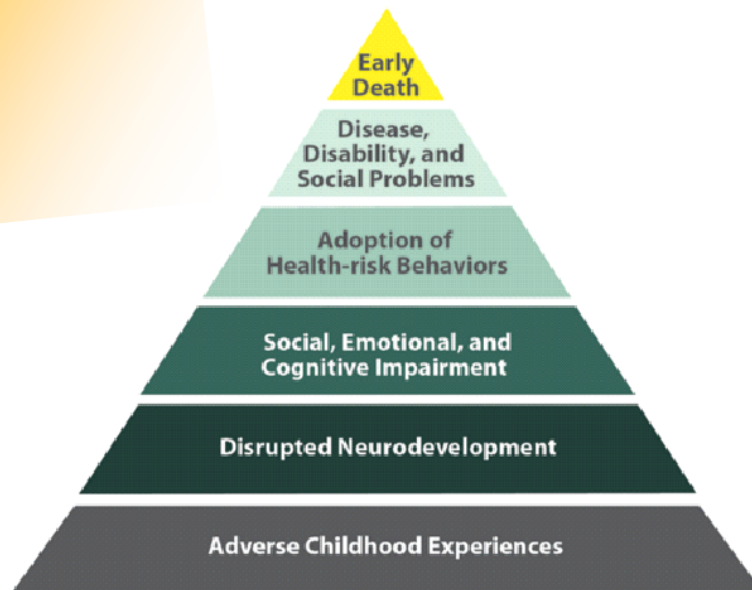


Adverse Childhood Experiences (ACE) / Trauma Informed Resource Guide

November 2016



Mechanism by Which Adverse Childhood Experiences
Influence Health and Well-being Throughout the Lifespan

<http://www.cdc.gov/violenceprevention/acestudy/about.html>



EMAIL: ACESatCAAMHPP@albertahealthservices.ca

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Issue 1 November 2016



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Background

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



ACE & Health Outcomes:

Compared to people with 0 ACEs, those with 4 or more ACEs are:

- 12 times more likely to have attempted suicide
- 4.6 times more likely to be depressed
- 7 times more likely to be an alcoholic
- 10 times more likely to have injected street drugs
- 3.9 times more likely to have chronic obstructive pulmonary disease
- 2.4 times greater risk to have hepatitis

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

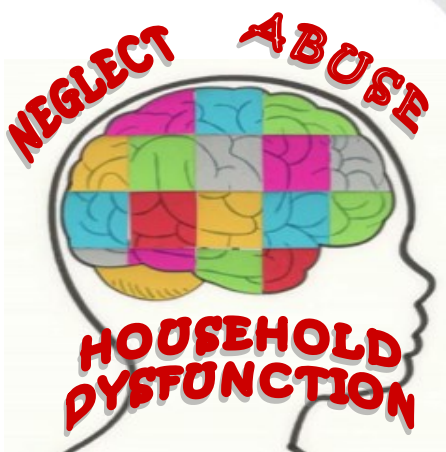
How is the ACE questionnaire and trauma informed care any different from what we are already doing?

“ACE and trauma informed care is just doing what we’ve always done – it’s a “reframe” not a “new frame” -
CAAMHPP Staff

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

Why is CAAMHPP investing in ACE?

To align with larger system priorities including the CAAMHPP Strategic Plan 2016-2021, the Addiction and Mental Health Review and research on the impact of toxic stress on the developing brain.

