services, as well as involving informal support systems, to allow the system to work as a functioning whole. A broad community of support would ensure that this system would be able to meet all the needs presented by survivors.
- A system that is easy to maneuver. Components that were identified as increasing this maneuverability were:
 - Minimizing procedures, guidelines and rules that block access.
 - Having a centralized service.
 - Advocacy within the system.
 - Staff that would act as a central team or coordinator who would advocate for and guide clients through the system.

6. Education for the Helping Community About How to Respond Appropriately

There was a realization that changes in the services and systems to better help trauma survivors would in part come about through education. The areas suggested for the focus of education were:

- Education about trauma including about the different types of trauma. Some specifically felt that the medical system and first responders needed to be trauma informed and sensitive.

- Training in appropriate assessments that do not re-victimize individuals.
- Information about available services, how the system works and how to make appropriate referrals such as when medical intervention is necessary.
- Interpersonal skills, and sensitivity to client needs, including cultural sensitivity.
- Workshops for professional development.

7. A Healthy Trauma Survivor/ Primary Service Provider Relationship

It was recognized that a close and trusting relationship between service providers and trauma survivors was required to facilitate healing, but that the close nature of the relationship could also become detrimental to healing. Participants suggested that:

- Time should be allowed for this relationship to develop, it should not be rushed as trust and a sense of safety builds over time.
- Boundaries should be clearly defined to avoid violation by either the service provider or the client.

8. Education Provided to Trauma Survivors

Trauma survivors were also seen as benefiting from information and knowledge. The areas identified for the focus of education were:

- General information about trauma including what to expect in terms of responses such as turning to substances as coping mechanisms. The impact of these coping mechanisms would be part of this education.
- Healthier coping skills.
- Available resources and how the system works including what to expect from the system, from the therapeutic process and social backlashes.
- Their rights, including their right to say 'no'.

9. Immediate Supports

The provision of food, clothing, shelter, and access to 'safe houses' was seen as important to the immediate response to trauma.

10. Alternative/Culturally Based Therapeutic Approaches

The need for providing alternative therapeutic approaches including culturally based approaches were noted. These would fit with a focus on individual needs. Given the cultural diversity in Manitoba, this would be particularly beneficial. Specific approaches mentioned were:

- Holistic approaches that incorporate spiritual components.
- Utilizing elders, sweats, circles, and traditional ceremonies.

11. Safety

Emotional, physical, psychological safety were identified as essential to dealing effectively with the effects of trauma.

12. Strong Informal Supports

Participants recognized the importance of personal support systems and the need to strengthen these in the lives of trauma survivors. These informal supports included:

- Friends and family.
- The wider community. Some suggested creating warm lines where emotional support could be available through a phone connection. These would be similar to crisis lines, but specific to emotional support.
- Housing with established supports.

13. Other

A number of other needs were identified, with most being related to the broader system. These included:

- Health care directives related to trauma response.
- Broad protocols for large scale traumas affecting many people.
- Funding issues need to be addressed in terms of equity and coordination.
- Trauma survivors need to have political impact.
- Action.

Question 2: What Happens to Trauma Survivors When They Try to Enter and Function Within the System?

Summary

Responses to this question fell into four large themes, three of which represented negative experiences related to entering the system. The first of these was categorized as clients' negative experiences and represented responses about individuals not being respected, listen to, or provided with what they need. Most feel overwhelmed, confused, vulnerable, powerless, depressed, fearful and anxious and thus are not able to rationally evaluate what is happening to them. Communication is sometimes difficult due to the aforementioned emotions, language and/or cultural barriers. Lack of knowledge often on both the part of the client and the service provider exacerbate these problems and together they lead to a lack of progress, re-traumatization and increased symptoms.

The second theme represented comments related to problems with services. A lack of immediate response due to waiting lists and automated phone systems are frustrating and delay survivors getting the help they need. Inappropriate referrals and waiting lists at the most appropriate service for an individual often mean that they don't enter the system where it would be the most helpful. Further, most get little support or assistance in going through the system and are not emotionally stable enough to effectively navigate the system alone. The contacts they do make change frequently. This means their having to retell their story to new workers many times. Assessments are often invasive and sometimes lead to misdiagnoses and labels that are difficult to shed. Many experience family, personal, financial, and legal problems that compound trauma effects and are perpetuated because the individual cannot get the help they need and are not strong enough to effect change themselves.

The third theme contained comments related to system wide issues. The system works on treating the symptoms rather than the whole person and its paternalistic attitude denies the person's participation in their treatment. System services lack integration and communication and are often in competition with one another, all to the detriment of the client. The lack of services to respond to the diversity of needs of trauma survivors and the lack of trauma informed staff leave survivors with little choice and little hope of effective personalized care. The need for a large overarching approach to trauma supported and promoted by the larger system and for a central location, a trauma service centre was clearly identified. This type of specialized centre would be able to overcome many of the previously mentioned problems with the system that leave clients without the proper assistance they need to heal.

The last theme was related to positive experiences, indicating that some individuals do find the help they need including caring service providers. Individualized care is available, but is not the norm. Finding these service providers seems to occur more by chance. However, this does provide hope that the current systemic problems can be changed.

Table 2: Experiences When Entering the System

Theme	Number of Comments Made
Section A: Clients' Negative Experiences	
Negative emotional reactions around entering the system	35
Attitudes/reactions trauma survivors experience from the system	34
Barriers to positive experience with primary service providers	8
Confidentiality problems	7
Lack of knowledge	7
Cultural barriers	5
Hindered progress	5
Section B: Service Problems	
Intake problems	31
Problems navigating the system	25
Diagnosis problems	20
Assessment problems	14
Practical hindrances	13
Section C: System Wide Problems	
Problems with system characteristics	41
Problems related to having multiple agencies	34
Problems with the larger system	33
Resource problems and deficiencies	28
Lack of standardization of staff and training	6
Broad systemic problems	4
Section D: Positive Experiences With Services	
	12

Detailed Descriptions

Section A: Clients' Negative Experiences

1. Negative Emotional Reactions Around Entering the System

Participants stated that clients have a number of negative emotional responses when they enter and try to function in a system that does not provide them with the assistance they require. These reactions include feeling:

- Overwhelmed and confused.
- Vulnerable, scared and exposed.
- Frustrated.
- Weak, dependent and shameful.
- Depressed, hopeless, discouraged and powerless.

2. Attitudes/Reactions Trauma Survivors Experience From the System

Participants reported that trauma survivors were often blamed, discounted, oppressed and further abused by the system that they entered in order to obtain help. Specifically, they identified the following experiences:

- Being blamed, judged, stigmatized, and labeled as attention seeking, 'crazy' or a trouble maker.
- Being discounted, minimized, not heard or believed, and not trusted.
- Encountering service providers who have an "us" vs "them" attitude about clients.
- Being bullied, oppressed through racism, homophobia, and prejudice, and abused.

3. Barriers to Positive Experience with Primary Service Providers

Among the things identified as interfering with the development of positive relationship with primary service providers were:

- Difficulty in finding a good fit with a service provider.
- Difficulty in communicating with service providers.
- Expectations are not met, leading to frustration.

4. Confidentiality Problems

Confidentiality is meant to protect the client, but there are times when issues around confidentiality create problems such as when:

- Clients encounter different levels of confidentiality within the system.
- Clients don't understand confidentiality and fear the consequences of entering the system and what information will be shared.
- Clients don't know their rights or what they are signing in terms of confidentiality agreements.
- Service providers are also trauma survivors and become clients of the system.

5. Lack of Knowledge

There was a perceive lack of knowledge about trauma on the part of service providers and trauma survivors. Survivors also tend to have limited knowledge about the system into which they are entering.

6. Cultural Barriers

Due to a lack of diversity of services and the multicultural nature of Manitoba citizens, there is difficulty in finding services that can speak to clients in their own language if it is not English. Awareness of all cultures and cultural traditions is also lacking.

7. Hindered Progress

Participants felt that the negative experiences and emotions related to entry into the system can stunt trauma survivors' ability to make progress, leading to relapse and possible escalation of symptoms.

Section B: Service Problems

1. Intake Problems

There are aspects of trauma services that from the beginning set the stage for negative experiences. Intake issues identified as initiating these negative experiences were:

- Waiting lists and waiting times (these were of particular concern), which can create feelings of hopelessness.
- Inconsistencies with where clients enter the system and their actual needs. Thus, the services they first encounter are often not the ones they need.
- The service that is first accessed can affect their whole experience by giving them a label that is difficult to shed afterwards. The system then sees only this label and not the person.
- Getting an automated phone system rather than a real person.

2. Problems Navigating the System

Because participants believed that clients were often alone in negotiating their way through the system, they reported on some of the problems that presented themselves through this process. These included:

- Not having any support in navigating the system and often when supports are found the high staff turnover rate means several changes in contact people.
- Not knowing where to begin, often due to being given inaccurate or insufficient information about resources.
- Being given referrals that are inappropriate, leading to dead ends and frustration.

3. Diagnosis Problems

A number of diagnosis issues were identified as being of concern such as clients being misdiagnosed, receiving multiple diagnoses, and being labeled. Once made these often follow

the client and affect their treatment by others. In some cases they may only be seen as a diagnostic category rather than a person.

4. Assessment Problems

Like the intake process, the assessment process can often begin the service utilization process on a negative note. There are a number of problems evident in assessments conducted by different services. These include:

- Having to go through assessments at each service accessed means retelling their story over and over. The need for a single, thorough, accurate assessment that is therapeutic and not re-victimizing was reported.
- Assessments are often invasive, triggering painful issues and re-traumatizing the client.
- Having intakes and assessments done at different times prolongs the entry process and delays clients actually getting help.

5. Practical Hindrances

A number of practical issues faced by clients that can compound the problems encountered in getting assistance with trauma recovery were itemized. These consisted of:

- Financial concerns and the cost of medication.
- Legal problems.
- Housing issues.
- Insurance issues.
- Lack of connection to medical services such as a general physician.
- Loss of employment.
- Family conflict and disruptions.

Section C: System Wide Problems

1. Problems with System Characteristics

Problems inherent in the current system services make entry into the system a negative experience for many trauma survivors. Among these problems are:

- It re-traumatizes victims as its processes are laden with various triggers for the trauma experience.
- It is not client centered, but rather patriarchal and paternalistic in its approach.
- It is mainly concerned with the symptoms rather than the person and thus is predisposed to focus on pathology and prescribe medication as the major form of treatment.
- It is not sensitive to the length of time needed to heal from traumatic experiences. Services are often short term and do not include the opportunity for continued access or follow-up care.

2. Problems Related to Having Multiple Agencies

Because the system contains multiple agencies that are not located in one centre and are not well coordinated in their response, obtaining a compliment of appropriate services from a number of these agencies is difficult. This often leaves the client feel like they have gotten the 'run around'. The problems related to this system of multiple agencies mentioned were:

- Services are fragmented and inconsistent.
- Different services have different philosophies and clinical approaches.
- There is a lack of communication among services, often due to privacy acts such as PHIA and PHIPA (Personal Health Information Protection Act).
- Agencies having competing mandates and often work against each other rather than cooperatively. Advocates from one agency can't necessarily come to another agency with the client.
- Services are not integrated. Some services, such as physicians, are often left out of the treatment team.
- There are duplications in services and other areas where gaps exist.

3. Problems with the Larger System

Just as there are issues within a system of multiple agencies that create a negative experience for trauma survivors, there are issues related to the larger service system that contributes to this negative experience upon entry into the system. These issues consist of:

- The larger system with its bureaucracy takes over and individuals fall through the cracks and are lost.
- Clients lose control and choice over their own treatment, as the larger system dictates which treatment will be given. This again speaks to the paternalistic nature of the system that believes it knows best what people need.
- There is a lack of follow-up and continuity of care, as the larger system does not fund these type of long term programs.
- With the systemic focus on the application of specific treatments, the clients are often isolated from their informal and personal sources of support.

4. Resource Problems and Deficiencies

Some of the problems mentioned centered around the resources within the trauma care system. Identified problems included:

- Survivors can't find the services they need. There is a lack of specialized services and gaps in service for men (few services even have male service providers), youth, and immigrants.
- There is a lack of funding for additional staffing and programming.
- There are regional difference in available resources, such as urban vs rural resources, meaning that some clients are left with even fewer options due to their geographical location.

- Personal finances often affect service choices. For example, psychological services are only available to those who can afford it.

5. Lack of Standardization of Staff and Training

There is a lack of standardization of staff that offer trauma services. This means that staff will have different qualifications and some will not be qualified for the types of services trauma survivors need. Further, there is a lack of standardized trauma informed training that could be provided to service providers.

6. Broad Systemic Problems

A few respondents felt that there were broader systemic issues that made entry into the system problematic. These issues included:

- The lack of an integrated provincial service plan.
- The lack of a government sponsored integrated trauma recovery centre.
- The lack of services located within the communities they serve.

Section D: Positive Experiences With Services

There were some respondents who felt that entry into the system brought about positive experiences. These positive experiences were linked to:

- Finding the right fit with a service provider.
- Receiving help in navigating the system and in establishing a new network of support.
- Being listen to, believed and validated.
- Services that took a client centered approach and that were integrated.
- Clients having a sense of hope.

Question 3: What Have Been the Challenges and Barriers Within the System That Make it Difficult to Respond to and Acknowledge the Needs of This Population? Please Consider Attitudes, Values, Beliefs, Training etc.

Summary

The lack of resources, especially in rural and northern areas is one of the major barriers to trauma response. In addition, rather than being client driven, services are most often system driven, resulting in an approach that applies pre-established models of care rather than supporting individualized treatment plans. Funding is often tenuous and relies on evidence of positive outcomes, something difficult to obtain when healing is a long term process. Further, funds tend to be scarce for long term programs providing a continuity of care. Because of the shortage of funds, staff are often overburdened and under paid, leading to burnout and desensitization. This can be manifested in a negative attitude towards clients including racism, prejudice, victim blaming, and discounting their experiences. Many staff lack the proper training to deal with trauma and consequently try to avoid dealing with it. Some fear doing more harm than good and so do nothing. There is a great deal of inconsistency among professionals as to their education and knowledge in how to deal with trauma. Although standardized training would be ideal, there is no support for this type of endeavor. The shortage of funds and the differing mandates and philosophies among agencies often form the basis for non-cooperation, lack of communication, competition, and the formation of cliques and hierarchies, all of which contribute to clients' difficulty in navigating the system.

Further, clients are generally poorly equipped to negotiate for the services they need due to their emotional problems, sense of shame (related to the trauma and/or to seeking services), inability to think rationally, lack of knowledge about the system, and other concerns such as housing and employment. Individuals with language and cultural barriers have added difficulties in finding services that can accommodate their needs. In fact, there is little regard within the larger system for alternative or cultural approaches, nor are there efforts put into cultural awareness and sensitivity training for staff. There was a general consensus that these barriers needed to be addressed before the needs of trauma survivors could be effectively met.

Table 3: Systemic Challenges and Barriers to Responding to Client Needs

Themes	Number of Comments Made
The attitudes and values projected onto clients by service providers	56
System driven instead of client driven programming	56
Limited resources	42
Administrative and staff related problems	42
Lack of training, knowledge and awareness of the staff within the system	32
Client qualities and characteristics that can affect service access	32
System services that are non-cooperative and fragmented	27
Problems navigating the system and accessing resources	23
Lack of funding and distribution of funds	18
Systemic barriers	14
Other issues	12

Detailed Descriptions

1. The Attitudes and Values Projected Onto Clients by Service Providers

Participants felt that service providers often made assumptions about clients and projected their own biases and beliefs onto them. This has interfered with the services' ability to respond in an effective way to trauma survivors. The projected biases and attitudes mentioned were:

- Stigmatization of clients and a general lack of sensitivity about the trauma they have experienced. This includes a lack of cultural awareness and sensitivity and cultural and religious beliefs that lead to stigmatization.
- Stereotypes and discrimination in certain services such as the police services.
- Victim blaming and judging victims negatively.
- Disbelieving survivors because the effects of their trauma are not visible, leading to minimization or denial of their suffering.
- Disdain for clients.
- Service providers assume that clients have the same beliefs as they do.
- Varying levels of self awareness in service providers which then affects their ability to understand others and their situation.
- The attitude that the professional always knows best.
- Differences in service providers understanding of and thus approach to holistic services.

2. System Driven Instead of Client Driven Programming

The system has its own agenda for services leading to inflexibility and a failure to offer individualized, client driven services, thus leaving many clients' needs unmet. Participants itemized the following issues:

- Services are funding and accreditation driven rather than client driven. This creates:
 - A model of managed care and a pre-identified pathway of care.

- A restriction in the types of activities and approaches that can be provided.
 - A focus on outcomes, when healing takes a long time.
 - A focus on intervention rather than prevention.
 - Top-down, power based determination of services.
 - A focus on government philosophies rather than front-line philosophies.
 - A lack of credibility for alternative therapeutic approaches.
- Trauma survivors have to justify their need for services and accept a diagnosis or label before they are given access. This process often takes time and the real trauma issues are sometimes lost along the way.
 - Trauma survivors are not treated as a whole person. Trauma affects all parts of a person and this needs to be recognized. Sometimes their trauma history is not central to their assessment or process through the system. Trauma history should direct services regardless of the point of entry.
 - The medical model persists and some clients are over medicated, incorrectly medicated (too much, too little, wrong medication), and there is a lack of therapy in combination with this medication.

3. Limited Resource

Several resource issues were found to present barriers to helpful responses to trauma survivors' needs. Generally these focused on a lack of resources. Specific issues consisted of:

- A lack of accessible resources in rural and northern areas including reserves.
- The fact that many resources are time-limited, precluding the opportunity for longer term treatment and accessing follow-up services when they are required.
- Some resources are not meeting the needs of clients because they are not being used effectively, while in some cases there are too few programs to meet the demand. Duplication of services and under utilization of resources further lend themselves to ineffective service use.
- The lack of outreach programs that bring services to survivors, including human and financial resources.
- Significant gaps in services such as:
 - Poor access to medical and mental health resources.
 - Few services for men, children, or intergenerational trauma.
 - Culturally appropriate programming for a diversity of cultures and little access to interpreters.
 - Lack of child care in existing services.
 - Lack of services with a trauma focused context.
 - No resources for the building of natural support systems

4. Administrative and Staff Related Problems

Working within the service provider system is difficult due to factors such as low pay, high caseloads, dealing with emotionally sensitive issues, and internal policies and politics. These can

lead to a lessening of the quality of the services given to clients. Participants identified these specific areas of concern:

- The shortage in service providers within trauma related services means that many take on a large caseload which involves a lot of paperwork as well as working with clients. Furthermore, many are paid low wages. These elements along with a frequent lack of support leads to burnout.
- The staff often have their own issues related to trauma, with some being fearful of broaching the topic and others being desensitized to it.
- Because funding for some services and programs is tenuous, many staff fear that they will lose their jobs. Some feel pressure to be an expert in the field and fear that they are not qualified for the job. This leads to concerns that they will do more harm than good, yet they need the job and so are reluctant to admit their concerns or to leave the job.
- Staff and administrators have to work within the rules, policies and established program criteria which limits the amount of flexibility in programming they can provide.
- Internal politics and work hierarchies can further place stress on workers.
- Staff with credentials such as a Ph.D. cost more and staff classification should be revisited as it too impacts funding.

5. Lack of Training, Knowledge and Awareness of the Staff Within the System

A lack of awareness and training regarding trauma related issues and/or cultural approaches to these issues is prevalent within service staff. This leads to failures to provide consistent and quality services. The problems reported by participants included:

- A lack of knowledge, awareness and training for staff working with trauma survivors.
- Inconsistent approaches among professions working with survivors. For example, some like the health care system are focused on a medical model, while others are averse to this model.
- Cultural sensitivity and awareness are not always present within staff, nor are they part of training. It was believed that accreditation of staff needed to be balanced with other forms of knowledge such as traditional cultural approaches.
- There is a need for more and better quality professional development, but there is no buy-in for specialized trauma training.

6. Client Qualities and Characteristics That Can Affect Service Access

Individuals who need help with trauma recovery are often experiencing instability, poor health, and irrational thinking and personal and social characteristics that hinder their capacity to access the services they need. Particular issues that can cause difficulties are:

- Trauma survivors' behaviour may be challenging to service providers. For some learned helplessness may preclude efforts towards healing, especially if they have encountered unsuccessful forms of intervention in the past. Some may not want to disclose critical information because of their sense of shame and stigma. Personal beliefs about mental health may feed into this sense of shame. They may come from cultural or ethnic communities that work to protect and/or isolate their members.

- Survivors may not have the skills to ask for appropriate services. Some may have language and cultural barriers or literacy issues.
- Some trauma survivors may not be ready for certain services such as therapy. They may have unrealistic expectations of therapy and become discouraged with the process.
- Their lack of financial security may limit their access to certain resources.
- Individuals suffering from health conditions and terminal illnesses may not be well enough to participate in some services.
- Age and gender may differently affect individuals likelihood of accessing services in general as well as particular services.
- Individuals who are service providers may feel particularly uncomfortable about seeking services, sometimes from agencies they know.

