WOOD'S HOMES

WORKING FOR CHILDREN'S MENTAL HEALTH

SINCE 1914

Wood's Homes Journal

• *Evidence to Practice: Special Edition* •

SPRING 2018

woodshomes.ca

Wood's Homes Journal – Evidence to Practice: Special Edition is published by Wood's Homes and is designed to showcase leading applied research and practice knowledge of mental health services for children, youth and families in Canada. Articles are the responsibility of the authors.

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PREAMBLE

This Special Edition of the **Wood's Homes Journal** should have been created some time ago. I say this apologetically as it is easy to "get busy" doing the work, tweaking the ideas and creating complicated and strategic interventions that help to create change for children, youth and families and forget that it is probably a good idea to write down what one is doing! Anecdotal narratives about "what happened" and "how" are good enough in the short term; but when one takes some time to think about how a therapeutic treatment model was created and tries to think back on 30+ years of work doing this, it is a challenge.

This is a start.

The documents within this Special Edition are the foundation of Wood's Homes work. They outline what happened over more than 3 decades; how the work of those years is informing the present and how we will use all of this information to continue to help children, youth and families well into the future.

Many thanks are in order to the many creators of these documents – both writers and support staff – without whom this special edition would not have been possible.

The first document – **The Wood's Homes Therapeutic Treatment Model** is a historical description of the components of this model that were created over time and as need arose.

There is an Appendix of Publications, Presentations, Teachings and Wood's Homes Blogs (1985 – 2017) that accompanies this work.

The second document – **Trauma-Informed Care: A Practice Guide** – outlines new learning about the brain, early development and trauma and how these concepts are connected with the many practices and principles created in the past 30+ years and firmly in place throughout Wood's Homes now.

Both documents are used as guides for all staff in the organization to understand our work and how it is practiced.

The third document is called A **Duty of Care**. This document is widely used in hiring new staff, orientation and training. It was created in order to help front line and management staff understand how the mental health of children, youth and the people who care for them is often manifested and how it behooves us, as helpers, to understand, respect and accept often mysterious and dangerous behaviour as emotions that need to be expressed in order to heal.

We encourage you to read this Special Edition to understand more about Wood's Homes and how we strive to "create and provide quality mental health services that promote and restore the well-being of children and families who struggle with problems big and small".

- Jane Matheson, PhD, RSW
CEO, Wood's Homes

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The Therapeutic Treatment Model - An Introduction

There is a Wood's Homes Therapeutic Treatment Model.

Unfortunately, in the 30+ years of operationalizing this model and creating 40 programs that align with it, Wood's Homes has not written about it per se, named it, presented or published articles about it specifically, nor collected data and produced research on the overall agency model and if it works. Nevertheless, countless presentations and publications have occurred about programs at Wood's Homes and the interventions used (see appendix). Courses were taught, training and supervision given regularly, practice offered and data collected on client success – this latter point during the last 20+ years.

This document outlines the components of this therapeutic model as well as how and why these components were introduced and are deemed important to Wood's Homes ultimate goals of helping children, youth and families access help quickly and ultimately succeed, improve, learn new ways of interacting with each other and managing significant mental health, child maltreatment and trauma-related issues, achieve goals and gain hope.

LOOKING BACK TO SEE AHEAD

WAY BACK

Wood's Homes is 104 years old in 2018. Over a century of work the organization grew, changed its helping direction, expanded its scope of practice, reorganized, suffered financial losses and gains, questioned its raison d'etre, adjusted to the ever-changing needs of clients and changed leadership - much like any other organization with this kind of longevity. Over the past 30+ years, leadership embraced the history of the organization and interpreted the story and the work of the past as transforming itself from first a foster home, then an orphanage, a group home, a residential treatment centre and now into a children's mental health centre.

The writer cannot speak with any credibility to the treatment focus prior to 1984 but post that date, the values generated by the moment George and Annie Wood said "yes" to people asking for help were interpreted into what they are today. The therapeutic approach started with this standpoint and built upon evidence-based practices, as will be outlined below.

THE EARLY YEARS

In 1984, the treatment model for Wood's Homes changed significantly. This change was due to a number of factors.