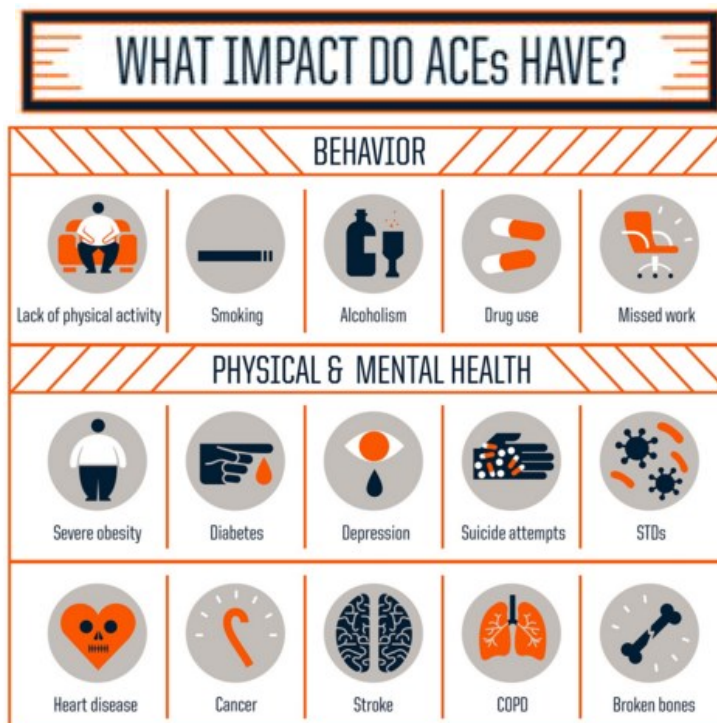


A clear relationship exists between the number of Adverse Childhood Experiences (ACEs) and many of the different types of problems you may see in your clients and/or their families every day such as early drug use, addictions, promiscuity, teen pregnancy, depression, suicide attempts, life dissatisfaction,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

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

1. The score on ACEs provides insight into an individual's possible health risks, inclusive of addiction, mental health, cardiac health, stroke, sexual health, cancer, and other medical conditions
2. It highlights valuable, clinically relevant information in an systematic way
3. Individuals who complete the ACEs questionnaire and understand its meaning show less health utilization, even when no other intervention is provided
4. ACEs provides information on the impact of intergenerational trauma on families

CAAMHPP believes collecting ACEs will have a significant impact on how we provide care to children and families who access our services and help our system better respond to growing demands.



ACE Mission & Implementation

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

By September 1, 2016

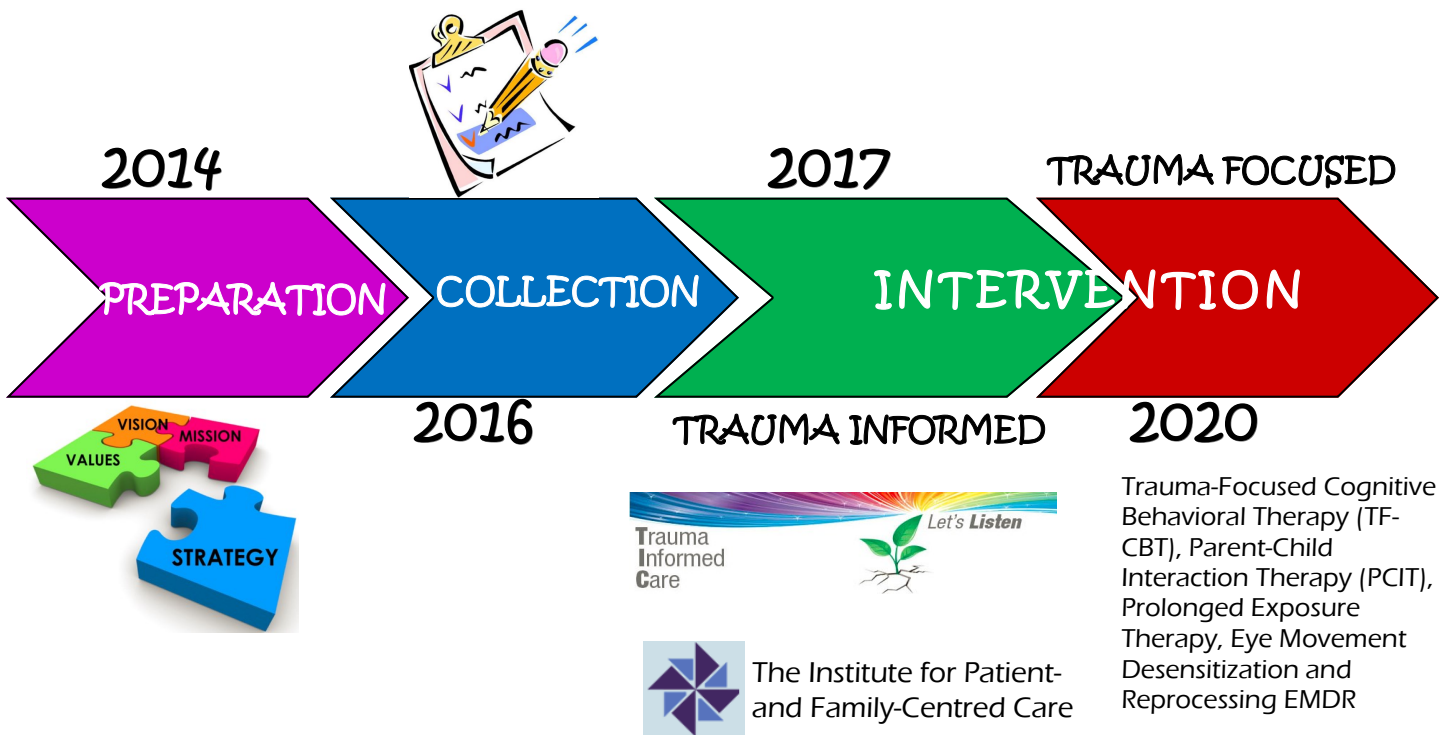
All clients and families seen within CAAMHPP will be asked about Adverse Childhood Experiences and their score will be centrally recorded in an electronic database.