7. System Services That are Non-Cooperative and Fragmented

Systems that are fragmented and do not work cooperatively result in clients falling through the cracks and getting lost in the system. The characteristics of these types of services include:

- A lack of communication and barriers to communication such as the culture of secrecy that often exists between different services. This makes it difficult to implement new ideas, as there is little information sharing.
- Service often have conflicting mandates resulting in:
 - Territoriality and protecting what they perceive as their 'turf'.
 - A sense of hierarchy among service providers.
 - The formation of cliques. It was suggested that Manitoba services are characterized by these types of cliques.
- Compartmentalization and lack of integration.
- The lack of a team approach. Participants identified the need for a multidisciplinary team approach characterized by networking and sharing of resources.

8. Problems Navigating the System and Accessing Resources

There are aspects of services and the system that make finding the appropriate resources a challenge. These consist of the following:

- Waiting lists that reduce the immediate availability of needed resources.
- Staff's lack of knowledge about resources which lead to inappropriate or no referrals.
- No maps or information as to how to get to resources can make them difficult to find, particularly if public transportation is used.
- The staff (contact persons, counselors) and programming change frequently.
- Central access centres with a single entry point and coordinated services that would facilitate accessing services do not exist in the current system.

9. Lack of Funding and Distribution of Funds

Funding is always an issue as the demand for services far surpasses the amount of funding made available through the system. Specific funding issues include:

- Insufficient funding.
- Time limited funding.
- Problems with how funds are allocated, such as:
 - Year to year funding; lack of stable funding.
 - Funding forces programs to be specific, thus they are not broad enough in scope.
 - Constraints on the amount available for rural programming.

10. Systemic Barriers

A number of issues related to the functioning and nature of the system make it difficult for trauma survivors to obtain the kind of help they need to recover from their experience of trauma. These are comprised of:

- Funding is often a component of political priorities and there is a lack of follow through if the political environment changes.
- Confidentiality breaches and concerns about and misunderstandings regarding privacy acts such as PHIPA and PHIA.
- Problems with the court systems functioning and its re-traumatizing survivors.
- The credibility of service providers and clients is based on their social status.
- Assessments are not always accurate and trauma is not always properly identified.
- There is often a time lag between the research and implementation of programs.

11. Other Issues

Among these more common issues, there are others that have been identified as creating problems when they are present, such as:

- Clients who have immediate needs related to issues of housing, transportation, and finances. These day to day stressors need to be addressed.
- Problematic relationships between service providers and clients. These relationships need to be characterized by rapport, accountability, and transparency.
- The policies of social agencies such as insurance companies, the Workman's Compensation Board, and Manitoba Public Insurance are often in conflict with the health care system and other social services and are restrictive in their demands on individuals who utilize them.

Question 4: What Prevents Systems From Working in a More Integrated Way in Manitoba

Summary

The predominant factor that prevents the system from working in a more integrated way is the poor communication and lack of collaborative work within it. In some cases geographic distance makes collaboration difficult. Specialization and differing structures, assessments and policies of the services also precludes their working well together. In addition the funding for services is limited leading to some regions and agencies being under funded, thus there are insufficient resources to meet the demands. Ultimately this means there is often not enough time devoted to each consumer. Limited funds also creates competition among services that contributes to feelings of territoriality and greater stigma and value placed on certain agencies within the system. This in turn discourages cooperation among agencies. The funding itself comes from three different levels of government, each with its own criteria for programming, resulting in fragmented services, gaps, and overlaps in resources. These funding agencies do not utilize input from consumers and frontline workers when determining where funds will be applied. In this way, the system maintains its tendency to be reactive rather than proactive and focused on intervention rather than prevention. The lack of consultation and agreement between funding and funded agencies leaves questions about who is ultimately in charge of programming, who has ownership of programs and who controls their process.

Further, agencies manifest some characteristics that interfere with integrated services. Lack of cultural awareness and trauma information, the use of jargon and a lack of awareness of what other agencies do are among these characteristics. Philosophical differences among agencies and systems diminish understanding and contributes to systemic hierarchies. Rigid program criteria and mandates limit agencies capacity for flexibility to work with other agencies cooperatively.

Table 4: Factors Preventing Integrative Functioning

Theme	Number of Comments Made
Fragmentation of the system and its services	55
Lack of collaboration among systems	16
Poor communication throughout the system	8
Programming and service differences	8
No central entry point	7
Specialization of services leading to compartmentalization	6
Power imbalances among systems	6
Funding problems	32
Resource deficits	25
Control, ownership and status issues	22
Negative attitudes and lack of awareness among services and systems	21
Lack of awareness of other agencies and resources	20
Administrative problems	18
Philosophical differences among agencies and systems	14
Geography	14
Rigid program structures	13
Confidentiality policies	13
Lack of input from the front lines	12
Leadership and control issues	8
Systemic approach	7
Other issues	5

Detailed Descriptions

1. Fragmentation of the System and Its Services

a. Lack of Collaboration Among Systems

Systems do not work together in the way that is required for improved services to trauma survivors. Some of the identified reasons for this deficit were:

- A lack of time and support for collaboration by organizations.
- A lack of training and planning in how to collaborate effectively.
- Isolation from other services and workers; a segregation of systems and policies.
- A lack of pooling of data and information across systems.

b. Poor Communication Throughout the System

There is a lack of adequate communication in many forms, impairing the systems capacity to work together. These forms include:

- Different levels of government do not share information.
- A lack of communication between government departments and agencies.

- A lack of communication between community workers and other professionals such as health professionals.
- Legislation inhibiting open communication (PHIPA, PHIA).

c. Programming and Service Differences

Because there are numerous different individual services that may be accessed by trauma survivors and these services are differently organized and funded, they often have a difficult time working in an integrated manner. The differences among these services include:

- Different mandates and policies, even for similar populations.
- Programming differences and different interpretations of programs depending on region and profession.
- Different organizational structures.
- Different processes of assessment.

d. No Central Entry Point

The fact that there is no central point of entry creates problems and confusion for trauma survivors and the services they access. The problems consist of:

- The criteria at the point of entry are very specific to particular symptoms.
- Paperwork and waiting lists prevent access to some systems.

e. Specialization of Services Leading to Compartmentalization

In order to obtain funding services can become very specialized in what type of assistance they provide. This leads to compartmentalization of services which has many effects including:

- There is less necessity to work together.
- Restrictive criteria and services.
- Non-holistic approach, as different symptoms and components of trauma are treated separately.

f. Power Imbalances Among Systems

The nature of the system is that some agencies, organizations, positions and professions have more power than others and these interfere with collaborative trusting relationships. Power imbalances that were identified were:

- A lack of trust between cultural groups and mainstream.
- Top-down information sharing.

2. Funding Problems

Funding issues were identified as creating a multitude of problems that hinder integrated services. Specified problems were:

- Competition between systems and programs for limited funds.

- Compartmentalized and fragmented funding from different levels of government. These differing levels of funding can also create confusion as to the structure of the funding.
- Lack of sufficient funding.
- Creating criteria and parameters that differ from one program to another.
- Topics that are currently popular or 'in vogue' drive funding.

3. Resource Deficits

Resource deficits add to the difficulty on integrating different services. Participants reported on the following resource deficits:

- Inadequate incorporation of cultural, spiritual and ethnic needs in responding to consumer needs, including providing interpreters and lack of follow through with cultural components of programs.
- Lack of time for service providers to work with clients as needed.
- Challenges in accessing needed services when they are needed. It was suggested that a centralized way to access services and up to date information about services and resources were required.
- Difficulty sharing resources among services.
- Gaps and overlaps in resources.

4. Control, Ownership and Status Issues

Jurisdiction issues such as a sense of control, ownership and status of programs and services exist and hinder a cooperative and integrated system of service. The jurisdictional issues that were believed to interfere with the integration of services were:

- Competition between agencies, professions and mandates.
- Territoriality about information and clients, which is often based on funding issues. Some felt that the medical profession was very territorial.
- Differential value hierarchies and stigma attached to some professions discourages cooperative work.
- Disagreements among levels of government about which is responsible for funding certain programs.
- Funding agencies imposing control over criteria about who gets services due to their funding the program and not due to their knowledge of the issue.

5. Negative Attitudes and Lack of Awareness Among Services and Systems

There are attitudes that result from a system that limits capacity and opportunity and some that result from personal issues. According to participants in the forum, those most detrimental to integration of services are:

- Systematic racism and prejudice. This is fueled by a lack of knowledge and understanding of different cultures including Aboriginal culture and history.

- The language or jargon used by different systems can create language barriers to communication.
- A lack of knowledge, information and awareness about trauma and some systems don't recognize trauma as a separate issues for service response.
- Shame, blame and stigma associated with trauma.

6. Lack of Awareness of Other Agencies and Resources

There is a lack of awareness of what resources are available, what other agencies are doing and an understanding of what other systems require to fulfill their mandates. Thus, there is little basis for communication and collaboration.

7. Administrative Problems

Administration can facilitate or hinder cooperative work with other systems and services. Those issues or characteristics that can hinder this process were identified as:

- Increased caseloads and lack of time to provide services.
- A focus on budget management versus a focus on services.
- Inconsistency in documentation.
- Micromanagement.
- Staff qualifications and capacity. There was concern about some staff being reluctant to go to reserves or to the inner city.

8. Philosophical Differences Among Agencies and Systems

Philosophical different lead to a lack of understanding, different approaches and mandates, and disjointed services. Some problematic issues mentioned by participants were:

- The prevalence of the patriarchal and medical models that do not always recognize trauma. Many felt there was a disconnect between communities and individuals and agencies such as hospitals.
- The lack of understanding between different philosophical approaches. Some individuals reported that the government does not understand Aboriginal culture and approaches, while others felt that the agency culture leads to different perspectives. The need for more direct service workers who work holistically was stated.
- Political differences in terms of policies, standards, and expectations.

9. Geography

Geographical distance can create problems in services connecting and working together. The cost of travel often preclude in-person communication. Some of the problems identified were:

- Geographical distance is a barrier to service provision.
- There are regional disparities in resource allocation.
- Health care is regionalized and thus limited in certain areas.

10. Rigid Program Structures

Rigid program structures that are dictated by mandates and parameters of funding can create problems in working in an integrated fashion. Structural issues identified as problematic were:

- Mandates are narrow and inflexible.
- The criteria for services are too specific and unclear. They are often program directed rather than client directed and the policies and rules come before people.

11. Confidentiality Policies

Confidentiality is important for privacy of information and to establish the trust needed to discuss very personal experiences. However, there are times when it can work against agencies working together. Examples given were:

- The PHIA and PHIPA privacy legislation prevent essential information sharing and access and involvement of personal support networks.
- Rules of disclosure differ between agencies and organizations.

12. Lack of Input From the Frontlines

Participants felt that funding systems were removed from the realities of frontline work and voiced these concerns with the following comments:

- There is no consumer input.
- Disenfranchised groups don't have a voice.
- Funders and governments are not aware of the real challenges faces by trauma survivors.
- Service planning does not look at frontline realities.
- There is increased focus on administration and not enough on direct service workers.

13. Leadership and Control Issues

Because the systems that provide funding and those receiving funding each have a vested interest in programming, issues of control often arise. A number of these issues were outlined by participants:

- Concern over who is responsible for the programming, including within the different levels of government.

- There is a need to set a political tone for what is valued.
- There is a lack of accountability for programming.
- A lack of decision making abilities within agencies.
- The ownership of programs is in question.
- There is a fear of loss of control by different systems and agencies.

14. Systemic Approach

It was stated that the system is reactive vs proactive and this places the focus on intervention rather than prevention. It was believed that this focus needed to change.

15. Other Issues

A few other issues of concern mentioned were:

- Workers and clients get lost in the system at all levels.
- There is a need to strategize goals and priorities.
- The client may be a difficult person and the lack of integrated services hinders the capacity to work with them.
- Because the system is not integrated, clients have to retell their stories, which is difficult for them and can contribute to their becoming re-traumatized.

Question 5: What Would Need to Change in Order for Systems to Work Together Better in Manitoba?

Summary

Participants felt that the primary change that has to occur is the development of working relationships and partnerships among systems and agencies. Sharing information, networking and improving communication would be part of this process. An interdisciplinary, nonhierarchical team could organize this process and plan for common goals and action. The focus of these plans and actions needs to be the provision of client centered care, where the client is involved in selecting services and making healing decisions. Clients, community agencies, government, grassroots organizations, and natural helping networks have to work together towards the same goals. Some of these goals would include increasing and enhancing the available resources and centralizing these resources in a major centre for trauma care where clients are individually assisted through the system.

Resources are also needed for service providers in the form of information on recent research and different approaches. Research centres of excellence specific to trauma that would work with service providers would be a particularly beneficial resource. These efforts must be supported through adequate funding. Funding for long term programming, wellness centres, and training in all regions is especially important to the process and can be achieved through building cooperative relationships with funders.

Changes within agencies and systems such as greater flexibility in the workplace and agency administration that supports these changes are needed. Specialized training about trauma and interdisciplinary training to allow holistic programming and culturally appropriate services are also required. Part of the training needs to work towards giving service providers credentials that will put them on equal footing with other professionals. With training, service providers could be given greater authority to help clients establish a personalized treatment plan. Another part of systemic change is related to accountability. Mutual accountability, establishing standards of practice and care and assigning an ombudsman to oversee the achievement of these standards were suggested. All of these changes will take time and within that time there is the necessity for preparation for change. Finally, it was advised that systems should not be afraid to be innovative in their approach to change.

Table 5: Areas Requiring Change

Themes	Number of Comments Made
Elements allowing for building relationships within and across systems	36
A centralized, nonhierarchical planning team or body	33
Client centered care	30
Collaboration of systems by working together in decision making	27
Financial support	25
Increasing and improving resources	23
Supportive administrative strategies	22
Education, knowledge, and accreditation of staff	18
Accountability	15
Cultural and diversification values	11
Enhanced direct services and approaches to treatment	9
Other issues	12

Detailed Descriptions

1. Elements Allowing for Building Relationships Within and Across Systems

Working together and communication are key elements in building relationships within and across systems. Specific elements mentioned were:

- Because the system is relationship based, it is critical to take time to develop working relationships across the system and develop trust and understanding with an attitude for collaboration. Collaboration should be promoted and opportunities should be sought.
- Improve communication among agencies and professionals, including among government agencies, social service providers and hospitals. Active efforts such as using common language would facilitate communication.
- Develop legislation and methods along for sharing of information such as umbrella consent and relaxing of PHIA.
- Increase networking opportunities.
- Liaisons between systems, including setting up a position for this.
- Form partnerships between agencies and work together to identify gaps and duplication of services.
- Grassroots need to advocate for themselves.
- Match service providers to communities in culturally sensitive ways.
- Encouraging being open to and committed to change.

2. A Centralized, Nonhierarchical Planning Team or Body

An interdisciplinary, nonhierarchical team is required to set the stage for working together towards a provincial plan and common goals. This planning body would:

- Involve interdisciplinary strategic planning with a plan for common goals (including long term goals), vision and action. These goals would work towards integrated service plans and a provincial plan with ongoing training and follow-up. Policies would then meet the defined goals.
- Encourage the system to be proactive rather than reactive, including preventative health. A cost benefit analysis is needed to understand the financial benefits of prevention.
- Recognize that trauma recovery is a long term process.

3. Client Centered Care

Models of care and all levels of the system have to be client focused. This requires:

- Collaborative treatment planning, which involves:
 - The client determining the team that will help them and having control over their healing decisions. Clients would meet with the team in person.
 - Involvement of peer mentors and natural supports.
 - Full case consulting and joint planning across programs.
 - Flexibility in what services are offered. This would include continuity of care and long term integrated planning.
- A holistic approach to treatment, including culturally relevant therapy and alternative therapies like yoga and traditional teachings.

4. Collaboration of Systems by Working Together in Decision Making

The client, community, agency, government, frontline workers, grassroots agencies, and natural helping networks all have to work together to make decisions and move towards mutually established goals. Participants stated that this would entail:

- Less fragmentation and territorialism, including addressing power imbalances and the hierarchies in the system.
- A balance between specialized and general programs.
- Coordination between levels of government and Aboriginal organizations.

5. Financial Support

Funding is needed to support the necessary changes for systems to work together. The funding needs mentioned by participants were:

- Funding for:
 - Long term support for stability, follow-up and long term recovery.
 - Integrated services and collaboration.
 - Community programs and wellness centres.

- Practitioner development and training.
- Hiring accredited professionals as part of the staff for service provider agencies.
- Funding allocation should be:
 - Based on values and priorities.
 - Equal across provinces.
 - Attached to people and not programs.
 - Cover a variety of types of services.
- Cooperative pooling of funds and resources for combined projects.
- Involvement and forming meaningful relationships with funders.

6. Increasing and Improving Resources

A number of resource issues were itemized as interfering with an integrated system of service, and thus would need to be addressed. The issues were itemized by participants and consisted of:

- Addressing resource gaps such as:
 - Investment of resources in rural and northern areas.
 - Providing translators when required.
 - A fully staffed mobile crisis unit operating 24 hours a day.
- Enhancing resource access in the following ways:
 - Have a one stop shopping centre.
 - Address point of entry issues by eliminating the hoops to access services, having a no wrong door policy, and establishing criteria to assist clients move through the system.
 - Streamlining referral and service access, such as sharing systems maps, a contact book for services with contact names for each service, and reducing waiting lists.
- Improve resources that would help services providers including:
 - Having centres of excellence to provide leadership in research and practice.
 - Agency and service providers having access to emerging research and recommended practices.
 - The creation of a resource coordinator position that would provide resource information for all services and system, make links between community resources and improve information technology linkages.

7. Supportive Administrative Strategies

The administration and leadership of agencies need to be supportive of the necessary changes and implement strategies that will facilitate these changes. These consist of:

- Better work balance giving more time for time consuming work.
- Leaders should reflect the goals and philosophies of the agencies and systems and should be well developed and accessible.
- Support for flexibility in the workplace in mandates and programming.
- Increased frontline staff, supervision, and diversity in staff.
- Organizational health.

8. Education, Knowledge and Accreditation of Staff

To address the lack of training in the area of trauma recovery, participants made a number of suggestions related to training and increasing knowledge about trauma. These included:

- All direct service workers need trauma specific training and training around suicide intervention and crisis counselling.
- Increased knowledge about resources and program criteria.
- The need for interdisciplinary training, which looks at the client holistically. This also includes education for physicians.
- Credentials for service providers that include registration. These credentials should take into account the skills and experience of service providers.

9. Accountability

Even with a change in the system accountability is still important, but it will have to reflect the changes that have occurred. Among the suggestions made were to have:

- An independent watchdog, ombudsman, or human rights activist.
- Accountability to service users instead of only to funders, including accountability in leadership and government.
- Standards of practice, care and evaluation.

10. Cultural and Diversification Values

The system needs to accept different approaches and see the value of offering culturally appropriate resources. Specific suggestions included:

- Culturally appropriate resources including traditional teachings and the involvement of elders. A greater understanding and sensitivity to different cultures and their practices is required.
- Vulnerability needs to be valued and oppressed individuals need to be valued.
- Diversity in hiring throughout the system.

11. Enhanced Direct Services and Approaches to Treatment

Direct service changes that are more respectful of the worker/client relationship were suggested. These consisted of the following:

- Frontline workers' ability to have the authority to determine treatment plans with consumers and to have the option to meet clients' needs as opposed to have choices imposed from management.
- Empowering clients to have a voice in their treatment planning.
- A trusting relationship between the client and the service provider.
- Evidence based practice with a focus on healing.

12. Other Issues

A number of other suggestions were made:

- Increased awareness workshops on reserves.
- Normalize trauma in the workplace.
- Mental health needs to be recognized as a real illness to eliminate the stigmatization that is associated with it.
- Having safer and more stable communities in part brought about through the efforts of service providers. This would include promoting wellness in communities and families.
- The system needs to look at what messages they are sending and to take more care the impact of their messages.
- Confidence in trying innovative approaches.
- Realize that change is a long term process and take the time to prepare for the change.
- Finding the right people to be the agents of change is important.

Question 6: What Would the Ideal System Look Like?

Summary

The ideal system would have a centralized service and resource centre housing many trauma relevant programs and resources. Services would provide a continuum of holistic care comprised of different models and evidenced based practices. Culturally appropriate approaches, prevention programs, and services for families would be part of this compendium of care. Specific efforts to network and utilize research services, share and disseminate information and stay up-to-date on the latest models, approaches and practices in relation to trauma care and service integration would need to be part of the process of this collaborative work. Clinical consultation services would also be available, especially for service providers working in rural and northern communities. A trauma resource centre would support activities that enhance the capacity of other organizations and systems to more effectively and appropriately respond to the needs of people and families affected by trauma.

Services would be client centred, and diverse and flexible enough to meet the needs of trauma survivors. An integrated team along with the clients themselves would make treatment decisions. This would mean agreement on intake, assessment, treatment and follow-up. Services would be strength based, focusing on the capacities of the clients rather than their deficits, and empowering them to expand these capacities. Clients would be involved in providing feedback about the services and modification would be based on this feedback. The services would be within the communities they served, making them easily accessible in terms of location and able to be responsive to the characteristics of the people within the community. Accessibility would also include availability 24 hours a day and eliminating waiting lists. Outreach would bring services directly to those who cannot physically access them on their own.