By March 31, 2017

Information collected and used to clinically inform treatment will help identify service gaps and inform program planning.

By March 31, 2020

Service provision will be targeted to help families prevent FURTHER accumulation of Adverse Childhood Experiences and mitigate potential health risks associated with toxic stress.



Patient/Family Centred Care & Trauma-informed Care

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

Patient and Family Centred Care (PFCC)

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



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

Respect & Dignity:

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

Information Sharing:

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

Participation & Collaboration:

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

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

Trauma-Informed Care

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

As a philosophy of care TIC is universally applied, this approach does not require a disclosure of trauma. TIC assumes service users may have experienced trauma, and would therefore benefit from services that privilege safety (physical, emotional, spiritual), choice and control throughout the spectrum of their engagement with the mental health system.

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

1. Trauma awareness

TIC begins with building awareness with staff and consumers regarding the true prevalence of trauma in CAAMHPP. The collection of ACEs will provide an understanding of the following:

- the impact of trauma on development and functioning,
- the subjective and diverse ways people experience & cope with trauma,
- the association between trauma, substance use, physical and mental health concerns.

2. Safety & Trustworthiness

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

There is an important **distinction between TIC and trauma-focused care** (see Arthur et al., 2007) in that trauma-focused care is an evidence-based intervention that include specialized assessment that focusing on treating trauma, provided by practitioners trained in trauma-focused care.

3. Choice, Collaboration & Connection

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

4. Strength-based and Skill Building

Empowering young people, families and staff to identify and develop their strengths, coping and resilience.

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

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

Chris Blodgett





ACE SCORES ACROSS CAAMHPP

- * As of July 1, 2016 over 1,500 ACE questionnaires were completed by 'early adopting' CAAMHPP programs.
- * Of the ACE scores entered into RAIS, 40% of had an ACE score of 4 or higher
- * ACE scores in CAAMHPP range from the minimum score of 0 to the highest score of 10, meaning that some CAAMHPP clients have experienced all 10 forms of abuse, neglect and household dysfunction as captured by the ACE questionnaire.
- * Higher ACE scores are predicted by:
 - Gender (female more than male, but both are significant),
 - Presentation to emergency services (this increases when the scores are linked to past patient registrations,
 - Family composition (single parent/blood relative caregiver/Child Services) and,
 - Lower function (as measured by the CGAS).

PRACTICE CONSIDERATIONS

While the information on the questionnaire is now a required part of the record within CAAMHPP, it is really up to the clinician to find the 'goodness of fit' with their practice in regards to how this information is gathered for the record. The remainder of this section of the guide are suggestions of how the results of the questionnaire may inform your care plan and intervention strategy.

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

The personal nature of the questions that are asked about a person's presenting problem in history may produce a stress reaction, and clinicians should be aware of this. Depending on the setting in which they are completing the questionnaire, the care provider will need to have access to backup resources in the event that the questionnaire precipitates a crisis for the individual.

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



With regard to the comfort of patients completing the questionnaire in a waiting room in a primary care setting, recent research reviewed but not yet published, indicates that patients do not, on the whole, suffer stress from providing the information on the adverse childhood experience survey. Furthermore, in the study patients were apparently comfortable with the information being on their record and used to guide intervention.

Everyone is capable of practicing in a trauma informed way
How Trauma Informed Care Is A Systematic Approach To Ensure All People Receive Care That Is Sensitive To The Impact Of Trauma

How do I use the ACE Questionnaire?

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

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

As a program, how can we explain what ACEs are to clients/families, other health professionals, schools, etc.?

Some programs have found it helpful to provide handouts about ACEs to clients/families and those they partner/collaborate with (see appendix IV & V).

Day-to-Day Practice within CAAMHPP

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

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

Most of the questions on the ACEs questionnaire parallel the information already being collected by clinicians. The ACE questionnaire gives us a standardized framework within CAAMHPP to collect the information.

The use of the ACEs questionnaire can change the conversation with a client. It shifts the conversation from **“What is wrong with you?”** to **“What has happened to you?”** in recognition that the experiences of the past shape current behavior, neurodevelopment and bio-psycho-social functioning of the child.

Using the information to Change a Child’s Trajectory

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



How the ACE questionnaire informs care?

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

13-year-old child presenting with Attention Deficit Hyperactivity Disorder ADHD

Symptom Focused Care:
 Examine and treat psychiatric symptom and presenting complaint.
 Trauma history may or may not be applied to case / diagnostic formulation.

Trauma Informed Care:
 Examine and treat psychiatric symptom and presenting concerns from a trauma informed lens.
 ACE Score was assessed (0 or any score that was higher) but was assessed to have no direct bearing on the focus of treatment or the presenting complaint.

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

Responses on each of the Adverse Childhood Experience questionnaire items need to be interpreted in the context of the client’s current presentation, address any concerns using clinical judgement and accessing appropriate resources as necessary.

Individual scores do not tend to change, hence over the course of treatment where a positive response is being recorded, one is able to focus on the particular issue that has been reported. Through intervention attempts are made to mitigate the effects of that experience on the child’s developmental trajectory. There is not anything additional or special that one would do, other than to use the information from each of the tools to develop a comprehensive clinical profile for that particular client.

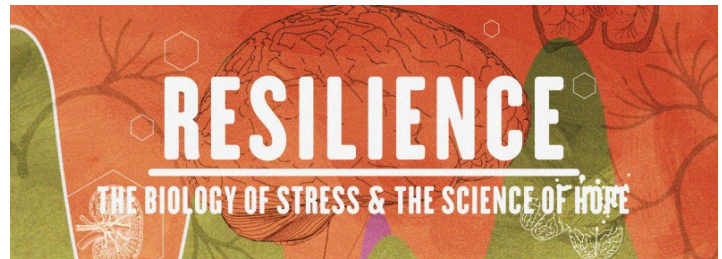
KPJR Films produce films that “confront society’s hidden challenges and honor those that fight them, one story at a time”.



Paper Tigers follows a year in the life of an alternative high school that has radically changed its approach to disciplining its students, becoming a promising model for how to break the cycles of poverty, violence and disease that affect families.

“Stressed brains can’t learn.”

That was the nugget of neuroscience that Jim Sporleder, principal of a high school riddled with violence, drugs and truancy, took away from an educational conference in 2010. Three years later, the number of fights at Lincoln Alternative High School had gone down by 75% and the graduation rate had increased five-fold. *Paper Tigers* is the story of how one school made such dramatic progress.