The larger system of governance and funding would be part of these integrated and cooperative of services. This would necessitate system practices and policies to be trauma informed and reflect the respect that they promote in their services. The current funding policies and structure would need to change to support the new trauma response system. Funds would need to be available to address issues such as poverty which exacerbate trauma experiences and delay recovery. Part of the system's support of integrated and cooperative services would include staff support strategies to maintain the physical and mental health of workers. Staff would also have to received the proper training and be given the opportunity for continued learning through professional development options. This would build their competency and confidence in helping clients heal from trauma.

Table 6: Components of the Ideal System

Themes	Number of Comments Made
Client centered programming	55
Centralized, integrated treatment planning and care	48
Coordinated services	45
Trauma informed practice and policy planning	39
Staff support	37
Minimize barriers to accessing services	35
Education for service providers	23
Sufficient funding	21
Policy changes	18
Community based programs and services	13
System accountability	12
Culturally sensitive/appropriate services	12
Outreach	10
Research	10
Prevention focused programs	9
Family, youth and child focused programming	9
Administration changes	7
More networking	5

Detailed Descriptions

1. Client Centered Programming

Programming needs to be comprehensive, flexible, and holistic enough to meet clients' specific needs. These include:

- Alternative therapeutic approaches that are valued and funded. These approaches could consist of the harm reduction model, intermittent models of care as individuals are not always in need and a resolution or mediation model.
- A strength based approach, even with long term needs. In this approach:
 - self help would be valued and adequately resourced
 - clients would be empowered rather than made dependent.
 - the idea that consumers know their needs best would be promoted.
 - clients would inform the political structure.
- A continuum of wellness and care that is flexible enough to allow clients to access services and programs as their needs change. For example, many clients are particularly vulnerable at night and need supportive and safe housing in the night.
- A diversity of programs such as community gardens, art therapy, yoga, massage, in home care, respite care, day-night hospitals, home care, crisis care in the home, vocational rehabilitation, spiritual supports, recreational resources, education and skills building.
- Support and funding for peer mentors and life coaches.

- Strengthening the ability of natural helping systems to provide resources.
- Evidence based practices.

2. Centralized, Integrated Treatment Planning and Care

An integrated treatment plan would involve a team of multiple services and the client themselves working together to establish and work towards a strategy for recovery. Specifically it would include:

- A centralized one-stop shopping centre for service that would be supported by all levels of government. The Health Sciences Centre is currently planning an emergency room for mental health issues and this might be an ideal location for the concept of centralized services.
- An integrated team that includes representatives from multiple services, community and informal supports and mentors. All team members would have clearly defined roles.
- A primary case manager to coordinate services and lead the care team.
- Clients being involved in all decisions including choosing team members and services.
- The team would ensure that clients' basic needs are met before further services are utilized and facilitating smooth transitions when client resources need to be changed.

3. Coordinated Services

Service providers and administrators across professions and jurisdictions need to work together in a spirit of cooperation and coordination for service planning and provision. Among the suggested means of achieving this are:

- Open communication and sharing of information.
- Coordinated intake, assessment and follow-up.
- Less bureaucracy and the reduction of rules and barriers between programs.
- Cooperation across jurisdictions.
- More integration and less fragmentation.
- Nurture relationships and respect among service providers, administrators and all professions.
- Values of egalitarianism.
- Having everyone take ownership for their role in service provision.

4. Trauma Informed Practice and Policy Planning

System practices have to be trauma informed and policies need to reflect these practices by being respectful and wellness driven. Participants identified the following components of these policies and practices:

- Holistic, integrated and wellness focused.
- Systems committed to healthy environments and practices and accountable to clients and to themselves.

- Mutual respect, valuing dignity for all people including the safety and security of service users and providers.
- Collaboration where all stakeholders (consumers, community, staff, government, grassroots) work and learn together.
- Clear objectives and long term goals.
- Programs instead of projects.

5. Staff Support

Various supports are needed to help maintain service providers' mental and physical health and make them better able to respond to the needs of trauma survivors. These supports consist of:

- Wellness programs for service providers.
- A healthy workplace for staff that would include professional development (especially in rural areas) and opportunities for self care such as mental health days.
- An economic system where employers value the need of employees to access services themselves and not stigmatize them for it.
- Working to reduce burnout and the effects of vicarious trauma that results in staff turnover. This could include opportunities for debriefing among staff and having staff work with others rather than in isolation.
- Equal pay for equal work across governments and communities.
- Utilize peer mentors to help deliver services.

6. Minimize Barriers to Accessing Services

Services should be easy to access to ensure the client gets care when they need it. Immediate access would be facilitated by:

- Making services accessible for those with travel limitations, such as:
 - Ensuring those in remote communities can get to services, including having staff go to the clients.
 - Have specialists and staff in rural locations.
 - Meeting transportation needs like emergency transport and bus route convenience.
 - Use chat rooms for support groups and have telephone counselors.
- Increasing after hours services by having them available on evenings, weekends, 24 hours a day.
- Increasing safe, affordable and clean housing.
- Ensuring the person is able to access the support they need when they need it. This would mean eliminating waiting lists, and having flexible criteria for admittance. Entering and exiting should be straightforward.
- Having child care access.
- Ensuring basic needs are met before further services can be utilized
- Having adequate resources for new immigrants.
- Having social workers in medical facilities.
- Using simple language that everyone can understand. Avoid using jargon.
- Working with clients and social supports on an out patient basis.

7. Education for Service Providers

Service providers and all responders need specialized training about trauma. Participants felt the components of his training should include:

- Be trauma informed and establish a standardized response for all systems and frontline workers. This would mean that all service providers would be trained to recognize trauma and symptoms like PTSD (post-traumatic stress disorder) and respond and refer appropriately.
- More ongoing accessible, affordable professional development on trauma.
- Educational institutions, programs, and faculty that reflect the demographics of the consumers. Graduates should be respectful, knowledgeable, culturally sensitive and open minded.
- Teaching standards of practice such as do no harm, be nonjudgmental, not be prejudice, and be attentive to survivors situation and needs.
- Teaching the value of integrated services.

8. Sufficient Funding

Current funding is based on the present structure of care which has been identified as inadequate. A new system of care would require a new funding structure. Suggestions made by participants included:

- Increased stable, long term and front-end funding ensured by legislation. This would allow service providers the time they need to support clients.
- A revised funding structure that would consist of:
 - Funding that would follow the client and allow service providers to provide the various supports needed by clients.
 - A more integrated funding structure.
 - Pooling of resources to serve the collective needs of a community.
- Take funding out of the political arena so it is not tied to whomever is in power (suggested model used by Manitoba lotteries and the Manitoba Liquor Board).
- Financial, time and human resources and political will to accomplish and support the changes being proposed.

9. Policy Changes

Policy changes that support a holistic approach to trauma responses would be needed. These changes would include:

- Government recognition that poverty is a significant factor in people's experience of trauma and addressing it by:
 - Legislative policy that guarantees food, safety and shelter for all.
 - Increasing money for income and disability assistance.

- Limiting or putting caps on rents for single parents, families and the working poor.
- Providing medications for the working poor.
- Introducing barter systems where people can 'work off' loans.
- Not wasting resources. For example, using empty army houses.
- Broadening guidelines to allow more than 15 hours of work to participate in assistance programs.
- A health model for funding that sees 'youth' as going beyond age 18.
- Development of trauma response policy that facilitates treatment, for example, not segregating the mental health system from other systems.
- Having one consent document for the entire system.
- Staff related policies such as:
 - Broadening the legislation that restricts the roles staff can fill.
 - Less union involvement as their policies restrict movement between programs.

10. Community Based Programs and Services

Programs that are based in the communities they serve are better aware of and therefore more responsive to the needs of the people in that community. Specific issues related to community based programs mentioned by participants were:

- Base the programs on community needs assessments in consultation with the community itself.
- Disperse funds to the communities to help them build programs.
- Place the programs in an accessible location.
- Be responsive to the uniqueness of the people who live in the community.

11. System Accountability

If the system becomes client driven, then it needs to be accountable in terms of meeting clients' needs. Part of this accountability would be:

- Ongoing evaluations by clients to monitor effectiveness of services and the use of this feedback to improve service delivery.
- Having an independent client advocate to ensure agencies are client friendly.
- Evidence of staff qualifications such as all counsellors being registered and having a mandate for training and professional development.
- Governments that are accountable for how money is spent.

12. Culturally Sensitive/Appropriate Services

Because Manitoba has a diverse ethnic population and a large number of Aboriginal people, services have to be respectful of these cultural backgrounds. These types of services would consider:

- Culturally, socially, and spiritually sensitive and adequate services and ensure that programs and services are relevant to cultural consumers.
- Culturally based and linguistically friendly services, including interpreters.
- Access to cultural services such as elders, sweatlodges and ceremonies when needed.
- The development of an Aboriginal mental health system.
- Workers who are comfortable with cultural differences.
- Working toward reconciliation through acknowledging the ongoing impact of colonization and awareness of the impact of residential schools.

13. Outreach

Outreach is important in bringing resources to clients who cannot physically access services and in educating the public about trauma and available services. Suggested outreach included:

- Building public awareness about trauma and available resources.
- Increasing the capacity of natural supports in the community.
- Going to clients to link them to community services.
- Hearing and sharing stories of people who have survived and helped others.

14. Research

Research provides information and offers resources that can benefit services. Specific suggestions were for:

- A centre of excellence and a research consultation team involving university based researchers. This centre could be part of developing practitioner competencies.
- Assessment of what has worked in other countries or cultures.

15. Prevention Focused Programs

Prevention reduces trauma experiences and promotes healthier, more resilient people. Prevention methods itemized by participants were:

- Building healthy communities including green spaces.
- Establishing a preventive versus reactive system of support.
- Using education for prevention. Education before, during and after early childhood could be used to develop resiliency.
- Investment in healthy children.
- Early intervention. For example, placing crisis workers within other programs.

16. Family, Youth and Child Focused Programming

Trauma effects entire families and can be devastating to children and youth. Therefore programs must consider families in their approach to trauma recovery. Some ideas for family services are:

- Treating the individual as well as having proactive support for their children and families.
- Having more resources and front end services for children, youth and families, such as Child and Family Services, crisis services, community centres, and boys and girls clubs. They need safe places to go without accessing the system.
- To go into the schools and talk to children and youth about mental health.
- Having a response model that allows families to ask for help, for example with parenting, to circumvent the need for child protection.
- Work at developing non-adversarial ways of dealing child welfare issues that allow family members to acknowledge and heal from experiences of trauma.

17. Administration Changes

Factors such as diverse staffing that reflects the community and decision makers that have field experience will help services respond more effectively to trauma.

18. More Networking

Networking is important in maintaining links and opening lines of communication and understanding among different systems and services. Identified networking needs included:

- Time for networking as part of the mandatory job description.
- Networking annual conferences to ensure everyone is aware of the work of others and how to maintain contact with them.
- Linkages to national organizations that may support research and appropriate practices.

Question 7: What has Worked Well in the Past?

Summary

There was a direct link between what participants felt was needed and what had worked well in the past. In particular this included client centered planning and collaboration among all system components, including the client themselves, community agencies, grassroots organizations and informal supports. It was suggested that the centralization of intake, assessment and treatment planning and the decentralization of community services worked the best, as this would necessitate accessing the system at only one point, but communities could provide programs that were maximally responsive to the people of that community. Coordinated community resources have been associated with more efficient response and a consumer friendly system has increased the likelihood that clients would access the system. Outreach raises awareness of an issue and of the services available to respond to that issue.

Collaboration and an integrated system of response that would be needed to establish a centralized response centre coordinated with community based program work best when there is a lot of regular communication. Meetings seemed to be the best method to share information and plan services. Opportunities for networking have increased positive regard and understanding among agencies, systems, and staff.

Resources for staff were felt to be particularly helpful. Resources to maintain staff wellbeing would contribute to healthier, happier workers who would then be more helpful to clients. Administration that supported a positive work atmosphere and manageable workload assisted in maintaining staff wellbeing. Document resources such as manuals, guides, and online resources have proven helpful to staff in the past. Continued education and professional development for service providers would ensure that services were based the most up-to-date, evidenced based practices and approaches. The building of staff skills would expand their knowledge and capacity. It would also provide the opportunity to expand their role. Flexibility in the service provider role would allow them to better meet the needs of all trauma survivors. The addition of emergency human resources to deal with the crisis aspect of trauma work to sufficiently stabilize the client to allow them to focus on programming for more long term effects. Increased staff in resources such as the police, emergency room response, and interpreter services have also been helpful to the systems response to other issues.

Table 7: What Has Worked Well in the Past

Themes	Number of Comments Made
Client centered care planning	21
Support services for staff	18
Integrated approach to service planning	16
Networking for agencies and staff	16
Coordinated system structure	12
Preventative resources	11
Community, grassroots and informal support involvement	9
A consumer friendly system	9
Flexible service provider roles	8
Supportive administration	8
Training, education and professional development	8
Available emergency services	7
Resource coordination	7
Treatment resources	6
Resources for staff	5
Outreach	3
Staffing resources	3
Other	4
Specific practices and programs	17

Detailed Descriptions

1. Client Centered Planning

Among the things that have worked in the past are client centered care planning including:

- A collaborative, cooperative, consumer driven approach to care planning with in-person case conferencing of all individuals involved and a case coordinator.
- Holistic models incorporating alternative methods and therapies.
- Ongoing evaluations and consultation with clients to inform services. Focus groups are often helpful in this endeavor.
- Follow-up with clients.
- Using consumers as educators about the issue.
- Gradual integration or orientation to new systems.

2. Support Services for Staff

Because staff are often overburdened, they require additional resources to support their wellbeing. Participants identified the following resources that have worked in the past:

- Trained peer mentors.
- Enhanced awareness of what other agencies and programs offer and to whom.
- Self care, holidays, and strong unions.

3. Integrated Approach to Service Planning

Participants reported that integrated systems around program planning have been successful. In particular, they suggested:

- Consumer advisory boards that oversee program planning.
- Joint meetings with the many system components represented in the program planning. Sharing practice and service successes would be part of these meetings.
- Collaboration among agencies, practitioners, family, interested groups, and clients in the planning and delivery of services.
- A clear definition of client and practitioner roles and responsibilities.
- Involving former and present consumers in the development, planning and provision of services.
- A focus on prevention.
- Strong interagency communication.
- A health care system where every person has a say, everyone's work is valued, and there is the opportunity for feedback and improvement.

4. Networking for Agencies and Staff

Networking both requires and maintains open lines of communication. Participants stated that opportunities such as forums, conferences, tours, and interagency interdisciplinary meetings have worked in the past to increase knowledge and awareness. However, they acknowledged that these depend on strong connections and good working relationships among systems.

5. Coordinated System Structure

Participants felt that a coordinated system structure with some services being centralized and some be decentralized had worked well. Specific characteristics of the coordinated systems were:

- Centralized intake with a one-door access to services.
- Decentralized community based services.
- Cost sharing of services including federal government involvement and communication at all levels of involvement.

6. Preventative Resources

Some respondents felt that certain prevention efforts had worked well in the past. Among these were:

- Gathering places such as community centres with resources like day care, clothing and food banks.
- Drop-in for schools, as in after school programs.
- Provision of adequate housing that addresses safety, affordability, quality and access.
- Free clinics such as Teen Clinic.
- Recreation drop-in services such as the Lighthouse Program.
- Community health clinics.
- Proactive initiatives focused on early supports for families, individuals, and children. For example, Healthy Baby, Head Start, parent community centres, and day cares in high schools.
- Resources that are highly visible in the community and are easily accessible (referrals are not required).

7. Community, Grassroots and Informal Support Involvement

Participants felt that community, grassroots and informal supports have strengthened the system by influencing:

- A strong sense of community and a sense of ownership and caring about the community.
- The growth of community, grassroots or church based centres that provide a holistic, multidisciplinary approach to care.
- Consistent values and philosophy.
- Services aligned with what people need.
- Mutual respect.
- Increased knowledge of recommended practices.

8. A Consumer Friendly System

Participants stated that consumer friendly systems have worked well in the past and increased the likelihood of system access. Aspects of a consumer friendly system mentioned were:

- System wide philosophical shifts for better continuity of care.
- System entry points are welcoming.
- The system is easy to navigate.
- Services are non-blaming and nonjudgmental, open to feedback and willing to change practices.
- A culturally appropriate or friendly setting.
- There are online service directives.

9. Flexible Service Provider Roles

It was suggested that when service provider roles were flexible enough, they were able to serve clients that fell outside of the criteria or mandate, and the benefit of doing this was noted. Roles could expand to include advocacy, teaching and coaching, and educating clients on available services.

10. Supportive Administration

When agency and system administration has been supportive of change by improving the work environment it has facilitated positive responses to clients. The following administrative supports were identified by forum participants:

- Ensuring a manageable caseload.
- Creating a regenerating, positive, nurturing work environment.
- Providing clinical supervision that has some flexibility and respectfully corrects errors rather than making harsh judgments.
- Introducing the use of internet and technology.
- Creating clear policies and proceedings with an openness to change.

11. Training, Education and Professional Development

Continued education would increase service providers ability to keep up-to-date with changing therapeutic methods. Examples of opportunities for training and education include cultural awareness workshops, cross program training, health fairs, community forums and conferences.

12. Emergency Resources

Trauma brings about immediate crises and participants felt that emergency resources to deal with these have proven effective in the past. Among the helpful resources have been:

- Safe houses.
- Crisis stabilization units.
- Crisis lines.
- Mobile crisis units.
- Tele-health system (especially good for rural communities).
- Emergency response services.

13. Resource Coordination

Coordination of resources and services was reported as being previously successful. Specific coordination efforts mentioned were:

- Creative problem solving for solutions that do not tie up formal resources or processes or require extreme measures.

- Streamlining access in community based agencies.
- Practitioners that focus on a range of issues rather than specializing. However, there were those who felt that existing specialized services continue to be a good source of knowledge for clinical practice.
- A bridge between acute care and community services.
- Community agency councils with regular formal meetings that are supported with a coordinating staff person.

14. Treatment Resources

Treatment resources expand the available supports and have been effective in other areas. Forum participants mentioned the following treatment resources:

- Peer support services to assist with groups and be role models.
- Access to support groups while in a 'wait group' for formal services.
- Acute treatment for children and youth.
- Treatment specific to refugee populations.

15. Resources for Staff

These resources could be used by staff to assist in service provision. The ones that were identified as being helpful in the past included:

- The Mental Health Resource Guide.
- The Mental Health Education Resource Centre Library
- An inventory of workers skills and experiences and areas of focus to facilitate help-seeking.
- Information on trauma.
- Service directories in print or online such as Contact, Encompass, and CODI (Co-Occurring Disorders Initiative) service area maps.

16. Outreach

In the past outreach has raised awareness of issues and services. Participants particularly felt that helpful outreach aspects were:

- Raising awareness so that trauma is no longer hidden using a variety of means including recovery stories of survivors and public figures.
- Increasing the visibility of services.

17. Staffing Resources

Extra staff within certain services were felt to have been effective. Suggestions were to add:

- Mental health practitioners at emergency rooms.
- Community policing and prevention.
- Interpreters and service providers who speak a variety of languages.

18. Other

Other things that were reported as working in the past were:

- Humour
- Remembering that relationships are important and boundaries need to be re-evaluated.
- Utilitarian vs rights based theory.
- Recognition of the need for change in the existing approach.

19. Specific Practices and Programs

Attendees identified specific practices and programs that have worked well. These are itemized below.

- The CODI initiative model.
- Corporate partnerships and alliances to support collaborative initiatives. These need to be supported by interagency agreements and protocols such as those of the Winnipeg Regional Health Authority and CODI.
- The t-point Child and Family Services entry system (no longer in service). Some people in the community saw CFS as supportive, accessible, and responsive to a wide variety of needs and not just 'policing'.
- System navigation phone lines has helped and something like this is needed for the whole system.
- An interagency discharge care plan from hospitals. These involve negotiating the extent and parameters of service in collaboration with clients.
- An interdisciplinary abuse consultation group with a funded coordinator. This group had two circles for consultation: regular therapy consultants and an outer circle of specialized people like lawyers.
- Klinik Community Health Centre has integrated peer mentors into program delivery and through the Dream Keepers Project has effectively involved peer mentors in a strategy for youth at risk of sexual exploitation. All of the involved agencies as well as the affected youth meet several times to determine needs, gaps and priorities. Efforts were made towards reconciliation between Aboriginal and non-Aboriginal services and individuals.
- Brandon has an excellent working relationship with the emergency room and police that allows for teaching, education and advocacy for mental health issues.
- Child and Family Services had an intake worker determine if a brief solution focused therapy would work and if so, they collaborated with the Alneau Renewal Centre who

would take the client for three to four sessions. This worked well and forged a strong relationship between the agencies.