RESILIENCE: THE BIOLOGY OF STRESS & THE SCIENCE OF HOPE chronicles the birth of a new movement among pediatricians, therapists, educators and communities, who are using cutting-edge brain science to disrupt cycles of violence, addiction and disease.

“The child may not remember, but the body remembers.”

The original research was controversial, but the findings revealed the most important public health findings of a generation. *RESILIENCE* is a one-hour documentary that delves into the science of Adverse Childhood Experiences (ACEs) and the birth of a new movement to treat and prevent Toxic Stress. Now understood to be one of the leading causes of everything from heart disease and cancer to substance abuse and depression, extremely stressful experiences in childhood can alter brain development and have lifelong effects on health and behavior.

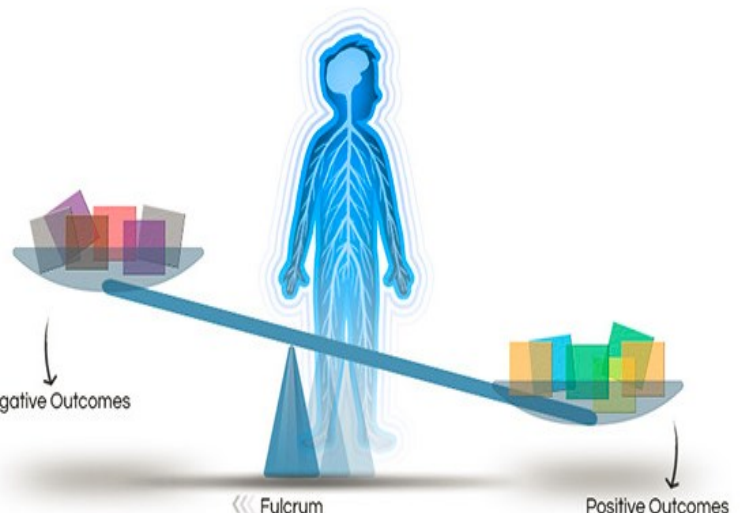
For more information on both films please go to <http://kpjrfilms.co/>



Resilience Video

One way to understand the development of resilience is to visualize a balance scale or seesaw. Protective experiences and coping skills on one side counterbalance significant adversity on the other. Resilience is evident when a child’s health and development tips toward positive outcomes even when a heavy load of factors is stacked in the negative outcome side.

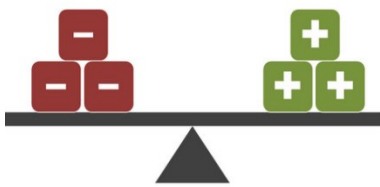
<http://developingchild.harvard.edu/science/key-concepts/resilience/>



ACEs and Resiliency:



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



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

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

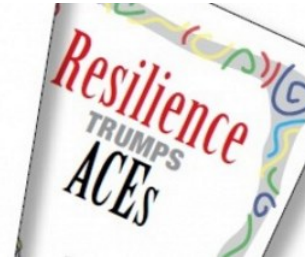
Definitions:

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

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

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

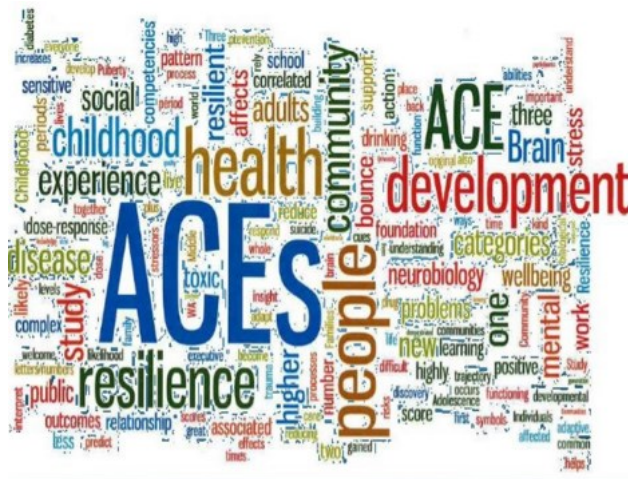
Assessing Resiliency



“Diagnostic Criteria” for Resilience:

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

Ungar, 2015



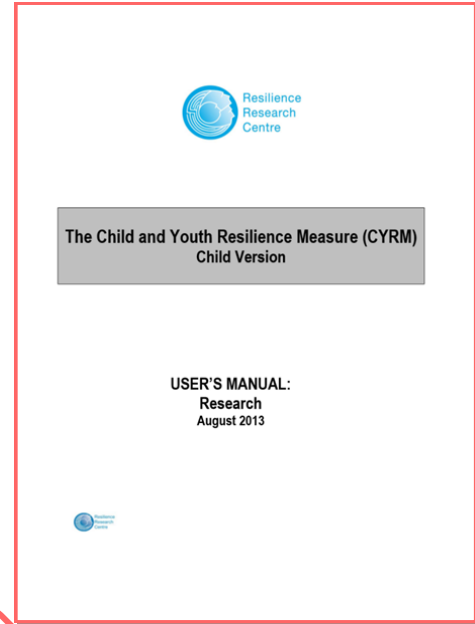
It is both complementary and necessary to address both risk and resilience. Environments may contribute to a person’s risk of developing problems, but can also provide protection, enhancing the likelihood of positive outcomes (Brooks, 2006). As resilience can be considered an ecological phenomenon, it is important for assessment tools to encompass this influence.

Resilience Assessment Tools

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

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

The CYRM is available for clinical use in both child and youth versions however is **not mandatory**.



OPTION 1: SECTION C

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

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

1. Ungar, M., and Liebenberg, L. (2011). Assessing resilience across cultures using mixed-methods: Construction of the Child and Youth Resilience Measure-28. *Journal of Mixed Methods Research*, 5(2), 126-149.
 2. Liebenberg, L., Ungar, M., and Van de Vijver, F. R. R. (2012). Validation of the Child and Youth Resilience Measure-28 (CYRM-28) Among Canadian Youth with Complex Needs. *Research on Social Work Practice*, 22(2), 219-226.

Subscales and Question Clusters on the CYRM-28:

Individual

- Personal Skills
- Peer Support
- Social Skills

Caregiver

- Physical Caregiving
- Psychological Caregiving

Context

- Spiritual
- Education
- Cultural

APPENDIX I – ACE/TRAUMA INFORMED CARE RESOURCE LIST

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

Alberta Adverse Childhood Experiences Survey

http://www.mtroyal.ca/cs/groups/public/documents/pdf/rvpc_gp_finalreport_ace.pdf

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

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

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

www.cbc.ca/radio/ideas/all-in-the-family-part-1-1.3523111

www.cbc.ca/radio/ideas/all-in-the-family-part-2-1.3532422

www.cbc.ca/radio/ideas/all-in-the-family-part-3-1.3545271

Child Abuse: Crimes against Children Research Center

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

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

<http://resilienceresearch.org/research/resources/tools/33-the-child-and-youth-resilience-measure-cy>

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

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

Family Smart

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

Family-Centred Care in Practice

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

Importance of Family Centred Care – Family Smart

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

Institute for Patient and Family Centred Care

<http://www.ipfcc.org>

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

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

Overview of Substance Abuse and Mental Health Services Administration (SAMHSA)

Six Key Principles Of A Trauma-Informed Approach And Trauma-Specific Interventions

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

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

Resilience Initiatives

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

Resilience Research Centre

<http://resilienceresearch.org/>

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

<http://resiliencetrumpsaces.org/>

The Center for Youth Wellness - Dr. Nadine Burke Harris

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

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

TIC Practice Guide-BC

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

TIP Practice Guide-SAMHSA

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

TIP Quick Guide for clinicians-SAMHSA

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

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

<http://traumainformedoregon.org/>

Trauma-Informed Care - Best Practices and Protocols Domestic Violence

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

Trauma-Informed Care Toolkit: Canadian Centre on Substance Abuse

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

APPENDIX II – KEY REFERENCES

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Donnon & Hammond (2007). **Understanding the Relationship between Resiliency and Bullying in Adolescence: An assessment of Youth Resiliency from Five Urban Junior High Schools**. *Child and Adolescent Psychiatric Clinics of North America*, 16(2)(April2007), 449-471.