- Multidisciplinary and multiagency teams, for example the Family Violence Intervention Team that combined police with social workers.
- A multidisciplinary approach such as PACT (Progressive Assertive Community Treatment).
- Wrap around process (Simcoe County, Ontario) where a team is structured around the needs of the client.
- ABI had a positive effect on the Child Welfare System and increased awareness of residential school damages.
- 'Role Model' awareness campaigns like Sheldon Kennedy, raises awareness of the need for service response.
- The Interagency Committee. The full committee has about 80 agency representatives who meet about two times a year. New initiatives and other agency information are brought to this committee.
- The Tri-Agency Program at the Seven Oaks School Division.
- Education, Child Guidance Clinic, Child and Family Services that:
 - Have a family health focus.
 - Prevent kids from going into care.
 - Have outreach components.
 - Contain crisis intervention.
 - Have long term programming.
 - Work with the highest risk families and children.

Question 8: What Recommendations Need to be Made to Government and Other Relevant Provincial Bodies?

Summary

The recommendations to government centered around changes in funding, funding of resources, active involvement and systemic and policy changes. There was a call for more trauma resources and programs. These included the support for trauma resource centres that would provide centralized access to numerous services. The centres and other services would employ a coordinated approach to accessing and negotiating the system to make the process easier and not re-traumatizing for clients. The need for more funding and services in rural areas was also voiced. Government support for enriching communities through education, capacity building and increasing resources would help the community respond to trauma. There was a general need to address poverty since meeting basic housing and health care needs would facilitate healing through renewed dignity and an enhanced sense of wellbeing. With these needs attended to, survivors can concentrate on their recovery process. The support of trauma informed education and training for all staff in all system levels and professions was suggested. In addition, fostering positive work environments that would maintain the wellbeing of staff and reduce burnout and turnover was recommended. Both of these measures would increase staff capacity and productivity, making them more helpful to clients. Changes in programming systems and services and the training of staff require much gathering of information about research on trauma effects and recovery and different practices and approaches to guide the development of these changes.

It was recommended that there be a change in the system structure to reflect the newly proposed system of service. A government system that adheres to the belief in safety, security and dignity for all and promotes this belief through policy and practice is required. An increase in stable and long term funding that is equitable and flexible was suggested. It was also believed that funding decisions needed to be made in consultation with frontline workers and consumers in order to be trauma informed. A holistic approach to funding would promote a broader range of intervention and follow up services. Governments and funding bodies need to be accepting of new models and approaches. Further, the government needs to recognize trauma as a health issue and this should then be reflected in funding and policy. With all of the suggested changes, there needs to be a change in the system of accountability. Increased accountability at all levels including government, community agencies, leadership, and staff is required for work done in trauma care. This multilevel accountability ensure quality services and adequate support for those services.

Beyond this higher level support, government representatives need to be part of the collaborative process to integrate the work of different systems. Political leaders need to take part in subsequent forums on trauma response. This active involvement will provide governments and provincial bodies with first hand experience as to the needs and efforts of the community and of survivors.

Table 8: Recommendations to Government and Provincial Bodies

Themes	Number of Comments Made
Increased support for more resources and programs	41
Support education and training for staff	40
Support collaboration among services and systems	32
Increase program funding	30
Increase positive work environment	30
Support resource/access centres	26
Address poverty	24
Support a coordinated approach to accessing and navigating the system	21
Increasing accountability	19
Support mandatory training for staff	18
Enrich communities	16
Change the system structure	14
Support safety and dignity for all consumers	13
Change policies	12
Recognize trauma as a health issue	11
Support a holistic and prevention approach to trauma	9
Expand the models applied to the system structure	8
Gather more knowledge	7
Other	9

Detailed Descriptions

1. Increased Support for More Resources and Programs

The largest identified area of need were increased resources and programs. Participants' recommendations were for:

- Increased resources for families and youth including:
 - Trauma counselling for children and adolescents in care.
 - Prenatal care that includes identifying risk and applying prevention measures.
 - Support and resources for family members, children and secondary victims in rural areas.
 - Counselling for families affected by violence.
 - Resources for vicarious trauma.
 - Healing centres for families.
- Housing that is decent, affordable and safe. This would also entail providing smaller social housing with resources and check-ins, and co-op housing.
- Childcare in the form of:
 - Extended hours for day care.
 - Temporary childcare while parents are receiving programming or are in residential treatment.

- Respite care.
- Increased relevant services for new refugees and immigrants, including more trained interpreters.
- Increased use of tele-health facilities.
- Peer mentor programs and the training for these programs.
- Multidisciplinary trauma intervention teams, including in rural and remote communities. An example would be a 24 hour mobile crisis service.
- Access to trauma recovery services in corrections consisting of more programs for sex offenders and for women who have used violence.
- Regional services for mental health.
- Life skills and employment skills training.

2. Support Education and Training for Staff

Recommendations for staff training and education related to trauma speaks to the need for trauma informed services. Specific suggestions were:

- Training should enhance knowledge of and sensitivity to trauma, mental health and populations being served, including cultural and ethnic sensitivity. It should:
 - Be practicum based, inclusive of lived experiences.
 - Involve clinical mentorship with supervision and consultation.
 - Include education on and incorporation of indigenous knowledge such as holistic healing training.
 - Include education and awareness about trauma symptoms in children.
 - Enhance staff knowledge about systems and resources.
 - Ensure that service providers have the skills and information to decrease their reluctance to work with people who have experienced trauma.
- More funds for training and professional development, including incentives for higher education and educational leaves. Education and training needs to be more accessible and affordable. For example, staff in rural areas should be brought in to city centers or have the educators go to them.
- Develop a centre of excellence for training. Possible ideas would be to train community persons as co-educators on trauma recognition and response and to rotate staff through all levels of the system.
- Use the CODI model for training for trauma training.
- Formal education institutions should develop trauma sensitive care competency.
- Have the Department of Healthy Living develop a protocol for education on trauma prevention.

3. Support Collaboration Among Services and Systems

Collaboration among services and systems is necessary to implement the integration of trauma care services. Governments can support this collaboration by:

- Establishing funding incentives for systems to integrate and provide collaborative services

- Taking a holistic view of how systems interact and need to work more collaboratively.
- Increasing resources and funding so caseloads can be manageable.
- Working collaboratively with different cultural communities in planning culturally sensitive services. Aboriginal communities need to take a leading role for their communities.
- Ensuring that strategies of intervention include all sectors.
- Having more frontline service provider and consumer input into system changes and planning for these changes.
- Promoting networking opportunities such as yearly service expos (i.e. the health fair) to share information about services and changes for all staff, including and especially frontline workers.
- Continuing the reconciliation process in relation to Aboriginal peoples in order to increase trust and to make positive collaboration possible.
- Collaborating with users and providers through forums and have political leaders attend any subsequent forums.

4. Increase Program Funding

Governments need to consider not only providing more funding, but also changing the distribution of funds and accepting input from others who are closer to the immediate need for programming. Thus recommendations are for:

- Increased stable, reliable, consistent and long term funding for programs and people, including mental health funding.
- Greater acceptance and funding for a healing focus.
- Examining the funding structure and consider:
 - Making funding guidelines more flexible.
 - A more equitable distribution of funding across communities and caregivers. Separate pots of funding limit agencies ability to provide flexible and multiple services.
 - Population and demographics based funding.
 - Separate funding from the diagnosis and end the reliance on and support for the medical model.
- Government commitment to think differently about how money gets spent in order to get the most effective use of service dollars. It is important for governments to listen to consumers and frontline workers about what works. Solutions should be kept realistic when considering establishing funding programs.

5. Increase Positive Work Environment

Positive work environments have been demonstrated to increase morale and productivity, putting staff in a better position to be helpful to trauma survivors who need a great deal of attention and care. Identified ways to improve the work environment are to:

- Have a flexible and supportive work environment such as:

- Providing support for staff who have been traumatized, which works to prevent vicarious trauma.
- Ensuring there are funds to support workplace wellness focus.
- Ensure equal pay for equal work across gender, education, experience, and culture. The wage disparity between community and government needs to be revisited.
- Employ retention strategies so that experienced staff remain in positions rather than relocating to better paying jobs. These strategies may include
 - Reasonable workloads.
 - Educational opportunities, touring other agencies, and self care opportunities in the work place. This would increase the likelihood of having the same worker for clients so they don't have to tell their story to a new person over and over, which delays progress and can lead to re-traumatization.
- Allowing retirees to fill in as casual staff, for staff on sick leave, or for teaching new staff.
- Have staffing reflect the diversity of the population.

6. Support Resource/Access Centres

Governments are recommended to support the establishment of wellness centres that are centralized and provide a range of services. Specific suggestions were for:

- Trauma recovery or wellness centres, especially in rural and remote communities.
- A centralized, comprehensive, holistic range of services, including transitional and basic needs, responsiveness to the needs of the community, and having available childcare.
- Specific suggestions for centres were:
 - Health access centres
 - More Crisis Stabilization Units.
 - Treatment centre for addiction, mental health and other co-occurring disorders.
- Community based centres.

7. Address Poverty

Poverty is a significant factor in trauma. It can exacerbate trauma and delay recovery by adding considerable stress to a person's life and limiting their ability to afford or focus on their healing.

Ways for the government to address poverty are to:

- Increase social assistance rates to meet basic needs and allow for extras that contribute to wellbeing and healing. For example:
 - Set housing rates based on the needs of the area.
 - Include phones.
 - Allow flexibility to move out of the system such as the ability to attend school.
 - Support all forms of medical care including medication.
 - Connect a community development model to social assistance.
- Design policies and programs to guarantee fundamentals (such as safe housing, adequate food, and medicine) for every citizen including income assistance clients and the working

poor. This may in part consist of having counselling and pharmaceuticals fall under the Canada Health Act.

- Provide transportation subsidies for people to get to services, especially in rural areas.
- Mandate Manitoba Housing to provide safe, affordable and appropriate housing.

8. Support a Coordinated Approach to Accessing and Navigating the System

Navigating the current system is difficult for trauma survivors who do not have the knowledge or emotional fortitude to cope with the multitude of different services with different criteria.

Therefore, a coordinated approach to negotiate the system is needed and can be supported by government through:

- Integrated and coordinated intake across the board and the construction of an intake form that does not cause further distress or financial cost. This would mean that clients would not have to repeat their stories to different people and reduce the likelihood of being re-traumatized by the intake process.
- Promoting a client centered, strength based, gender sensitive model that involves clients working with practitioners in the planning of their own treatment. Providing clients with information will help in their decision making process.
- Multiple entry points for treatment for a no-wrong-door policy.
- Funding for staff to develop the coordination of trauma services, perhaps out of Manitoba Health or Healthy Living.
- A 'system navigator' to increase access and direction to appropriate services.
- Face to face meetings between service providers rather than cold calls.
- Regular checks to see that basic needs are being met.

9. Increasing Accountability

Increasing accountability and having accountability at different levels will bring about a higher quality system of care. It will also increase a sense of fairness so that accountability is not unidirectional. Ways to increase accountability consist of:

- Establish provincial standards and regulations such as
 - Standard training levels for direct service jobs and accountability once qualified.
 - Provincial standards and/or guidelines for trauma treatment.
 - Regulation of practitioners and mandatory supervision.
 - Standards of service and practice. Practices should be evidence based.
 - Accreditation for agencies, licensing and certification program for helpers.
- Accountability of leadership, including the government, community leadership, management and band leaders.
- Ongoing program evaluations that include client feedback and response to this feedback. It is also important to have measurable outcomes for programs.
- Independent advisory boards for staff and clients.
- An on-site advocate who is at arms length from the funder.
- Trauma informed audits for all services to ensure that trauma work is welcome.

10. Support Mandatory Training for Staff

The government needs to support mandatory training for staff in all professions and at all levels that work with the public and trauma survivors. Ideally training would occur across professions to ensure staff are trauma informed.

11. Enrich Communities

Healthy, thriving communities produce healthy families and are better able to respond to trauma among their members. Government efforts to enrich communities could include:

- More public education and awareness to reduce the stigma of seeking help.
- Empowering and building capacity within communities to address and resolve issues, including Aboriginal communities.
- Community resources such as brochures, forums, commercials, phone book ads, that would be publicized in all communities.
- Welcome services for persons who leave rural areas or reserves for the city.
- More outreach workers.
- Support for natural leader in communities. Value needs to be placed on non-formalized service providers and cultural, spiritual and ethnic supports.
- Getting churches involved.
- Integrating mental health awareness within school divisions and working with children in schools to help them learn how to best respond to classmates who have come through trauma.

12. Change the System Structure

To formulate a new system of service, a new system structure must be established. This new system requires government support and could include:

- Broader criteria to alleviate obstacles to programming.
- Strategies to reduce waiting lists such as:
 - Implementing a plan for service while on a wait list.
 - Increased funding for mental health and hiring more frontline workers (for example in Child and Family Services and Mental Health).
- A system that is flexible and evolves.
- Seamless transitions from youth to adult services, including Child and Family Service wards.
- Developing a forum for government where all systems are present. This could take the form of an executive council that would include ministers of education, health, justice, family services, housing and labour. Conversations should be undertaken regarding service financing and development, along with consumers and frontline workers.
- Identifying needs in families for early prevention, intervention and treatment.
- Developing infrastructure and technological supports for services.

13. Support Safety and Dignity for All Consumers

A government that believes in individual rights to safety and dignity needs to promote this belief through its policies and practices. Doing so will ensure greater comfort for trauma survivors seeking services and thereby facilitate their healing. The promotion of safety and dignity can be achieved through:

- Gender, spiritual and culturally sensitive and racially unbiased services, policies and practices including:
 - Culturally relevant services.
 - Utilizing medicines and practices from other cultures.
 - Providing multi-lingual services.
- Service providers, administrators and planners need to stop stereotyping and discriminating and the racism that exists within the government system needs to be addressed.
- A stronger focus on the promotion of individual strengths.
- Acknowledging and responding to the impact of vicarious trauma.
- Acknowledging and addressing the disparities between urban, rural, remote and northern services.

14. Change Policies

A number of policies need to be revisited in order to implement change towards a new system of service. Participants specified the following policy changes for consideration by government:

- Establish an umbrella legislation that allows information sharing across agencies, while protecting clients.
- Have the legal system consider the effects on trauma survivors when determining the consequences for crimes.
- Allow youth younger than 18 years refer themselves for needed services.
- Permit immigrants to Canada to work in the profession in which they are trained.
- Reinstate status by terminating Bill C-3.
- Have insurance programs that encompass all scopes of health.
- Have trauma response plans based on community needs.

15. Recognize Trauma as a Health Issue

Participants recommended that governments recognize trauma as a health issue, with specific suggestions as to how to represent this link being:

- To have government funding bodies and all human services acknowledge that trauma and mental health are critical health issues and the system needs to be restructured to support this through:
 - The promotion of healthy living.

- Having mental health prevention and promotion moved out of health care and into the Healthy Living portfolio.
- A closer working relationship between the Department of Health and Healthy Living.
- Having hospital funding depend on community partnership with Aboriginal and immigrant agencies.
- To have staffing to support the notion of trauma as a health issue including:
 - A visiting nurse for prevention and promotion.
 - Community based therapists involved in in-patient care.
 - Sexual assault nursing examiners in every Regional Health Authority.
 - Giving mental health a place in emergency rooms.

16. Support a Holistic and Prevention Approach to Trauma

Trauma affects the entire person's being and thus services need to address these effects in a holistic manner to be maximally effective. Recommendations to governments for supporting a holistic approach included:

- Funding holistic services that run the continuum from prevention to crisis response.
- Ensuring a client centered, culturally sensitive approach to intervention and follow-up care, especially for youth with legal involvement.
- Increasing receptivity to complementary therapies and enhance coping skills by funding social, sporting, art and craft activities.
- Increasing funding for basic needs such as safety, shelter, food, and medication.

17. Expand the Models Applied to the System Structure

It was recommended that governments be open to using different models for the structuring of a new trauma system. Suggestions were for:

- A philosophical shift from a sickness model to a wellness or strength based model, including in a hospital setting.
- The development of a trauma model like the CODI model, as it has been shown to work.
- The use of a family group conferencing model.
- The use of more community development models.
- More work opportunities for those that are educated in ways other than western universities.

18. Gather More Knowledge

Knowledge about current research on trauma and approaches for prevention and intervention will provide a basis for a trauma informed system of services. The knowledge gathered should:

- Look into the provincial development of evidence based practices and models.

- Include awareness and consideration of current research and recommended practices in the development or redevelopment of programs, including research on early prevention and intervention.
- Tap unused resources such as seniors, Aboriginal people and elders and provide a guide to gather areas of expertise from other cultures.
- Look globally for models that have worked and build upon them.

19. Other

Additional recommendations for government included:

- To take direct action based on the recommendations given.
- That it promote existing trauma services.
- Implementation of Senator Kirby's report titled: *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* from the Standing Senate Committee on Social Affairs, Science and Technology. May 2006.
- To have political leaders go out to experience what navigating the system is like.

Question 9: What Do You See as Being the Immediate, Intermediate and Long Term Priorities?

Suggestions were made for each level of priority, although most suggestions were for immediate and intermediate levels. Themes such as funding, networking, resources, system wide planning, training and education, service providers and forum attendees, and administration were where most suggestions fell. The majority of the immediate and intermediate priorities were in the system wide planning theme, however many suggestion within different themes are linked. Themes and suggested actions are presented within each priority level below. The suggestions are not in any particular order.

Immediate Priorities

1. System Wide Planning

- Begin the process of making the system trauma competent.
- Create a trauma leadership group made up of consumers and professionals to undertake the system change process by developing a provincial action plan. The team should be interdisciplinary and contain a funded coordinator position.
- Write and disseminate a report from this forum and develop a knowledge transfer plan for dissemination.
- Share the recommendations made in this report with the Minister of Health and the Minister of Healthy Living.
- Conduct a community assessment. Some suggested that this be done by community members.
- Begin trauma screening and make more thorough assessments at the front end of services.
- Formalize a trauma consultation team and link them to tele-health.
- Encourage a self reflective practice where workers think about and do what they can to work collaboratively within the current system. This might be achieved by assigning a coordinator of integrated services within each agency including hospitals.
- Increase client directed services.
- Conduct trauma audits to make sure that the people currently using the system are being helped and not harmed.
- Resolve jurisdictional issues between government, both federal and provincial, and government departments and services.
- Obtain an accountability response from the government action plan.

2. Resources

- Create a manual intended to increase the sensitivity of workers to trauma.
- Utilize more holistic trauma resources to lessen wait lists.
- Provide more trauma resources for children and adolescents.
- Work with more trauma educated personnel.
- Ensure that additional services are culturally appropriate.

- Begin to attend to people's basic needs such as housing, financial, and education.
- Make contact among all agencies free and available online.
- Create a contact book or up-to-date resource list.
- Provide more outreach work. It was recognized that funding would be required for this.

3. Training and Education

- Provide orientation training and ongoing education on trauma issues to raise awareness for workers.
- Establish standardized trauma training for all frontline workers.
- Develop trauma education programs for clients.
- Provide increased education and support for Aboriginal trauma survivors, workers and communities.
- Provide training for the collaborative process.
- Increase public education on trauma services and how to access them.

4. Service Providers and Forum Attendees

- All forum attendees should return to their workplace and share the information that was learned. The voice of trauma survivors could help in this process.
- All attendees should participate in the action follow up to the forum.
- Generate awareness and enthusiasm within the workplace or agency.
- Stop victim blaming.

5. Funding

- Secure funding for implementing the trauma initiative.
- Establish new funding policies with input from service providers and frontline workers.
- Ensure adequate funding for programs and staff.

6. Networking

- Develop networks and relationships.
- Make linkages with national government and non-government networks.
- Create networking opportunities for case managers.

7. Administration

- Address staff burnout, vicarious trauma, large case loads and long wait times.
- Make offices user friendly and welcoming.
- Allow for crisis intervention even in non-violent cases.

Intermediate Priorities

1. System Wide Planning

- Develop a consensus of position paper to allow all agencies to place their support behind one vision.
- Initiate the development of a centre of excellence that would provide research, information on current practices and approaches and assist in education and training.
- Consolidate existing information on trauma and then develop a way to disseminate this information to currently practicing professionals (for example, basic training for different agencies).
- Begin the development of a trauma centre in Winnipeg to provide services.
- Develop multidisciplinary trauma response teams.
- Establish a trauma informed team or teams to provide the system and service providers with the following services: advisory services, consultation including system and case consultation, auditing and accreditation. Teams should be interdisciplinary and consist of both consumers and professionals; team membership could occur on a rotating basis.
- Increase the seamless transition from youth services to adult services.
- Mover towards a determinants of health model.
- Provide continued care between the hospital and the client's integration back into the community.
- Develop provincial policy and standards around trauma care.
- Develop legislation around information sharing among agencies.
- Develop a collaborative relationship between justice, health and family services.
- Changing mandates and policies to reflect more holistic services.
- Maintain an action focus.

2. Resources

- Piloting of the trauma sensitivity manual (construction of this manual was recommended under immediate needs)
- More community based services for smaller rural communities and Aboriginal communities.
- Develop and provide programming for consumers on wait lists (examples: coping skills group).
- Increase the amount and quality of housing and train service providers on the importance of the housing issue in being sensitive to trauma survivors. Providing co-op housing.
- Increase work incentives.
- Provide affordable, accessible and universal childcare.

3. Training and Education

- Work to educate the public on trauma impact.
- Introduce knowledge about trauma across disciplines including medical schools, nursing, social work, lawyers, police etc. One way to accomplish this is to integrate instruction programs on suicide and trauma in existing educational institutions such as universities (social work and medical programs). Compulsory courses on trauma related issues could also become part of the curriculum.
- Develop and undertake interdisciplinary community based practicum related to trauma care in collaboration with universities.
- Develop interdisciplinary training teams to provide training on trauma informed practices. Part of this training would include information on counter-transference reactions to trauma.
- More cultural awareness related to the historical trauma of residential schools, the intergenerational impact of these traumas, and response to these traumas. Awareness of historical trauma related to other cultures could also be developed.
- Training in conflict resolution.
- Beginning skill level cross training with the goal to provide services to clients that can be assisted and to know when referrals to a specialist are the best option.

4. Funding

- Prioritize funding for interdisciplinary and integrated programming.
- Increase provincial child welfare rates and funding childcare funding.
- Increase income assistance payments or funds.

5. Administration

- Hire more direct staff.
- Reduce caseloads.
- Talk with staff about their internal barriers (vicarious trauma, fear, job insecurity etc) in dealing with trauma survivors.

6. Events

- Establish forums such as this one on a regional basis.
- A large scale public expo for people who have experienced trauma, where they can express themselves through various forms (for example, spoken word, artwork, theatre, etc). This event would be attended by all levels and departments of government, the media and the general public.

Long Term Priorities

1. System Wide Planning

- Provide more community based connection for psychiatrists.
- More collaborative work among all areas of care including government and trauma survivors. The collaborative process has to be depoliticized in terms of access to government funding, attitudes and communication.
- Work to integrate all systems of care and legitimize this as part of the job not something additional to the job. Utilizing existing interagency groups to facilitate access to services could be part of this integrated work.
- Address intergenerational impacts.
- Establish a determinants of health model of care.

2. Centres

- Establish residential trauma centres throughout the city and province.
- Establish centres of excellence.
- Establish wellness centres of trauma care.
- Establish holistic community centres specific to certain populations (for example for Aboriginal people).
- Centralized intake so only one intake has to be done.

3. Resources

- Ensure that wage parity continues.
- Conduct long term research focusing on trauma in conjunction with the university.
- Have ongoing research and evaluation.
- Ensure affordable housing with a range of supports as appropriate and as needed.

4. Training and Education

- Have a system of standardized trauma training that is certified.
- Ensure practitioners at all levels are trauma informed.
- Increase cultural awareness.
- Have ongoing workshop and in-services to maintain education for staff.
- Increase education for the public to help people recognize their own or others responses to trauma and where to go for service.

5. Funding

- Have mental health and community services on par with the physical-medical field in terms of power and funding.
- Have health insurance include mental as well as physical health.
- Increased access to funding and research dollars.

6. Administration

- Ongoing annual evaluation of service provision.
- Work towards a province wide integrated service delivery model.

7. Networks

- Established professional networks consisting of government and non-government representatives.
- Share information on an ongoing basis, for example develop a website to disseminate information.

8. Events

- Hold annual forums with service providers to continue the work started and improve the collaborative and integrative efforts.

RECOMMENDATIONS FOR ACTION

Recommendations for Immediate Goals

1. Establish An Action Committee

Just as a committee was gathered to organized and deliver the trauma forum, a committee should be formed to oversee the initiatives that result from this forum. As with the forum planning committee, this action committee should be composed of representatives from a variety of systems including community agencies and organizations, health care, provincial and federal governments, and consumers. A funded coordinator position would be needed to organize meetings and events, disseminate information from the committee, and act as a contact point for committee members and other individuals providing input into the committee activities. Among the first tasks of the committee would be to formulate a provincial plan of action based on these recommendations and the results of this forum. This plan could be circulated to a variety of system services for approval and to ensure a shared vision of change.

2. Construct and Distribute a Resource Guide for Dealing with Trauma

A manual or guide comprised of information on trauma, practices and approaches for dealing with trauma, and listings of other trauma related services should be developed. The guide should use information and language that makes it accessible to all levels of service. Forum participants indicated that these types of guides were helpful in assisting them in providing services for other issues and thus, would be helpful in trauma recovery services. The information within the guide ought to be based on current knowledge and research and should be constructed in consultation with service providers and consumers. A working committee could be formed for this purpose.

3. Increase Communication and Collaboration

Increasing and maintaining communication is important in beginning the process of more integrated services. Lines of communication among all levels of services and with governments and funders must be kept open. There are several ways this can be accomplished. Opportunities to work together collaboratively will enhance communication, understanding and trust. Funders could be more open to input from frontline workers and consumers. Networking opportunities such as annual conferences and meetings on trauma and annual forums to discuss progress and ways to improve efforts towards trauma responses would open avenues of communication and build a familiarity among different areas of service. Establishing a website where trauma information could be accessed would help link individuals and keep them apprised of the progress made in implementing changes, access

documents produced related to trauma informed services, and remind them of upcoming networking events.

4. Gathering Information on Trauma

Many of the immediate goals would benefit from available information on trauma and trauma services. This information could be disseminated to all systems of service and consumers for a greater understanding of trauma. Information that could be immediately useful would be: causes, effects, recovery, treatment practices and approaches, existing services in different locations, a bibliography and summary of trauma approaches (including cultural approaches). This information would also facilitate the construction of the recommended resource guide for service providers. If a website on trauma issues is established, this information could be posted on the website.

Recommendations for Intermediate Goals

1. Standardized Trauma Informed Training

Certified trauma informed training for practitioners at all levels of trauma care was suggested. A manual should be constructed to guide this training and the resource guide (the construction of which was recommended as an immediate goal) could be used as a guide for the construction of this manual. Training should include information on different cultural approaches and alternative practices that may be used. An interdisciplinary training team that involves trauma survivors as guest speakers or co-trainers should be established. Beyond this training, practitioners should be offered opportunities for continued education in order to keep up with new developments in treatment and new trauma issues. Further, increased knowledge about trauma would reduce the stigmatization of clients.

An added component of training could include encouraging post-secondary education institutions such as universities to add trauma informed training as part of the curriculum for disciplines such as nursing, social work, medicine, mental health, psychology, and education. Practicum students from some of these disciplines could be placed in trauma response services for further specialization in training.

2. An Integrated System of Services

Establishing a province wide integrated system of services would greatly benefit trauma survivors. The integration of all systems is important to the success of this endeavor, these include community agencies, health care agencies and governments. Within agencies this integration of services has to become part of the job rather than the occasional exception. Therefore agency administration and funding has to support this integration of service. Training in how to accomplish this integration of services on a daily basis must become part of job training. Government has to modify policy related to information sharing among agencies. To facilitate the process of service integration an interdisciplinary trauma

consultation team would provide system and case consultation. Members could be rotated on a regular basis to avoid overburdening the same individuals.

3. Funder and Funding Support

Governments and other funding bodies need to become involved in the plan of action for change. This will mean support for the new trauma initiatives and involvement in planned activities. Funders could set priorities for funding interdisciplinary and integrative programming. They must also support the need for increased staffing to accommodate the recommended expansions to trauma care, including staff care and reasonable workloads. Further, although project funding can be short term and time limited (for example, constructing a resource guide), program funding needs to be long term. Rather than funding three year demonstration projects, programs could be given a probationary period and long term funding would be predicated on their demonstrating their capacity for valued service provision.

Recommendations for Long Term Goals

1. Establish a Centralized Trauma Care Centre

One of the common themes resulting from the forum was the need for a centralized wellness or trauma care centre that would conduct one intake and one assessment that could be accessed and used by all other services the client utilized. This would limit the number of times the client would have to undergo these preliminary steps to treatment. The centre would also contain a number of trauma related services that would provide cooperative and integrated care. These services would also coordinate treatment with community based agencies for a holistic and complete continuum of care.

2. Client Centered, Strength Based, Holistic System of Services

One of the issues recognized through this forum was the need for clients to be involved in their treatment planning. They, along with an interdisciplinary team of service providers or a service provider who has experienced (or been trained) in treatment planning, could jointly decide on a plan of action and the client could then be guided by this team or worker through this plan. This plan could be part of the services offered at the centralized trauma care centre recommended above and would require funding support. Services taking a strength based approach would also build on clients' capacities while they are healing from their trauma. These would also work with the recommended holistic approach to treatment, where all aspects and needs of the client are addressed and informal support systems are respected and encouraged. These approaches recognize the multidimensional nature of trauma survivors and respects them as active agents in their lives.

3. Establish a Research Centre of Excellence

This type of research centre could be part of the system of collaborative service. Its tasks would revolve around being responsive to the needs of the systems of trauma response. It would provide consultation on community research and program evaluation, conduct research on trauma in conjunction with the community, assist with agencies evaluations of their services, conduct service audits to ensure clients were being helped rather than harmed, and assist in the recommended trauma informed training. This centre could also maintain a website on trauma information that would be accessible to all.

4. Additional Programming

Programming for clients on waiting lists, additional programs for clients in rural, northern, and remote areas, and culturally based programming need to be considered as highly beneficial to trauma survivors and as recommended courses of action. The establishment of a multidisciplinary trauma response team (in the nature of the Family Violence Intervention Team that combined police with social workers) that would respond in crisis or emergency situations should also be considered. These added services would have to be supported through long term funding. Additionally, there was a call for addressing social stressors that exacerbate the effects of trauma and hinder recovery, such as poverty, housing and employment. It is realized that these are systemic issues that go beyond the scope of the forum, nevertheless, they do bear mentioning.

PART II: THE PROCESS

INTRODUCTION

In the spring of 2007 a committee of service providers, provincial and federal governments, and trauma survivor representatives formed a committee to plan a provincial forum on trauma and service provision to trauma survivors. The event was based on a similar forum on suicide and suicide prevention (Shaw, 2001) that successfully launched a number of projects and policies that were effective in education, intervention and prevention of suicide. With the same goals in mind for trauma, the committee organized a forum on trauma for the 4th and 5th of July, 2007 at the Franco Manitobaine Cultural Centre in Winnipeg, Manitoba.

THE COMMITTEE

The committee consisted of individuals who represented service provider and systemic agencies that have an interest in providing more effective services to trauma survivors, including:

- The Public Agency of Canada, Government Canada
- The Department of Health, Government of Manitoba
- The Winnipeg Regional Health Authority
- The Provincial Addictions Network
- Klinik Community Health Centre
- Native Women's Transition Centre
- Department of Sociology, University of Manitoba.

THE ATTENDEES

The event was attended by approximately 325 individuals from a variety of agencies and systems across Manitoba. Among the areas represented were:

- Winnipeg
- Thompson
- Brandon
- Eden
- Headingley
- Brokenhead Ojibway First Nations
- Pinaymootang First Nations
- Peguis First Nations
- Fort La Bosse S.D.
- Inwood
- Rolling River
- Swan River
- Norway House
- Selkirk
- Flin Flon
- The Pas

Agencies and systems registered for the event included:

- Social services
- Family violence service agencies
- Health care agencies
- Justice and corrections
- Education and school systems
- Mental health services
- Addictions
- First Nations and Aboriginal organizations
- Provincial government
- Federal government

THE AGENDA

The event began with greetings and opening remarks from the planning committee, the Minister of Healthy Living, and the Public Agency of Canada. Blessings and a drumming group were also part of the opening session. These were followed by a keynote address by Clarissa Chandler on the importance of taking a collaborative approach. A copy of this keynote address can be found in Appendix B. Presentations of personal stories of trauma from a number of different individuals were the last component of the morning of the first day. DVD copies of these presentations are available from Klinik Community Health Centre. A presentation on the generational trauma associated with residential school experience, given by Chickadee Richards was part of the opening session on the second day. The purpose of these stories was to exemplify the range of trauma experienced, the systemic response to the needs of trauma survivors, which responses prove helpful and which are less helpful. It was expected that these presentations would focus forum participants for their tasks within the two days and help them work towards improving systemic responsiveness to trauma.

The remaining time was spent having participants brainstorm and respond to questions designed to determine the most effective means of improving systemic response to trauma survivors.

These questions were:

1. What do trauma survivors need to minimize the effects of trauma and/or to survive?
2. What happens to trauma survivors when they try to enter and function within the larger system?
3. What have been the challenges and barriers within the system that make it difficult to respond to and acknowledge the needs of this population? Please consider attitudes, values, beliefs, training, etc.
4. What prevents systems from working in a more integrated way in Manitoba?
5. What would need to change in order for systems to work together better in Manitoba?
6. What would the ideal system look like?
7. What has worked well in the past?

8. What recommendations need to be made to government and other relevant provincial bodies?
9. What do you see as being the immediate, medium and long term priorities? What should be the next steps?

Part I of this report presents the content and analysis of forum participants' responses to these questions. The agenda for the event can be found in Appendix C.

There were approximately 30 tables with eight to ten participants per table. Each table had a facilitator, who helped to maintain the discussion and keep people on topic, and a recorder, who wrote down the participants' responses. For each questions four randomly selected tables were asked to report their responses to the larger group and other tables were invited to add responses not already presented. The recorded responses were gathered and given to researchers from RESOLVE for thematic analysis. Each table was asked to note the name and contact number of the recorder in the event that researchers required clarification of responses.

LIGHTBULB MOMENTS

Participants were invited to share their views of the event, sessions, presentations, and activities and/or personal or professional revelations coming from their participation in the forum on flip charts at the back of the room. People could read others' comments and share their own perspectives and revelations. Comments followed the content of the forum with most pertaining to systemic and service responses to trauma and perspectives of trauma. The comments made can be found in Appendix D.

EVENT EVALUATION

During the last session of the second day forum participants were asked to complete a brief evaluation form. A copy of this evaluation form can be found in Appendix E. The results of this evaluation are presented below and may prove helpful for individuals planning a similar event.

EVALUATION RESULTS

Response Rate

Out of the 325 attendees at the forum, 170 completed an evaluation form, for a 52% response rate. Given that this sample represents over half of the attendees, there is a great degree of confidence that these results are representative of the opinions of those attending the forum. Biases inherent in those returning the evaluation and those who did not, however may exist.

Perceptions and Impact

Overall, the evaluation results were very favorable. Attendees responded to a set of 10 questions about their experiences and perceptions of the forum by indicating their degree of agreement or

disagreement on a scale from 1 (strongly disagree) to 5 (strongly agree). Responses were averaged; the higher the score the more positive the experiences and perceptions of the forum. Table 10 below present the items and the average scores obtained. Attendees expressed positive views and in particular felt that the forum was a good use of their time, that it was helpful, that they would be more involved in promoting the need for trauma informed services, that they were more aware of the needs of those affected by trauma as well as the barriers they face in accessing services, and felt more prepared to work with other organizations and systems to better meet the needs of these survivors. The general consensus was that they would attend another forum in the future.

Table 10: Average Scores on Evaluation Questions

Item	Average Score
Attending the forum was good use of my time	4.09
The forum was helpful and useful.	3.89
The forum will likely make a difference in improving services for people affected by trauma.	3.48
The forum will make a difference in how I work.	3.55
I will be more involved in promoting the need for trauma informed services.	4.07
I am more aware of the needs of people affected by trauma.	3.88
I am more aware of the barriers people affected by trauma experience when accessing services.	3.95
I feel more prepared to work with other organizations and systems to better meting the needs of people affected by trauma.	3.75
I am leaving the forum with concrete ideas for how my organization could improve how it responds to people affected by trauma.	3.57
I would attend another forum.	4.13

Changes Resulting From The Forum

Attendees were asked to describe one or two things that had changed for them as a result of attending the forum. A total 125 of the 170 (74%) who completed evaluation forms responded to this question. A number of changes were listed and these are summarized below. Only 4% of these individuals stated that nothing changed for them as a result of attending the forum. Table 11 below outline the responses related to changes experienced by participants. Some individuals had more than one response and therefore percentages often add to more than 100%. All comments falling in the category of "others", in the detailed descriptions that follow the table, were mentioned by 1% - 4% of the respondents.

Table 11: Changes Due to Attending the Forum

Response Category	% out of 125
Increased Awareness of Service Needs	30%
Increased Awareness of Trauma Effects	25%
Knowledge of the Nature of Existing Services	22%
Increased Motivation	14%
Personal and Professional Validation	14%
Other Changes	6%

1. Increased Awareness of Service Needs

Among the most prevalent changes reported by attendees was an increase in their knowledge and awareness of service needs for trauma survivors. These included:

- 14% reported a greater understanding of the needs of trauma survivors. The barriers they face to obtaining services, an understanding of a strength based approach and the need for a one-stop-shop with numerous services in one locations were part of this service needs awareness.
- 8% stated an increased awareness of the need to integrate services within and between agencies. The need for interagency collaboration, networking, the "no wrong door" principle were part of this awareness. Some had also learned why there was resistance to integration.
- 5% indicated that they learned the importance of working with clients where they are in their journey of healing and to involve them in the assessment and treatment process.
- Others gained an awareness of cultural issues and needs, including the need to include more cultural information in services to trauma survivors.

2. Increased Awareness of Trauma Effects

Gaining knowledge was reported by a number of individuals. This consisted of:

- 19% learned more about the issue of trauma, with most becoming more aware of the effects of trauma.
- 6% reported a greater awareness of the effects of trauma and subsequently what types of services are effective and what is not effective.
- Others reported greater understanding of the issue and of individuals' resilience.

3. Knowledge of the Nature of Existing Services

Many attendees also reported an increase in their awareness of existing services and the nature of existing services. These included:

- 14% gained greater awareness of the available services for trauma affected individuals. For some this included networking and making contacts at the forum.

- 6% gained a greater understanding of the systems response to trauma, including the fragmentation of services and the insufficiency of existing services.
- Others learned about the differences between urban and rural services, including the more collaborative nature of rural services.

4. Increased Motivation

A number of individuals stated an increase in their motivation to action. These consisted of:

- 8% reported being more focused, committed and enthusiastic about working with trauma survivors.
- 5% who wanted to begin implementing the suggestions and solutions that were generated at the forum. Some of these individuals expressed that they now had concrete steps to take.
- Others were more motivated to work with a holistic system.

5. Personal and Professional Validation

Some of the attendees obtained validation for their own and/or their agency's knowledge and work including:

- 10% felt validated in their knowledge and work, greater confidence in their understanding and skills, and no longer alone in their interest in this issue.
- Others stated that it was good to know that their agency was not alone in struggling to obtain or provide quality services for survivors.

6. Other Changes

A number of other changes were mentioned by 1% to 4% of respondents. These included:

- Issues related to research such as recognizing the need for more research about trauma and its effects and concern that research may re-traumatize participants.
- Greater awareness of the experience of Aboriginal people such as changes in their views of residential schools and a greater awareness of systemic racism.
- Increased awareness of the need for more information dissemination including the need to promote understanding of the needs of survivors and the barriers to service.

The Most Helpful Aspects of the Forum

Attendees were asked what they felt was the most helpful part of the forum. A total of 152 out of 170 (89%) responded to this question. There was quite a bit of consensus about the most helpful parts of the forum. The categories of responses are outlined in the table below, with more detail following. Some individuals had more than one response and therefore percentages

often add to more than 100%. All comments falling in the category of "others", in the detailed descriptions that follow the table, were mentioned by 1% - 4% of the respondents.

Table 12: Most Helpful Components

Response Category	% out of 152
Hearing from Trauma Survivors	53%
Interacting with Others	33%
Group Work	27%
Information on Trauma	16%
Other	9%

1. Hearing From Trauma Survivors

The most prevalent responses given were related to the panel discussion and being able to hear directly from trauma survivors. Specifically:

- 47% stated that they liked listening to the trauma survivors. Some felt it helped to focus their discussion and gave them a sense of different types of trauma.
- 6% particularly liked hearing what worked and what did not work for trauma survivors.

2. Interacting With Others

Many individuals appreciated the opportunity to interact with others about this topic. Among the responses in this category were:

- 17% like sharing ideas and learning from others.
- 16% liked meeting others and networking.

3. Group Work

A number of responses referred to certain aspects of the group work done by attendees. These included:

- 24% liked the brainstorming and discussion. The questions leading the discussions, coming together for the same purpose, and beginning to plan how to reduce service barriers were part of this response.
- Others particularly liked the group and/or Clarissa's facilitation. Some felt that the pre-assigned process for reporting discussion results freed up their time to answer the questions.

4. Information on Trauma

A few individuals like the information about trauma that they were given.

- 9% liked Clarissa's presentation.

- 7% liked the broad perspective of trauma services and the focus on the single theme of trauma for the entire forum.

5. Other Responses

Other responses included (made by 1%-4% of the respondents):

- The diversity of the crowd.
- Validation for what they were doing.
- The attendance of government representatives.
- That the conference was free.
- The lunch provided.
- The first day's events (no specific aspect was mentioned).
- The surroundings, acoustics, sound system.
- The handouts on trauma from Klinic.
- Knowing the information resulting from the forum will be processed further.
- Everything about the event.

Suggestions for Doing Things Differently

Attendees were asked what could have been done differently in planning the event. A total of 122 individuals out of 170 (72%) responded to this question. Several individuals (12%) stated that nothing could have been improved and that the event was well done. The remaining people had wide a variety of recommendations that have been summarized in the categories outlined in the table below. Some individuals had more than one response and therefore percentages often add to more than 100%.