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

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

Shonkoff, Jack P., (2016). **Capitalizing on Advances in Science to Reduce the Health Consequences of Early Childhood Adversity**. *JAMA Pediatrics*, doi:10.1001/jamapediatrics.2016.1559 from <http://archpedi.jamanetwork.com/article.aspx?articleid=2546141>

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

Ungar, M.(2008b).**The Child and Youth Resilience Measure, International Resilience Project**. . In D. University (Ed.). Nova Scotia, Canada

Ungar, M. (2015). **Practitioner Review: Diagnosing childhood resilience: A systemic approach to the diagnosis of adaptation in adverse social ecologies**. *Journal of Child Psychology and Psychiatry*, 56(1), 4-17. <http://resilienceresearch.org/research/resources/publications/24-peer-reviewed-journal-articles>

APPENDIX III – ACE Questionnaire

Adverse Childhood Experiences (ACEs)

Finding Your ACE Score

While you were growing up, during your first 18 years of life:		Yes	No
1.	Did a parent or other adult in the household often or very often ... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Did a parent or other adult in the household often or very often ... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Did an adult or person at least 5 years older than you ever ... Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Did you often or very often feel that ... No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Did you often or very often feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Were your parents ever separated or divorced?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Was a family member: Often or very often pushed, grabbed, slapped, or had something thrown at him/her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit at least a few minutes or threatened with a gun or knife?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Was a household member depressed or mentally ill, or did a household member attempt suicide?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Did a household member go to prison?	<input type="checkbox"/>	<input type="checkbox"/>
TOTAL ACE SCORE Each answer of 'Yes' is scored as a '1'. Count the total number of 'Yes' responses.			

Your ACE Score is: _____

APPENDIX IV — Early Childhood Handout

Alberta Health Services - Early Childhood Mental Health Outreach and Collaborative Mental Health Care

ACEs: Adverse Childhood Experiences

The **ACE Study** is an American-led project studying the long-term effects of negative childhood experiences on the physical, mental and social health of adults. The more ACE's one has, the greater the risk of being diagnosed with a mental health disorder, addiction, cancer, diabetes, auto-immune disorder, heart disease, and/or HIV & STD/STI.

Alberta has recently been conducting its own ACE Study. Participants reported that before the age of 18, almost 30% experienced one form of abuse and nearly 50% experienced one form of household dysfunction (eg. mental illness, criminal activity, addictions, disrupted relationship to parent).

What is an ACE?

Any experience that causes toxic stress in a child. This stress can impair the development of the child's brain, affecting their ability to function and make healthy relationship and lifestyle choices as an adult. The following experiences may create household dysfunction, resulting in toxic stress:

- Physical, Emotional or Sexual Abuse or Neglect
- Witnessing Domestic Violence
- Living with someone with chronic mental or physical illness
- Living with someone with alcohol or drug abuse
- Absent, separated or divorced parents
- Living with someone involved with criminal activity /imprisoned

Did You Know.....

- 54% of all depressions are related to ACE's?
- 25% of people with 4 or more ACE's are unemployed or unable to work?
- Students with 3 or more ACE's are 2.5 times more likely to fail a grade?
- The more ACEs you have, the more likely you are to smoke, have liver disease, heart disease, lung cancer, and die younger?

Alberta Health Services - Early Childhood Mental Health Outreach and Collaborative Mental Health Care



APPENDIX IV — Early Childhood Handout Continued

Building **HEALTHY** Childhood Experiences

As a parent, how can I reduce the effects of prior ACE's on my developing child?

While you cannot change previous adverse experiences, there are lots of things you can do to minimize the impact of these risks and to optimize your child's physical and mental development and their healthy functioning in adulthood:

Safety First: Protect/remove your child from any violence & criminal activity (eg. don't fight in front of your children or within hearing distance; seek marital/family counselling when necessary).

Put YOUR Oxygen Mask on 1st: In order to meet our children's physical and emotional needs, caregivers need to be healthy. If you have a mental illness/addiction, seek treatment so that you can be the parent you want to be.

It Takes a Village to Raise a Child: Use community resources to help build social support for your family (eg. library & community resource centre programs, school and sports activities, Boys & Girls Club, Big Brothers and Sisters, etc).

Parenting Power in Numbers! Maintain healthy contact with both parents, whenever possible, in cases of separation/divorce.

All Emotions are OK: Children need to understand that all of their emotions are O.K. (this doesn't mean you have to agree with them!) Children will learn to manage their feelings in a healthy way when we provide empathy and help them *recognize and label their emotions*.

Keep Calm & Carry On: Stay calm when you are feeling overwhelmed with your child's behaviour. Children take their cues from parents and when you are calm this helps your child calm down faster. It's okay to take a brief time away if you are having difficulty staying calm.

Time In (*not time-out*): Stay with your child, whenever possible, when they are upset. Children need to co-regulate *with* you to help them return to a calmer state.

Prescription to Play! 5-10 minutes of daily play & child-friendly activities with your child is our prescription for a healthy parent-child relationship. This is not a time for teaching or asking too many questions - follow your child's leads and interests.

SOURCES

The Progressive Nature of Adverse Childhood Experiences: Building Self-Healing

Communities; Robert Anda, MD, MS (Accelerating Innovation Symposium; October 6, 2014)

Center for Disease Control and Prevention - <http://www.cdc.gov/violenceprevention/overview/index.html>

The Alberta Adverse Childhood Experiences Survey 2013

APPENDIX V — School Based Mental Health



ACE Script for Parents – School Based Mental Health

Do you know what ACES is?

A good analogy is that your doctor takes health measurements and family history when they meet with you. These help them assess risk and likelihood about future issues. ACEs are similar but it focuses on your early development as a child. It examines events or situations that caused stress when you were growing up. The more of the events the more at risk you are for health issues and mental health issues. Remember that high scores don't mean that you will develop a health issue; it just means that you are more at risk for issues. The ACE scale isn't a 'predictive tool' rather a marker or guide that helps health care providers make better decisions. The more information we have the better we can assist your family. We know that sometimes that risk for medical issues can be similar amongst family members and can be passed down from parent to child. Remember that this is voluntary. There are ten questions and ask about adverse experiences before you were 18. These might be difficult to talk about but we don't need to talk about the details just your final score out of ten. If any of these questions bring up any uncomfortable feelings let me know and we can talk about how to get help. Are you willing to look at the form and give me a score out of ten?

Follow up questions / statements

Do you want to know what your score was?

What does your score mean?

Research shows that higher scores put you at risk for potential physical and mental health problems.

There are smokers who end up with lung cancer and there are others who remain cancer free. There are some people who never smoke but develop lung cancer. What we know your risk goes up with negative environmental factors.

For more information on what your score means go to <http://acestoohigh.com/>



We can do this!

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

Acknowledgements:

In addition to all CAAMHPP staff, we would like to acknowledge the ACE Advisory Committee and sub-committees, the contributions of Decision Support Team and especially to the CAAMHPP staff who participated in the focus groups.

Without the contributions of these individuals we would not have been able to advance the ACEs initiative as quickly as we have.

Special thanks to those who produced this document: Jennifer Kuntz, David Cawthorpe, Sandra Cheung, Avril Deegan, Adrienne Hotz-Oman, Brian Marriott, Alan McLuckie, Dany Pellegrino, Andrea Perri and Caroline Westwood.



We would love to hear about your challenges, successes, as well as questions and solutions that you have found with using ACEs.

Please contact us at: ACESatCAAMHPP@ahs.ca