Table 13: Recommendations

Response Category	% out of 122
Changes in Event Processes	48%
Changes in Individuals Attending	33%
Provide More Information	24%
Changes in Environment/Facility	8%
Lunch	7%

1. Event Process Recommendations

The largest number of recommendations were related to the process of the event and its planning and preparation. The most common ones were:

- 23% felt that the questions in the small groups were repetitive, making the process tedious. They suggested having greater variation in activities and a shorter time for the

small groups and more time for sharing among groups. Some wanted a variation or change of activities to maintain the energy. Among the suggestions were having certain exercises or ice breakers and having wellness breaks other than just having snacks. Some felt these were especially important after the lunch break.

- 8% suggested having a greater diversity of occupations and/or agencies represented within the smaller groups.
- 5% wanted the people in the group rather than pre-assigned facilitators to write out the responses. Alternately they suggested training the facilitators, as it was felt that the facilitators only represented their own perspective in the responses.
- Others suggested that forum planners (made by 1%-4% of the respondents):
 - Send out more information before the event to allow people to prepare. For example, sending out the questions that would be discussed.
 - Narrow the scope of the topic to community or individual trauma, doing both is too much.
 - Leave more time for events, as the schedule seemed too tight.
 - Have a follow-up event where ideas about how to implement the suggested ideas could be discussed and people would be able to stay involved in the process.

2. Recommendations Related to the Individuals Attending the Event

Several people made suggestions related to the presenters and the attendees.

- 12% suggested including a greater diversity of attendees including political decision makers and politicians, police, hospital staff, more Aboriginal organizations, and spiritual leaders.
- 5% recommended having fewer panel members to allow each person more time to speak and to allow time to ask panel members questions.
- Other suggestions were to (made by 1% - 4% of respondents):
 - Have more people sharing their experiences and focused more on what was and was not helpful for them.
 - Have a moderator/facilitator for the impact narratives.
 - Include greater cultural diversity in the survivors who share their experiences by including immigrants and war refugees.
 - Have a panel discussion with government and political leaders and have a national or international forum for service providers and administrators.
 - It was not necessary to get a facilitator from Toronto (perhaps they wanted someone local, but this was not specified).

3. Recommendations for More Information

About a quarter of the individuals made a number of recommendations related to providing them with more information.

- 6% suggested that to facilitate networking, a contact list for everyone attending (with the permission of the attendees) including the sectors/disciplines they represented should be provided, and time should be set aside specifically for networking.

- 5% suggested that more information about trauma care and what services currently exist be provided, concentrating on services for rural and remote areas. This can include having agencies display information on their services.
- Others suggestions were to (each made by 1%-4% of respondents):
 - Provide a list of common terminology and definitions.
 - Provide information about trauma services in different regions of the country and in different countries, especially services and strategies that work to facilitate treatment and address barriers.
 - Let people know about presentations such as the panel talking about their trauma experiences before the event so they are prepared for the resurfacing of their own trauma and to have resources available if this occurs.
 - Provide more information about traditional Aboriginal healing.
 - Let people know how the information will be used to promote services for trauma survivors.
 - Give participants copies of the small group discussions.

4. Recommendations Related to the Facility or the Environment

Others made suggestions associated with the venue, the supplies given, and the room, including (each made by 1%-4% of respondents):

- Have smaller separate rooms for small group discussions.
- Have a room with natural rather than florescent lighting.
- Have live cameras so everyone in the room can see the speakers.
- Have the event occur earlier in the year.
- Provide more comfortable seating.
- Have a different venue.
- Provide supplies such as pens, better overhead pens, and more paper for recording notes and have only brief notes for overheads and more detailed notes on paper.

5. Recommendations Regarding Food

Others made suggestions about the food/lunch provided:

- Have fruit available.
- Have recycling bins.
- Have a shorter lunch period.
- Make lunch reservations on email prior to the event.
- Have everyone stay for lunch.

RECOMMENDATIONS FOR FUTURE FORUMS

1. Include Experiential Stories

Other forums should include experiential stories discussions. Half of the individuals who responded to the evaluation expressed that this was one of the most helpful aspects of the forum. These stories were not only informative, but they helped to focus the subsequent discussions in the forum.

2. Ensure Diversity of Participants

Forum participants should represent all of the services and systems relevant to the topic of discussion. Further, each table should contain representatives from different systems and services to allow networking and a more direct exchange of ideas, a component that was suggested by several participants. Related suggestions that could be taken into consideration are: circulating a contact list among attendees, setting aside time for networking, and having participants stay in the same facility for lunch to provide an added opportunity for networking.

3. Provide More Information for Participants

Attendees suggested that more information be provided before the event such as the services that will be represented, the questions that will be asked, and the general content of the forum presentations. These would allow people to better prepare for the information they will be given (it was felt this would be beneficial especially for hearing personal stories and the issues they may trigger for some attendees). Information provided at the forum could include a list of provincial and national services dealing with the issue at hand; services could be encouraged to display information at the forum. Handouts on traditional/alternative approaches and/or topic related definitions could also be given out for clarification of discussions and for future reference.

CONCLUSION

The forum was successful on many levels. First it was well attended by individuals from various regions of Manitoba and a wide range of agencies and systems. Second, it was positively evaluated by attendees. Third, participants worked hard and completed all of the tasks assigned to them. Consequently, all of the objectives of the forum were achieved and this has meant significant movement towards achieving the goals of the event. Thereby the forum achieved what it intended to accomplish. Below each of the goals and objectives are revisited along with evidence of their achievement or of significant accomplishments towards their achievement.

Goals

1. Promote and facilitate systemic change in order to
 - a) increase the capacity of organizations and systems to better respond to the needs of people affected by trauma;
 - b) increase the capacity of individuals, families and communities to better respond to future crises, trauma and emergencies.

Participants were very supportive of this type of capacity building and implementing some of the recommendations from the forum will help to achieve this goal.

2. Begin developing a strategic plan and identify priorities and the next steps for facilitating systemic change and capacity building in the area of trauma recovery.

Priorities were identified by the participants as part of their responses to the ninth question for discussion. Specific priorities have also been outlined in the recommendations section of the report. These recommendations can be used to develop a strategic plan of action, in fact one of the recommendations is to develop such a plan.

Objectives

1. Provide a venue and format for service providers and individuals with a vested interest in trauma to meet and discuss issues related to addressing the needs people and families affected by trauma in the province of Manitoba.

The forum fulfilled this objective. Within the forum there were specific questions that formed the basis for discussions on the needs of families and people affected by trauma in Manitoba. Participants gave very thorough responses to these questions thereby providing a lot of information upon which to base future strategic plans. Further, participants expressed a lot of appreciation for the forum, its process and its intent. In fact many wanted more of an opportunity to network and interact with attendees from other agencies and systems. They suggested that future forums place individuals from different systems within discussions groups and have participants stay at the forum location for lunch to provide more time for networking.

2. Review current research and practices in the area of trauma with an emphasis on recovery and treatment.

This task was completed through a collaborative effort of members of the planning committee. A bibliography can be found within Appendix F of this report. Implementing the recommendation to construct a resource guide or manual related to trauma effects and practices and approaches to treatment will utilize and add to this bibliography.

3. Identify and review services currently available for people affected by trauma in Manitoba.

This review was accomplished by the planning committee and the information gathered was utilized to disseminate notices and invitations to the forum. The forum was attended by individuals from all regions of Manitoba and all systems that respond to trauma. A list of these services and contact people were requested by forum attendees. This list could be one of the products of this forum and could be included in the resource guide or manual that was recommended.

4. Identify gaps in services and current needs of individuals and families affected by trauma.

This was completed as part of the questions posed for discussion within the forum. The most frequent responses referred to trauma survivors needs for compassion and respect from service providers, supportive therapeutic process that was client centered, and more resources to assist in their recovery. It was also these three areas that were the most frequently identified systemic barriers and challenges that interfered with responding to the needs of trauma survivors. In the evaluation of the forum, participants stated that their increased awareness of the effects of trauma and the needs of trauma survivors was what they gained most from the forum.

5. Identify core components for promoting a comprehensive and integrated framework of approaches to trauma recovery.

This too was completed as part of the questions and discussion of the forum. The most frequent responses were related to building relationships within and across systems, a centralized, nonhierarchical planning team, client centered care and collaborative decision making across systems of care. Recommendations were related to integration of services and the implementation of the strategies identified as essential to establish this goal.

6. Identify a process for developing a trauma recovery strategy in Manitoba including short term, intermediate and long term goals.

The last question posed during the forum had participants identify immediate, intermediate and long term goals for development a provincial trauma recovery strategy. Immediate goals included the formation of a leadership group to plan and oversee new initiatives, the creation of a trauma recovery resource guide for service providers, and increased communication and collaboration. Intermediate goals included establishing standardized training for all those who work with trauma survivors, integration of services, and develop provincial policies and standards in relation to trauma care. Long term goals included the establishment of a trauma research centre of excellence, a centralized centre for trauma care, and implement client centered, strength based and holistic treatment. The recognition for increased networking, involvement of government, and established funding for trauma initiatives was part of each level of priority. Therefore the process for development a trauma recovery strategy was achieved.

7. Identify opportunities for enhancing service coordination and collaboration.

Again the forum included a specific question and discussion session around this issue. A number of suggestions were made including increasing opportunities for networking and communication such as having regular forums, workshops, conferences and meetings; engaging in joint projects such as working together to take action based on this forum; and the formation of a provincial interdisciplinary planning team to coordinate action towards goals. Client centered care that utilized treatment planning teams and the development of a centralized trauma recovery centre that housed a number of services would also provide opportunities for service coordination.

8. Identify a process for enhancing health care systems and service organizations becoming more trauma informed and thereby increasing their capacity to effectively address the needs of individuals affected by trauma.

This was accomplished and suggested means of enhancing services included developing standardized, accredited and specialized training on trauma; ongoing education and professional development opportunities; and the creation of a guide or manual on trauma and recovery that could be used as a resource by service providers. The call for accountability at all levels would further work to ensure that the best services are being offered and that clients are being helped rather than re-traumatized. The recommended establishment of a centre of excellence that could provide trauma related information and consultation, advise and conduct research on trauma in conjunction with the community, assist with agencies evaluations of their services, and conduct service audits, would help to enhance systems of service.

9. Identify opportunities and initiatives for promoting professional development and increase the capacity of individual service providers to better respond to the needs of trauma affected individuals and families.

This too was accomplished. As mentioned, participants suggested that standardized trauma based training be developed and that all service providers would take part in this training. The training would be delivered by a multidisciplinary team that would teach a variety approaches and practices for trauma care. Exploration of the possibility of having post secondary education institutions such as universities include trauma training as part of the curriculum for disciplines such as social work, nursing and medicine was also suggested. Continued education through attending trauma workshops, conferences, and in-services were recommended.

10. Establish a trauma recovery network.

A significant amount of networking occurred at the forum. Further there were discussions and suggestions as to how to enhance networking. These include creating a website where trauma information could be accessed, holding regular conferences, meetings and events for networking, and sharing a list of provincial trauma services and contact persons at each service. In the evaluation of the forum, participants stated that interacting with others was one of the most helpful aspects of the event.

Although the forum only occurred at the beginning of June, there are already actions towards collaborative work being done. Dr. Elaine Mordoch and Dr. Wanda Chernomas from the Faculty of Nursing at The University of Manitoba, who attended the forum, are working in

collaboration with the forum planning committee and RESOLVE to plan a presentation on response to childhood sexual abuse trauma at the Mental Health Conference in Banff in November 2007, and there are have been follow up meetings of the planning committee to discuss future plans for action. These along with the accomplishment of objectives and the positive response to the forum demonstrate its success and value.

APPENDIX A: Introductory Comments

Tim Wall's Welcoming Address

Good morning and welcome to the Manitoba Forum on Trauma. I'd like to especially welcome our friends and colleagues who have traveled from all over Manitoba to be here with us today. The response to this event was overwhelming and it is extremely gratifying and encouraging to see that so many people share our interest in trying to enhance the capacity of organizations and systems across Manitoba to respond to the needs of the thousands of people in our province who have been affected by trauma.

Trauma comes in many forms and affects at least one in four of us in some way. There are likely few people who are here today who have not been either directly affected or knows someone who has been affected by trauma be it; childhood abuse, family violence, suicide, homicide, war, residential schools, physical or sexual assault, and other forms of crime. Many of the problems people, families, communities and our province face today can be directly linked to previous and current trauma and posttraumatic stress. Poverty, addictions, sexual exploitation, homelessness, crime, suicide and many mental health problems such as depression, anxiety and personality disorders find their roots in trauma. When trauma goes unresolved the cost to our health care and social service systems is enormous and the pain and suffering that people endure is incalculable. Yet in spite of this knowledge much of our resources and efforts focus on only addressing the symptoms rather than the causes and going to the heart of the problem.

While those of us who work in trauma recovery are constantly inspired by the resiliency and strength of the human spirit time is not always the only requirement for healing the hurt, pain and suffering that comes with trauma. There still exists in our society a belief that people will and should get over it. While not everyone who has experienced trauma needs or may want therapeutic support those that do often experience many barriers and are challenged in finding and accessing that support, especially in remote and rural communities. Even among health and social service providers we often see a hesitation to directly address the issue of trauma. There still exists many misconceptions, misunderstandings and, fears associated with trauma which contributes to the reluctance among some service providers to accompany the trauma survivor on the sometimes long and turbulent journey to recovery. Many times service providers may opt to take an easier route that may not require the same degree of investment in terms of time, resources, funding and self. Frequently these approaches pathologize, discredit and marginalize the injured person. These seemingly shorter paths may only serve to prolong the journey and over time may actually consume more resources, time and money. Nothing comes easy and there are no short cuts. We should avoid making decisions based on what is easiest for us and rather what is best for people who have been hurt. Systems need to accommodate to the needs of the people we serve and not expect that people should accommodate to the needs of the system.

This forum is intended to examine how our systems currently respond to the needs of people affected by trauma and how we can enhance our capacity to respond effectively and appropriately. Over the next two days we will start addressing a series of questions that we hope will lead us towards developing a long range plan for facilitating systemic change and a blue

print for the future. While we may not be able to prevent all trauma's we can make the road to recovery easier to get on and travel, creating a system of care, compassion, that empowers those who have been disempowered and that recognizes people for their ability and ingenuity to survive.

I'd like to take this opportunity to introduce to you the people who committed their time and talents to organize this event;

Mary Jo Bolton, Klinik

Dr. Tracey Peter, Faculty of Sociology, U of M

Yvonne Block, Executive Director of Mental Health, Addictions and Spiritual Care,
Dept. of Health

Chez-Roy Birchwood, WRHA

David Hutton, Public Health Agency of Canada

Lori Pedden, Native Women's Transition Center

Suhad Bisharat, Executive Director, Laurel Center

Clarissa Chandler our Moderator

and a very special acknowledgement and thank you to Donna Reid from Klinik for all her work as our event planner. Thank you Donna for all your hard work and dedication to this project.

I'd also like to take this opportunity to introduce Dr. Jocelyn Proulx and Maggie Nighswander from RESOLVE Manitoba. Jocelyn and Maggie will be working with us to prepare the final report on the forum. Jocelyn and Maggie will be helping to track items and issues that are raised over the course of the two days. We greatly appreciate their support and having Resolve as a partner.

Finally I would like to thank our sponsors for their support and commitment to this important issue, The Department of Health, Government of Manitoba, the Public Health Agency of Canada, Government of Canada, the Winnipeg Regional Health Authority and Klinik Community Health Center.

Comments from the Minister of Healthy Living

Thank you to Wahbung for another wonderful performance and I know that there is not a person here than can say it did not touch their soul. Thank you elder Richard for sharing her blessing with us and a great beginning to a wonderful conference we will be having. Listening to Tim speak his opening introductions I know that for some of us we could feel the pain of the people, for the experiences that they have had and as we work with these individuals and families and communities we will feel that but we will also see their resilience, their determination, their strengths, and their dreams. And that is one of our challenges as professionals working in the community, to try and help them, support them, in a way that they can realize their dreams and living to ensure their quality of life is to the best of their ability.

I think when I talk about this I keep saying "we", well I am still a social worker and your not going to take that out of me. I might have the privilege of being elected and being the Minister

for Healthy Living, but everyday I use those skills that I have learned from people like you. I have lots of friends in the crowd today and I know the importance of what you do, what you do to support communities and families and individuals. Its not easy and the task that is ahead of you for the next couple days isn't easy either.

We are really saying to you, lets work together. Lets get out of our silos. Lets work on a plan, the plan that is going to make a difference, a plan that is going to challenge some of our systems a lot. We are going to rely on you to be the change agents and make it happen. Part of making that happen is going to make Manitoba a better place because we are going to recognize the issues that people are facing.

Another thing that came to mind as I was listening to Tim speak is that the wounds of trauma sometimes they are visible but most of the time they are not. You'll look and you'll say "well this person looks fine." Well, its up to us to help them identify what is happening for them, to help them come up with a strategy. But again, we can't do that alone. We have to rely on all the systems that impact individuals, and families, and communities.

So I am really looking forward to reading and reviewing the information that you come up with. And also, challenge me to help you make that systemic change. I know some of you have heard me say this before in crowds - use me. I have got another four or five years. We could do a lot of things, so challenge me. I have an open door policy. I'm pretty accessible. People know how to find me. But if there is something that we need to do, talk to me about it and lets see what we can do together because together we are that much stronger. I think as you develop your plan that's going to be what you find out too, is that together we can make changes, and changes for the betterment of Manitobans.

I would like to thank the working group for coming together and identifying the need to have a forum like this, as well as Clarissa Chandler for coming and participating with us. Good luck. Its going to be exciting. Its going to be challenging, but I feel that there is a sense of hope here. And with these quilts around us, they are going to provide us with the comfort that we need and help us find the direction in which we have to go truly to make a difference. So I hope you haven't come to relax and put your feet up and just listen to people today. We are relying on all of you to come and work really hard to make a difference. So thank you for your time and enjoy coming up with a plan that is going to change things for Manitobans.

Comments from Dave Hutton, Public Health Agency of Canada

I actually spent a lot of years working in community mental health in Winnipeg Manitoba so its interesting to come back. I thought it might be helpful to talk about when this opportunity came up why we thought it was important to support it. I would just like to start off with a little story. Last year I was down in Baltimore and I was at a workshop on how to facilitate recovery after disasters. It started off by their asking everybody to split up and share a traumatic story with each other and I said, well do I really want to do that? And they sort of implied that I was in a state of denial and I said perhaps, but perhaps there is some ethical and clinical considerations about this. They said perhaps, but this sort of works for us. I left that day and I came back to

Canada and I thought you know we really do need to find ways where we develop better practices and we do this together and find ways where we don't have these programs happening. But I also thought, if we are going to make this happen, then we have to do that together. As the federal government, we are trying to work with provinces and territories, but we also need information from organizations that are doing the work and I think we also need information from individuals and families.

Looking at emergency preparedness, being from the Centre on Emergency Preparedness and Response, and then you look at trauma and what is the connection? As Tim said, trauma takes many forms and while we are in the business of emergency preparedness, I think we realize that for people to cope and adjust to disasters we have to find ways where we can support people in daily life. I think its not only about trauma and the absence of symptoms when we talk about health and wellbeing. Its really providing skills for people to cope on an everyday basis so when things happen, people do have those skills.

That is one of the key things that we are interested in is looking at resiliency. I think when we look at resiliency, the first step, the number one step, is to hear from people who know about it so we can have informed policies. We can have informed research. We can have an informed way forward. So the opportunity here today - I haven't seen anything like this in Canada, where we come together and I really do hope that collectively we come to a common understanding, we come to some common solutions. And I hope by the end of tomorrow we can come up with some action plans where we can continue the working relationship and revisit it at this later time with progress made. I know having worked in Manitoba, all the commitment in the room, so I am convinced we can come up with some really good action steps from this room. And I hope that the Centre for Emergency Preparedness can continue supporting the work. Thank you.

APPENDIX B: Presentations

Key Note Speaker- Clarissa Chandler

(The following transcript has been paraphrased from Ms Chandler's presentation).

Why System change is important?

In 1988, 1989, 1990, I was in Los Angeles doing a project called double jeopardy. Where, we were looking at how to understand sexual abuse, domestic violence, alcoholism and drug abuse. How do they link? How do they join? Why do they occur so frequently? The main thing we did was to have a series of community forums over a period of a year. We invited people from different sectors to stand in a room and say what worked and what didn't work. It really changed our lives forever. It changed our thinking, it changed our behavior, changed our program design and our attitude about working with each other.

So, what I value and look forward to is hearing each one of you throughout the next 48 hours, begin to articulate, name and describe, what you feel is of value, importance and urgency around how the system should respond. This can be done individually or collectively, even if you don't have any recommendations at this time. What are your own experiences? I would like to get a sense of the people in the room. Everybody that has been looking at issues of trauma for at least a year....please stand up. At least 5 to 10 years...remain standing. If you have done that for 10-15 years would you remain standing.....? 25 to 30 years remain standing30-35 years. I want to point out the range of information and resources that we have in the room. We have people who have worked on this issue less than one year and people that have looked at it for almost 40 years. In each one of those stages there are ways of at looking at how this issues has profoundly affects us.

When I first started looking at the issues of trauma I remember kind of going into body shock at the volume and intensity and I was unable to articulate how much I witnessed. After, the years passed I began to change how it affected me and those around me. I began to understand that doing this work successfully is not really possible if you work in isolation. That is when the whole collaborative process began for me. No matter what stage you are in that process, each day you become more keenly aware of the importance of the people you work and consult with and how issues of trauma intersects and it relates to other issues.

In my talk today, I have two key reminders:

1. The pain of trauma is really powerful and is exacerbated and increased by our lack of understanding on how to respond effectively to trauma survivors. The pain is intensified for anyone who is trying to recover or heal because they are both dealing with their own pain and also the inability of those around them to respond effectively.
2. At an organizational and systems level what we have is a pattern of success and failure, of remembering and forgetting, of enthusiasm and regret. That pattern doesn't mean we are not making progress but, part the way we articulate and experience our relationship to trauma.

Two key points of discussion:

1. What are trauma informed services? And how can that assist us in understanding some of the changes that need to be made.
2. How can a collaborative approach assist the development of trauma informed service delivery systems in Manitoba?

The Effects of Trauma

Many of you know many of the details of the effects of trauma, but we are here talking about it for a very specific reason: trauma has baffled us in multiple ways for a long time. The impact of trauma has not been predictable and we have had problems understanding why some people come through trauma with resiliency and continue with their lives, while others are unable to recoup and rearrange their lives.

Over time we started to realize that there were some commonalities related to the impact of trauma. One of these is the severity of the trauma in terms of duration and being younger when the assault occurred. The agent of the trauma can be just as significant. When someone who was supposed to love and care for you or respond to you positively instead attacks you, it shapes you in a profound way. Its not just that bad things happen, but that bad things happen and the people who should have taken care of us turn against us or attack us themselves. All of these interactions profoundly affect the long term effects of the traumatizing event by affecting how people cope.

Depending on how severely the traumatic experience is internalized, some victims take action, while some cannot make sense of it, they can't metabolize it or grasp it. They wonder what does this mean? It goes against everything that they thought was true about themselves, their life or their situation. If we can't metabolize it we dissociate or separate ourselves from it. That detachment or dissociation provides us the opportunity to survive the moment, but has a haunting refrain later that becomes a predictor of long term consequences. Therefore what we know is that the severity, duration, age of the person and the agent increase the likelihood of dissociation and dissociation increases the likelihood we will have long term effects.

Further trauma has interesting and peculiar interactions. Oppression will intensify the experience of trauma. The oppression of women and children and the experiences of racism interact with trauma events because it shapes how we think people should respond. For Example, a recent major catastrophe that should have been a neutral event was the hurricane Katrina. When there was a lack of response by the US government to the victims of hurricane Katrina and the majority of the victims were black people, it had a profound re-opening of old wounds around race and racism in America and that increased the pain of that neutral event. So an event that should have had less long-term effects took on characteristics of historical racism and re-embellishes that pain. the experience of domestic violence and violence against children is often affected by the racism experienced through residential schools and we will see that later on in the talks today.

We know that how we respond to people and how much they have to re-live the experience through retelling also interacts with trauma and traumatic events. People affected by trauma

have difficulty in taking action in these situations – difficulty with problem focused coping. When the people they most trust to care for them don't respond in the way they we need then we begin to change how we feel and how we think in order to survive. We change how we feel by numbing, dissociating, disconnecting, depersonalizing and all of these reactions intensify the effects of the abuse. It's a highly interactive experience, not a neutralizing experience. An powerful piece is then how we respond to the person. Our compassion, understanding, and ability to see them within their context rather than in isolation impacts the long term effects.

Some of the long term effects makes it difficult to know how to interact with trauma survivors particular if they have long term effects such as fear, anxiety, fatigue, sleeping and eating disorders, intense startle responses, physical complaints, depression, outbursts of anger, self destructive behavior, feelings of shame, self blame and mistrust. There are also life disorganizing coping mechanisms that begin to emerge when we don't address the source of the victimization. These coping mechanisms increase their vulnerability to addictions, substance abuse disorders, eating disorders, self inflicted injuries, harmful relationships, mental health issues and conflict with the law. We start to see more victims in emergency rooms, on crisis lines, emergency housing, being re-victimized, being unable to self sooth. They rhythm of survival becomes an overproduction of paralysis and anxiety and a long term deterioration of their overall health.

The uniqueness of trauma memory as oppose to our general memory is that when people reflect on those experiences they are not unable to put those memories of trauma in the past and so the event becomes a dominant theme in their everyday life. This means that the meaning of their lives and their ability to feel joy is directly affected by those past events. They can't put it into the past because they can't comprehend it. When we comprehend how ghastly something is, it goes into our bodies and we metabolize it and put it into a narrative that becomes part of our life story. When we can't metabolize it or comprehend it, it becomes overwhelming and beyond belief. When something is incomprehensible it never goes into a narrative, so one of the ways we tell the story is by re-acting it. They tell the story very much like we would in a theatre but, through their lives through the dysfunction and destructive action taking place. They story is in our bodies, in a sensory experience and we can tell it in body or re-enactment. This change in body and brain increases health risks. What makes the memories traumatic is a failure of the central nervous system to syntheses the sensations related to the traumatic memory into an integrated semantic memory (a narrative or story).

Why is that so important to look at systems and discuss how systems work together? In order to recover from trauma, what we felt that we needed to do was provide trauma specific services. This would give people space and time to tell their stories about trauma. This is still important but, one big chunk that is missing is that the people that most utilize trauma specific services without a tremendous amount of additional services or supports are people who are the least traumatized. So they have been traumatized with the symptoms but, some parts of them are able to articulate that experience into a narrative. The people that are most profoundly effected are the people that were most severely abused, who endured for the longest period of time, who were young, and who were targeted by those that should have protected them or should have responded in a positive way. That means that people that are least able to utilize and identify trauma services are most profoundly effected.

Some of the keys to understanding trauma inform services is that we have to be able to identify trauma survivors both by the stories they tell and by the behavior and context in which they live. We must protect their vulnerability in their telling of their story because each time we ask them to tell it the more likely we are to rekindle their hyper aroused nervous system. They are more likely to describe and articulate their pain through re-enactment and they are more likely to express greater health issues and somatic symptoms.

How can we respond to the people who are most likely to be re-victimized, most likely to be intolerant and have difficulty with trauma specific services, are most likely to survive the greatest consequences, to utilize multiple services without becoming significantly better, who are in desperate need and constantly trying to find meaning and relief from the pain? These are the questions that really pushed us. What is trauma informed? How do we actually become informed? How do we as a society and as a group of people that are witnesses of the negative effects of trauma and who are actually trying to design and develop services to respond to this complex issue and its complexity of its interactions, how do we get the system to respond in a more effective way?

Something to think about is what have I witnessed and how have I responded. Our first failure was denying the prevalence and the intense effects of violence in dealing with sexual abuse, incest, sexual assault, racism. For a long time we denied the significance of those events. One of our big successes, in the late 80's and early 90's was when we started to say that child abuse really matters and that the violence experienced by women shaped the lives of children and was detrimental to society and when we developed trauma specific services. Our failure was to offer them in a very limited, isolated and unintegrated way. In addition, one of our successes was when we found that we were only helping a portion of society we said "Let's increase the research". "Let's identify better and more effective services." A huge push was to name and describe this trauma and to train people to do more research. One of our failures was that we became very fearful of directly servicing trauma survivors. If we became integrated we would exhaust the whole system or we would burn-out practitioners or there would be a whole bunch of people we couldn't help. There was a generalized fear that we not be the only informed person and that we develop a parallel or sequential services. What this means is that I do the counseling and you do the trauma work...or we be a women's agency that will do women's services and have a trauma specialized or we will do addiction services and we refer out for trauma services. We had a lot of ideas on how to make the system parallel.

What we know now is that parallel or sequential services are not as effective. The people who access services over and over feel really pushed down because of the multiplicity of difficulties and problems they have in the system. Part of what we figured out is that what works much better is a trauma informed setting. We have the beginnings of the understanding of what might work....I wouldn't say we know what works yet.... But, we know a lot about what hasn't worked and we have some beginning of what might work.

Part of what is so valuable about your time here today and tomorrow is your lived experience is the thing that would inform us as to what would work best. Some of the things that we know about a trauma informed model is that it works better if it is integrated and if we responded to

people as whole people rather than parts of a problem. When somebody is traumatized and is having difficulty living their life day to day they do better if we integrate trauma, addiction, eating disorder, mental health and when we interlace them together and respond to them in a whole way and as whole people. They respond much better and our capacity to respond as individuals and organizations really increase. Rather than parallel and sequential services, we need to integrate them. One of the core of integrated services is that everybody in the process must be educated in trauma. That includes administrators, managers, support staff, clinical staff, and all the counseling staff not just the trauma specialists. This ensures that everybody is seeing through the same lens.....the array of life issues and experience that person might be going through ... and in the center of it understanding the nature of violence and the long term affects. Because there are so many different parts of the experience of trauma survivors, often they are not seen as individuals and the core issue is not addressed. Rather they are seen as one part of the problem. We see this person as a person with addictions, eating disorders, or a person who has difficulty with slashing. We take these factions of the problems rather than the whole person. How do we respond in a whole way?

The next piece I want to discuss is the pieces of the system that interfere when we want to combine these components, when we do see the connection. There are excessive boundaries and exclusions. Policy, funding and the practice ignore and sacrifice the complexity of individual needs. We haven't learned how to collectively acknowledge and address them. There is inadequate recognition of people affected by trauma, a lack of trained staff, polarization both between field and mental health, addictions, corrections, polarization between culture and contexts, and a medical versus community based approach. We are not population specific. We want to talk about it in general but, we know that even though we know all these general things, when it comes down to implementing the actual responding it matters whether you are a man or a women. It matters whether you are a child or an adult, a native or white person. All those culture details really matter.

It is important that we train staff and we beginning to move past our polarization and our territoriality to really understand that we have an inadequate array of services, rigid funding strains, and lack of a strong sheer constituency. For a long time we make statements like: If we are doing women services it should look like this.....If you are doing trauma services it should look like this.....if we are doing addiction services it should look like this.....if we are dealing looking at eating disorders it should look like this....if you were looking at race or culture, it should have another context. We looked at the people as parts rather than wholes. In addition, often when we really succeeded at creating an integrated approach, it has been successful because of the leadership of individual people and that has created a real fragility in the type of integrated services we can provide. When those individuals left the structure, the will and the understanding wasn't there collectively to maintain it. We have this feeling of moving ahead and then contraction and forgetting and confusion about did we really succeed or not.

As we look at the trauma informed pieces, there is a powerful emerging picture and that's that each one of us has part of the picture. It is the same issue as needing to look at trauma survivors as whole persons rather than individual problems. Agencies have to come together as a whole integrated system. Every person here has to put their information, experiences, and opinions out because we have to collectively come together to see the larger picture. Our limited view of the

problem, which really is the effects and consequences of trauma, has limited our ability to respond.

It really matters in the next 48 hours that you give your thoughts and opinions and your lived experiences even if they do not match the people around you because we really all need to understand how as workers and survivors and people working and living and functioning in a community, we need to respond and address these issues. Each one of us has a part of the puzzle. The more pieces we leave out the longer it will take to get to a system that works. We do not just want to work on a trauma informed system that worked in LA or somewhere else, we need one that will work in Manitoba. This is place specific, Manitoba has needs, and people here have needs that are unique and specific and special to this region. The more you talk about both how it affects the larger picture of trauma the more it becomes trauma informed.

As we move through this emerging picture, also it becomes important that when we think about implementing it we are really asking ourselves for a level of sophistication and complexity that we haven't brought to this before. Meaning that, it needs to be integrated, it needs to be comprehensive enough that the whole person is responded to. But, it also means that the implementation level needs to be individualized. When it comes right down to a person making their life better, it has to be about how that person at that time, living at this place, has integrated or metabolized or rejected their experience and therefore has these consequences. Just like it has to be in Manitoba and the year 2007, and context of where I live, what would really be effective? What would be effective in a urban environment in LA, would not necessary be effective in a rural environment in Manitoba. Just like you need a specific response in terms of location, so does the individuals that are suffering and going through the day to day journey of trying to find their own path to healing need an individualized response.

In the Mental Health system's phrases I like to incorporate here is “ nothing about us, without us”. Think about some of the phrases is that we started at a grass roots levels such as with addictions and in AA and the trauma services that came out of women's services that said “the nature of women's experience and lives are significant in the nature and description of the services”. When we begin to look at Manitoba and look at your experience here, you will come up with many more that have to with us. What does it mean for this community? What is the phrase that will say it best? That will place it in the cultural context that really matters for making it work for this community.

As I begin to close this discussion, one of the things that is important to note is that people do not recover and communities do not recover by only looking at what doesn't work, what has failed. Understanding this is important because it gives us a clue as to how to protect against increasing vulnerabilities. So where we have failed in the past and where things have not worked out tells us something about the vulnerabilities either in the population, in an individual or a community. But what really allows an individual to heal or a community to heal are its strengths and resiliencies, just as we look at trauma survivors and think, how does a person really cope? How do they stay alive? What have they brought to the table that's worked for them. No one can rebuild their lives by failing. Everyone has to re-build their lives on the strengths that they have. So, when we look at trauma survivors, what we are looking for, is their insight, their level of independence, their strength, their incentive, creativity, humor, morality, their own self authority

over their memory, integration of memory and affect, tolerance of trauma related issues, symptom mastery, self esteem, safe attachment, meaning making.

All of those elements become a part of what you have to do as a group. To begin to share what didn't work, what does work, what you would like to see happen, what you would like to create. Talk about how frustrating it has been, what strengths can you uniquely bring to this and who can you align with that you can enhance their strength and enhance the community. For a long time we have thought of trauma recovery as something that can be done in isolation. One of the things that we know is that people that have been traumatized do much better when there is a community of people responding and looking at an issue. We know that a collection of providers and practitioners work better when they are working with another collection of trauma practitioners who want to respond. That systems do better when the whole system is informed and thinking creatively with an eye to what will work.

So as we move through the two days, I am going to ask you to really think about what strengths you can bring to this, who you can align with that you can increase your strength and their strength, how can you step back and listen and really hear things that seem really contradictory to you and understand at a larger level how it fits in the picture that we are to generate some real change and priorities that would work in Manitoba. Thank you.

Presentation by Dr. Tracey Peter and Mary-Jo Bolton

Bridging the Gaps: The Interaction of Community and Hospital Care Among Trauma Survivors

Mary-Jo

Tracey and I have decided to do something that we think is rather unique here today. We want to speak from the perspective of a trauma survivor and care giver about the journey of healing from trauma and suicide ideation. Rarely do we get an opportunity to hear about that intensely painful world from someone who has survived it yet Tracey is taking those courageous steps here today and in her professional work. Currently Tracey is an assistant professor in the department of sociology at the University of Manitoba where she primarily teaches research methods and statistics and conducts research in many areas including family violence, mental health, suicidal behaviour, socio-legal studies, and political sociology.

Based on our experiences, the main goal of our presentation is to build a case for why community agencies, psychiatrists, doctors, and family/friends should work together to help trauma survivors. We are not proposing a complete overhaul of community agencies or hospital policies. Rather, many of our suggestions are based on an increased sensitivity, empathy, understanding, and a willingness to work cooperatively and collaboratively. Ultimately, the fundamental question that we are asking is: What is best for trauma survivors?

Tracey

Originally I was going to start by saying a few words about my childhood and the subsequent events that caused me to go through a period of intense mental health struggles, which included suicidal ideation. But before I get to where I ‘came from,’ I want to say a few words about my life now. It is important for me to start by saying that even though I feel incredibly honoured and privileged to speak today, it also comes with some trepidation. See, three years ago when Mary-Jo and I first gave this presentation it was in another city to an audience where I knew 3 people – ergo, the threat of overt stigma was at a minimum. Today, I stand in my home province and city where many of you have come to know me solely in a professional capacity and may be ‘surprised’ to hear about my lived experiences with trauma. In fact, when I was first asked to speak today, my initial thought was ‘no way,’ but ultimately I know my silence means that the threat of stigma wins. So I speak and I will continue to speak because I fundamentally believe in the resiliency of trauma survivors as well as the need to break the barriers of stigma. The funny thing is in 2002, when I started my Ph.D., I naively believed that becoming a ‘doctor’ would eliminate the stigma of being both a mental health consumer and a trauma survivor. I now realize that becoming a professor does not exempt me from such stigma, but what I have come to understand is that my position of privilege opens doors and enables me to speak about my experiences, which has ultimately informed much of my research.

To this end, I feel that it is necessary to speak briefly about these two worlds and the inherent fusion I see between them. For me, it is very important that you do not simply see me as an ‘academic’ (I mean, really, who would want to be known just as that!). But I also hope you choose not to focus solely on my life story of trauma, which I am about to tell you. The reality is that I am both an academic and a trauma survivor. I am also a mother-to-be. I am a friend to many, I laugh at funny jokes and when I am cut, I bleed. So just like every trauma survivor in this room, my identity is plural. I also want to make clear that while I am extremely proud of my academic achievements and my community accomplishments, I am not ashamed of my past, because, like every person in this room who has experienced trauma, I survived and even though our healing and recovery is a non-linear process, by surviving we have already climbed the mountain.

So I am going to take a deep breath and start at the beginning. I grew up with, and have obviously retained, a relative amount of privilege in that I am white, educated, and middle-class. By all external appearances I really had a storybook life. But lurking behind the shadows was a very dark secret of childhood physical and sexual abuse by both my father and mother.

By the age of twenty-six, I had survived over twenty years of violence. While most cases of childhood sexual abuse end with the passing into adulthood, mine did not. At this time, however, my life was starting to unravel and I sought counselling. By most accounts, seeking counselling is regarded as a healthy coping strategy, but for me disclosing my secrets in a therapeutic environment meant that I was embarking on an incredibly dangerous path. It took little time for my father to recognize that something was not ‘right’ with me. In what has now been the last sexual assault from my father, he lodged six industrial staples in me saying ‘If I can’t have you, no one will.’ For three days I walked around with those staples in me doing everything I would normally do in my everyday life. I told Mary-Jo about the incident and together we went to the hospital to have the staples surgically removed.

I was assured by the medical staff at the hospital that the police would not be involved and that no one would know I had been hospitalized. Shortly after I left the hospital, however, the staff breached confidentiality and notified the police. My father was arrested on a total of 27 charges – including aggravated sexual assault and forcible confinement. I was only informed of the arrest when the police knocked on my door at 3 in the morning.

When my father was arrested, my entire life was turned upside down and I went into an instant crisis state. The day after the arrest was my first suicide attempt. For me, suicide was always my ‘backdoor.’ I needed this option in order to move forward because I was too scared to live. Literally overnight my world as I knew it disappeared. Obviously the abuse and degradation had to stop, but with it went a life that I knew. I had no idea how to think for myself, to care for myself, or to like myself. I really had no idea how to live. I grew up always wondering if death was better than life. I choose survival but in order to do this as a kid I had to give up on life. When I became estranged from my entire family I felt completely exposed. Facing my present reality was incredibly painful, daunting, and surreal. When I tried to look forward into my future, the image was blank – I grew up believing that there was no me without them. In my mind, the only option was my suicide.

As time went on I was diagnosed with post-traumatic stress disorder where major components of my mental illness were depression, anxiety, and extreme bouts of suicidal ideation and attempt all of which, I believe, stemmed from my need to feel some sense of control. When you are in so much pain for so long, suicide is often the only sense of control that you have – the control over your death. In a very simplistic way, this makes sense because you feel like you have absolutely no control over your life.

Over the next few months there were multiple suicide attempts – some which would have been fatal without medical intervention. In one particular episode a few months after my father’s arrest, I was placed in a maximum security unit in a psychiatric ward, where I was the only female patient among a dozen or so men with severe mental illnesses. I was also the only patient who was not medicated. I was given hospital clothes that were made for men, were too big for me, and exposed a large portion of my chest. I told the male nurse that I did not feel comfortable and asked to wear my t-shirt with my hospital pants. I was told that this was against hospital policy and that when I earn trust in the ward I would be granted those special privileges. Being locked in that ward was an absolutely frightening experience. In my journal I wrote:

I am so scared in here... I have to listen to sexist comments... One person tried to look down my shirt. Another said outright that he ‘wants to fuck me because I look good.’ Another told me that he wants to ‘eat me.’ I feel scared. I am scared.

After a few days I was informed by a senior psychiatrist that he was going to conduct a thorough assessment. I had requested that my therapist be present – for support and also to answer questions that were too difficult for me to disclose to a stranger. This request was denied so I had to endure the two plus hour meeting alone being questioned on every aspect of my life. Here is some of the writing from my journal after that meeting.

I feel like I am being punished for being bad. I feel like I have to tell things to people I don't know who scare me with their presence – people who play tricks on me and who use their power and control to manipulate me. These people ask question after question with no emotion – with no care for me. I am merely an object for analysis – look at the poor freak. I have to be good so that I can get out of here – even if it means letting them do things to me I don't want to do. How much of my dignity must they take? I have to tell them all my dirty secrets and then look normal enough to convince them that I will not kill myself. How can I possibly be normal in here? I am alone and I am scared beyond belief.

Ironically, after the two hour assessment session with the psychiatrist, I went back to my room, curled up in a ball and cried uncontrollably. My nurse was unable to calm me down and even offered to medicate me in order to feel better. After exhausting all options, she paged Mary-Jo who spent an hour on the phone with me and successfully managed to calm me down enough so that I could eat my dinner, journal, and sleep. Thus, initially my community therapist was excluded and regarded as a non-expert, but in the end she was called upon to 'clean up' the mess.

What I found particularly distressing about my multiple stays in hospital was that here I was trying to decide whether to live or die and I felt like I was being treated as a non-person. As a trauma survivor trying to overcome suicidal behaviour, a psychiatric ward is a very threatening place, and from my experience, my fear was founded. From a healing point of view I am skeptical of such intervention. I needed a safe place to go, but even though safety interventions may have to be invasive, they should never be re-traumatizing.

In all, I spent 11 days in the psychiatric ward before they released me. The issue here is not whether crisis intervention was needed. I would never dispute this point because I was in an extreme crisis state. My question, however, is whether a psychiatric ward is the most appropriate place for sexual assault survivors or any trauma survivors for that matter?

Mary-Jo

Severely traumatized individuals maintain a delicate and tenuous balance between numbing and intrusion, control and chaos, and interpersonal connection and alienation. Their lived experience of violence and abuse means they live with often brittle defences that splinter and shatter in the face of stress in their external environment. Current traumatic experiences or circumstances that mimic past traumatic events may result in overwhelming intrusive symptoms. Aspects of hospitalization can mimic the frightening experiences of trauma. This can be especially intense in the case of an involuntary hospitalization as it can be associated with previous violence or abuse involving confinement or threat. These are frequently reality-based fears that the hospital staff must be sensitive to if the stay is to be at all therapeutic.

New relationships may be regarded as frightening and dangerous as the trauma survivor is attempting to adjust to a hospital stay. He/she may engage familiar survival techniques in the face of this actual or perceived threat, one of which is isolation. In some regards this may feel like the safest avenue, but it results in a profound experience of aloneness. In order for the hospital stay to be productive, a general acceptance of trauma-related disorders is essential for

the successful treatment of people with post-traumatic and dissociative disorders. The hospital's therapeutic milieu must place a high value on respect and collaboration, as opposed to authoritarian attitudes and control. This can become a difficult task for hospital staff, especially if they lack understanding of the dynamics and effects of childhood abuse and other forms of trauma. Treatment that is undertaken without the knowledge or consultation of the on-going therapist or community worker may lead to splits in the treatment. Splits between "helpers," however defined, may play out the dynamics of secrecy and the allying of one family member against another that are often legacies of family abuse. In addition, adjunctive treatments that contradict the main treatment approach may cause the traumatized individual to become more symptomatic and to regress or decompensate further. Adjunctive treatments can be especially problematic if they involve strategies undertaken to retrieve or review traumatic memories of the violence.

Next, we want to share with you some of our lessons learned for assisting trauma survivors, especially those who become hospitalized.

Tracey - Innovation and Consistency

The first involves innovation and consistency. Being in crisis caused me to have a lot of needs, which was hard because I grew up training myself to need as little as possible. Mary-Jo understood that both having *needs* and having *hope* were probably my biggest fears. Despite this she would never allow me to say that people would be better off without me if I died. Thus, in terms of innovation, it is important to take the time to understand the struggles of each trauma survivor. For instance, we eventually made a deal: If I did kill myself (because that was a choice I had), I could not do it because people would be better off. I did not get to make assumptions for other people. Indirectly, this helped me to choose life because Mary-Jo was skillfully taking away some of my 'reasons' for suicide.

I would also suggest that service-care providers try to find consistent ways to help trauma survivors gain some control over their life. For me, the decision to live or die was a balancing act. It was like I kept a 'pros' and 'cons' list in my head. This list was constantly changing depending on the amount of pain I was in. The advice that Mary-Jo gave me was that my feelings of intolerable pain were temporary. I remember that when she would first say this, I would not believe her – the pain was just too overwhelming. But Mary-Jo was consistent and overtime I began to see that she was right – no matter how dark things became, if I could just manage to find enough resources, either within me or from others, the intense pain would pass. As time went on, this became easier to do and today I am able to tell myself what Mary-Jo has repeatedly told me throughout the years – 'just hang on, this will pass, just hang on.'

Mary-Jo - Combining Assessment and Treatment

We believe that combining psychiatric assessment and community ongoing treatment makes for better quality care. Trauma survivors are usually only in a hospital setting for a short time and then are discharged into the community. When the hospital and community are fragmented, they ultimately succeed in working against each other, which cannot help but be counter-intuitive to the trauma survivor's healing.

It is vital that the main community-worker and the hospital staff providing the acute care be in communication around decision-making within the established treatment plan. Continuity of contact between the community-based care provider and survivor should be maintained throughout the hospital stay. Ideally, the community-worker should continue to be active in treatment planning and implementation, as the client's primary community contact and as a member of the treatment team. Because of the prominence of trust, betrayal, separation, abandonment and rejection issues, the extent of, and reasons for, the community-worker's involvement, or non-involvement, should be discussed fully with the survivor. Without active efforts to maintain a unified and coherent treatment approach, it is common for the treatment to flounder. If the hospital is experienced as a frightening and disrespectful place, this may increase the individual's risk for crisis in the future – especially if they need hospitalization again, but refuse to see it as a viable option.

Tracey - *Hierarchy of Expertise*

In addition to experiencing a fragmented service delivery system, we found that a hierarchy of expertise exists within the health care and social service systems. Psychiatry appears to function with the most power and perceived expertise, then community services, followed by the survivor at the bottom. What was most disheartening was that many times this hierarchy of expertise resulted in my voice not being solicited or heard. Being a trauma survivor means that I have remarkable coping skills, intuition, and resiliency. Contrary to what many (including ourselves) may think, trauma survivors can be, and often are, highly functioning individuals. Not having a hierarchy of expertise allows trauma survivors to be at the centre – because really, we are the best experts over our lives. Even though we sometimes have an inability to care for ourselves and make safe choices, this does not mean we are strangers to ourselves and do not know our needs.

What was particularly confusing and frustrating during my multiple hospital stays were the instances when Mary-Jo was disqualified and regarded as a non-expert. We did witness a lot of disparity among doctors and nurses in that some were far more willing to involve Mary-Jo. In fact, some were remarkably compassionate. For instance, one psychiatrist paged Mary-Jo to attend the initial assessment. This doctor was also the only one who attempted to develop some rapport with me as a person by asking me about my life, my work and my interests. I found I was the most honest and the most open when I was treated with compassion and respect.

In other instances however, hospital staff did not want to involve my community supports because they felt that they got in the way of me establishing a good rapport with the hospital staff. I would suggest that this is a very rigid way of thinking. The ironic part is that I did not end up establishing a good rapport with one particular psychiatrist in large part because Mary-Jo was excluded. In fact, at one point during a 15 minute assessment, the psychiatrist was so frustrated with me she said: 'Why don't you just trust me'?

We have also experienced times when an obvious hierarchy of expertise was absent. For example, a few years ago I began to re-experience bouts of depression and quite severe anxiety. Suicidal thoughts started to become frequent. Mary-Jo and I did our best to work through this

intense state, but it soon became clear that medical help was needed. Over a course of several appointments, my doctor, Mary-Jo and I developed a plan which involved ideas, input, and on-going monitoring by each of us. My doctor was able to prescribe medications to address my struggles with anxiety, headaches, and sleep disruption. I started to re-connect, albeit slowly at first, with friends to reduce the isolation I was experiencing. Together, Mary-Jo and I worked on cognitive therapy techniques by addressing negative thought patterns, which seemed to exacerbate my depression and anxiety.

In the end, we all had an important role to play. By combining our individual knowledge and expertise, we were able to come up with the best assessment of the situation – one that allowed for a favourable treatment plan with optimal healing.

Recommendations

Mary-Jo

- 1) There needs to be a willingness from both psychiatry and community health agencies to consult each other in order to get the best out of the resources for trauma survivors. The community-based worker is often the central professional in formulating a dynamic understanding of the survivor's struggles and implementing a productive treatment plan. The community-based worker can also act as a liaison with hospital staff, supportive family/ friends and other helpers in aftercare planning.
- 2) Individual therapy and/or case management are critical in the treatment of people with post-traumatic conditions. Ideally hospitalized survivors should be provided with individual therapy during the course of their stay because therapeutic gains are best realized in an on going trusting relationship. Community-based service providers are able to offer specific interventions that have been effective over the course of the individual work.
- 3) Community-based workers should be given the autonomy and authority to make important decisions in collaboration with the survivor and hospital staff during an acute care episode. Trauma survivors are likely to better tolerate hospitalization when decisions that affect them are made by someone who has taken the time to develop a trusting relationship, rather than when decisions are based on inflexible and rigid unit rules.
- 4) Awareness of the root struggles for trauma survivors needs to inform treatment approaches as well as the hospital environment itself. This is important because the dynamics of trauma survivors' abuse experiences can be replayed in a hospital setting and can lead to regression and decompensation. A big limitation that exists in Winnipeg is that there is no special facility to treat trauma survivors in crisis. We see the need for a facility that does not put men and women together in locked wards, especially women who have been sexually assaulted. For sexually traumatized women, being made to wear ill fitting men's pyjamas in the presence of men creates feelings of extreme vulnerability, sexualization, humiliation and re-victimization. Many current hospital practices can contribute to survivor's perceptions of the hospital as an environment of danger.

Tracey

- 5) Finally, we can't stress enough, the importance of being 'empathic.' I think the best way to do this is to try to imagine what a trauma survivor is going through. Everyone has a story to tell and at best we only ever get a partial picture. When you interact with a trauma survivor in crisis, you don't get to see him or her smile, but you would be remiss to assume that he or she is incapable of laughter. Unfortunately, many only get to see the pain and suffering of trauma survivors, but never forget that we are so much more. This is why I think it is important to remember that every trauma survivor is different. Contrary to popular belief, one size does not fit all. Even though the bureaucracy of mental health systems means that they often operate in rigid environments, the *people* who work within these systems need not. So let's collectively try something new. Take pride, stay real, engage in non-judgment, and truly be empathetic – after all, you never know who you are inspiring or helping to heal.

APPENDIX C: Agenda

Day 1: Monday July 4th, 2007

- 9:00 am Opening Session
1. Introductions: Tim Wall
 2. Opening blessing: Chickadee Richard
 3. Women of Tomorrow: Aboriginal women's drumming group
 4. Introducing:
 - a. The National Healing Quilt: Healthy Land, Healthy People
 - b. Grandmothers Quilt: Butterfly Patterns of Light
 - c. The Healing Journey Quilt
 5. Greetings from the Hon. Kerri Irvin-Ross, Minister of Healthy Living
 6. Greetings from Public Health Agency of Canada: Dave Hutton
- 9:45 am Keynote Address: The Importance of the Collaborative Approach Clarissa Chandler
- 10:30 am Break
- 10:45 am Panel Discussion on Experiences of Trauma: Kim Trossel, Mayran Kalah, Kevin Richardson, Donna Besel, Sheila Bradford, Ann Loewen
- 11:30 am Presentation: Mary Jo Bolton and Tracy Peter
- 12:00 noon Lunch
- 1:30 pm Small Group Sessions and Questions
- Session 1: Trauma Survivor Needs
- Question: What do trauma survivors need to minimize the effects of trauma and or to survive?
- 2:15 pm Large Group Review
- 2:45 pm Break
- 3:00 pm Session 2: Large system Responses to Trauma Survivor Needs and Systemic Barriers
- Questions: What happens to trauma survivors when they try to enter and function within the larger system?
- What have been the challenges and barriers within the system that make it difficult to respond to and acknowledge the needs of this population? Please consider attitudes, values, beliefs, training. etc.
- 3:45 pm Large Group Review
- 4:15 pm Closing remarks, wrap-up and instructions for day 2: Clarissa Chandler

Day 2: Tuesday July 4th, 2007

9:00 am	Opening Session
9:15 am	Presentation: Aboriginal teachings and understanding the residential school experience: Chickadee Richard
9:45 am	Small Group Sessions Session 3: Large System Response to Trauma Survivor Needs and Systemic Barriers Questions: What prevents systems from working in a more integrated way in Manitoba? What would need to change in order for systems to work together better in Manitoba?
10:00 am	Large Group Review
10:15 am	Break
11:00 am	Session 4: Planning for the Future and Recommendations What has worked well in the past?
12:00 am	Lunch
1:15 pm	Session 4 continues Question: What recommendations need to be made to government and other relevant provincial bodies?
1:45 pm	Large Group Review
2:00 pm	Session 5: Priorities and Action Question: What do you see as being the immediate, medium and long term priorities? What should be the next steps?
3:00 pm	Break
3:15 pm	Large Group Process
4:00 pm	Closing remarks: Clarissa Chandler and Tim Wall

APPENDIX D: Light Bulb Moments

System and Service Response Related Comments

- Written trauma care plan clients can have with them to communicate their needs/what work best/triggers
- Validating “normalcy” surrounding an absurd situation (crisis/trauma)
- In the spirit of “doing no harm” would helpers be expected to do their own personal growth work?
- We need to say the buck stops here you have been “referral-ed” to death. No more looking for the expert – you are the expert, you provide the therapy!
- Systemic change needs involvement from:
 - Grassroots
 - Mid-range leaders
 - GovernmentAll must be involved for sustainable transformation
- Current system is top-down, power based and adversarial
- Consumer based is good idea, but often consumers don’t know what they need ... confused, overwhelmed
 - Comment/response: actually, consumers/survivors can articulate what is missing and not working. Confusion and being overwhelmed is often a response to what is not working!!
- Specialized trauma training for helpers working with trauma

Trauma Related Comments

- What do we need to do to accept men as victims – from women not just other men?
- Trauma survivors that are incarcerated in jails/prisons
- What is a “normal” reaction to an “abnormal event?”
 - Comment/response: Means your not crazy to feel that way, to read these ways, etc (trauma Survivor) = it makes it understandable/cope-able; human

Other Comments

- The word “metabolizing” says so succinctly what is hard to explain
- Invite us all back for a follow-up session so we know if our collective voices were heard!

APPENDIX E: Forum Evaluation Form

Rate the following questions on a five-point scale from 1 = strongly disagree to 5 = strongly agree.

Attending the forum was a good use of my time.	1	2	3	4	5
The forum was helpful and useful.	1	2	3	4	5
The forum will likely make a difference in improving services for people affected by trauma.	1	2	3	4	5
The forum will make a difference in how I work.	1	2	3	4	5
I will be more involved in promoting the need for trauma informed services.	1	2	3	4	5
I am more aware of the needs of people affected by trauma.	1	2	3	4	5
I am more aware of the barriers people affected by trauma experience when accessing services.	1	2	3	4	5
I feel more prepared to work with other organizations and systems to better meet the needs of people affected by trauma.	1	2	3	4	5
I am leaving the forum with concrete ideas for how my organization could improve how it responds to people affected by trauma.	1	2	3	4	5
I would attend another forum.	1	2	3	4	5

Questions

What was the most helpful part of the forum?

Describe one or two things that have changed for you as a result of attending the forum.

What could have been done differently in planning this event?

APPENDIX F: Bibliography

- Allen, J.G. (1995). *Coping with trauma: A guide to self-understanding*. Washington, DC: American Psychiatric Press.
- Blauner, S.R. (2003). *How I stayed alive when my brain was trying to kill me*. Harper Collins Publishers: New York.
- Balcom, D. (1996). Interpersonal dynamics and treatment of dual trauma couples. *Journal of Marital and Family Therapy*, 22(4), 431-443..
- Blume, E.S. (1990). *Secret survivors: Uncovering incest and its aftereffects in women*. New York: John Wiley.
- Butler, S. (1978). *Conspiracy of silence: The trauma of incest*. New York: Bantam Books.
- Chu, J. A. (1998). *Rebuilding shattered lives: The responsible treatment of complex post-traumatic and dissociative disorders*. New York: John Wiley & Sons, Inc.
- Compton, J.S. and Follette, V.M. (1998). Couples surviving trauma: Issues and interventions. In Follette, V.M., Ruzek, J.I., Abueg, F.R., (Eds) *Cognitive-behavioral therapies for trauma*, (pp. 321-352). New York: The Guilford Press.
- Courtois, C.A. (1979). Characteristics of a volunteer sample of adult women who experienced incest in childhood and adolescents. *Dissertation Abstracts International*, 40-A, Nov-Dec.
- Courtois, C.A. (1988). *Healing the incest wound: Adult survivors in therapy*. New York: W. W. Norton & Company.
- Courtois, C.A. (1999). *Recollections of sexual abuse: Treatment principles and guidelines*. New York: W. W. Norton & Company.
- Everstine, D.S. and Everstine, L. (1993). *The trauma response: Treatment for emotional injury*. New York: W. W. Norton & Company.
- Figley, C.R. (1985). *Trauma and its wake: The study and treatment of post-traumatic stress disorder*. New York: Brunner/Mazel, Inc.
- Finkelhor, D. (1979). *Sexually victimized children*. New York: Free Press.
- Greene, K., and Bogo, M., (2002). The different faces of intimate violence: Implications for assessment and treatment. *Journal of Marital and Family Therapy*, 28 (4), 455-466.
- Greenspan, M. (2003). *Healing through the dark emotions: The wisdom of grief, fear and despair*. Shambhala: Boston & London.

Greenspun, W. (2000). Embracing controversy: A metasystemic approach to the treatment of domestic violence. In P. Papp (Ed.), *Couples on the fault line: New directions therapists*, (pp. 152-177). New York: Guilford Press.

Harris, M. (1998). *Trauma recovery and empowerment: A clinician's guide for working with women in groups*. The Free Press: New York.

Herman, J.L. (1981). *Father – daughter incest*. Cambridge, MA: Harvard University Press.

Herman, J.L. (1992). *Trauma and recovery: The aftermath of violence – from domestic abuse to political terror*. USA: Basic Books.

Hesse, E., & Main, M. (2000). Disorganized infant, child, and adult attachment. Collapse in behavioral and attentional strategies. *Journal of the American Psychoanalytic Association*, 48, 1097-1127.

Johnson, S.M., and Williams-Keeler, L. (1998). Creating healing relationships for couples dealing with trauma: The use of emotionally focused marital therapy. *Journal of Marital and Family Therapy*, 24 (1), 25-40.

Johnson, S.M. (2002). *Emotionally focused couple therapy with trauma survivors: Strengthening attachment bonds*. New York: The Guilford Press.

Ketring, S.A. and Feinauer, L.L. (1999). Perpetrator-victim relationship: Long-term effects of sexual abuse for men and women. *American Journal of Family Therapy*, 27, 109-120.

Levine, P.A. with Frederick, A. (1997). *Waking the tiger: Healing trauma*. North Atlantic Books: Berkeley, California.

Lew, M. (1998). *Victims no longer: The classic guide for men recovering from sexual child abuse*. Harper Collins Publishers Inc. New York.

Maltz, W. (1991). *The sexual healing journey: A guide for survivors of sexual abuse*. New York: HarperCollins.

Nelson, B.S., and Wampler, K.S. (2000). Systemic effects of trauma in clinic couples: An exploratory study of secondary trauma resulting from childhood abuse. *Journal of Marital and Family Therapy*, 26 (2), 171-184.

Nelson, B.S., and Wright, D.W. (1996). Understanding and treating post-traumatic stress disorder symptoms in female partners of veterans with PTSD. *Journal of Marital and Family Therapy*, 22 (4), 445-468.

Peter, T. (2005). Hearing 'silent voices': Examining mother-daughter sexual abuse. (Dissertation: University of Manitoba).

- Rosenbloom, D., Williams, M.B., and Watkins, B.E. (1999). *Life after trauma: A workbook for healing*. New York: The Guilford Press.
- Rosencrans, B. (1997). *The last secret: Daughters sexually abused by mothers*. Safer Society Press: Brandon, Vermont.
- Russell, D. (1983). The incidence and prevalence of intrafamilial and extrafamilial sexual abuse of female children. *Child Abuse and Neglect*, 7, 133-146.
- Schiraldi, G.R. (2000). *The post-traumatic stress disorder sourcebook: A guide to healing, recovery, and growth*. Lowell House: Los Angeles.
- Shaw, S. (2001). *Connecting communities: A provincial forum on suicide prevention*. Winnipeg, MB: Clinic Community Health Centre.
- Shilket, C.J. (2005). Some clinical applications of attachment theory in adult psychotherapy. *Clinical Social Work Journal*, 33 (1), 55-68.
- Solomon, A. (2001). *The noonday demon: An atlas of depression*. New York: Scribner.
- Van der Kolk, B.A., McFarlane, A.C., and Weisaeth, L. Eds. (1996). *Traumatic Stress: The effects of overwhelming experience on mind, body, and society*. The Guilford Press: New York.
- Westerlund, E. (1992). *Women's sexuality after childhood sexual abuse*. New York: W. W. Norton & Company.
- Wilson, J.P., Friedman, M. J., & Lindy, J.D. Eds. (2001). *Treating psychological trauma & PTSD*. The Guildford Press New York.