The first factor actually occurred some years before and was "in the works" philosophically for years. It was spearheaded by psychiatrists at the Foothills Hospital who desired a community-based service for patients leaving the Young Adult Program – located inside the hospital. This desire and plan resulted in a funding change (1980) that meant a doubling of the existing Wood's Homes budget and a major focus on in-depth mental health treatment for children began. The Parkdale Campus was built (at that time called the Adolescent Care Centre – ACC). The Ministries of Health and Children's Services funded services on both campuses equally – although the focus of these services was different. (In those days, on each campus there were 4 residential buildings, a school and an administration building. There was a group home in the community – Hillhurst).

The second factor was the arrival of Dr. Philip Perry – as the Executive Director/CEO in 1984. Dr Perry was a psychologist who was well versed in children's mental health, crisis and family work. He was also a man of ideas. Under his 11 year tenure, many innovative programs that still are in place today were created (for example: Stabilization, Phoenix, Community Resource Team, Eastside Family Centre, Evergreen, the Exceptional Needs program, Exit). He came with basic tenets under which all these programs and the overall organization ran. Some of these were (and still are):

1. Any crisis is an "opportunity riding a dangerous wind." We need to be prepared and we need to be present – either in the moment or able to accept the fallout from the crisis – however that would be manifested. Training was always a priority in this area - as was writing and presenting our ideas.

- Note the number of presentations and publications done by staff members since 1984 in Appendix 1.

2. Mistakes are opportunities

- Human service work is difficult and messy. Human beings doing the work are not perfect and human beings needing help are often afraid, perhaps angry, seemingly resistant to services and nor are they patient. This makes for challenges for helpers and caregivers; they are trying to do the right thing and often, something is just not working. Wood's Homes appreciates these challenges and encourages the taking of responsibility - when things go awry - quickly, asking for help and then forgiveness.
- This is the same gift we give to our clients.
- In these early years Wood's Homes was also very involved in Family Group Conferencing and Restorative Justice techniques with young people charged with crimes.

3. Attachment, separation and loss are important concepts to understand when dealing with children who come to need any therapeutic intervention.

- Note the number of publications and presentations between 1984 and 1998 on attachment, separation and loss as well as self-harming behaviors (appendix 1).

4. No child is too difficult and we fail if we give up on that child

- Wood's Home's motto – "we never give up, we never say no, we never turn anyone away" was created in the late 1980's for 3 reasons: we were being asked to help with children no one else would take, we were developing an ability to handle very complex problems with our "relational model of practice" and we truly believed Bronfenbrenner's statement that one person being irrationally connected to a child can make all the difference[1].

5. The power and challenges of milieu

- Much is written about the negative and/or worrisome effects of residential milieus. It is true that a group of children or young people is hard to manage, difficult to organize and can create contagion when crises occur. It is a daily undertaking to manage the challenges of group living. However, it is also true that a positive, well planned and operated milieu can have a major positive effect on groups of children and young adults – teaching them how to get along with others, manage emotions in tandem with others and much like a family learn how to accept and even appreciate differences.
- Wood's Homes has a daily intention to create strong and positive milieus for clients – starting with positive physical environments, trained and caring staff, reasonable rules and routines and a focus on hearing the voices of children and their parents.

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[1] Bronfenbrenner, U., (Ed.). (2005). *Making human beings human: Bioecological perspectives on human development*. Thousand Oaks, CA: Sage Publications.

6. A family focus is imperative regardless of who or what is the identified presenting problem.

- Wood's Homes created the Family Restoration program in 1988 and the Family Focus program in 1990
- The Stabilization Program (1985) was able to accept children without child welfare status as long as parents were involved daily
- The Exceptional Needs program (1985) was, at one point, funded ONLY by Health and families were required to be involved with programming.
- The Community Resource Team was originally called the Family Resource Centre until it became clear that a crisis line to call into was more needed by families than a place to come in to.
- The Habitat Program operated from 1999 to 2010. The Habitat program was a residential program for boys who had witnessed domestic violence. Parents were expected to be involved and while this was a difficult challenge for people who were the perpetrators of harm, the program did have successes. The program won a ***Dare to Dream*** prize in 2000.
- Even though our traditional residential treatment programs were placements for children and young people with permanent child welfare status in these early days, we always encouraged parental involvement even in the face of disagreement and resistance. It is interesting to note that many of these young people returned to live with parents after being at Wood's Homes for many years a or resolved many past issues allowing them to have relationships with their parents as adults.

7. Lashing out, acting out, violence, running away and such behaviours are the language of despair, anger, past upsets, neglect, maltreatment and trauma; we must not fear this language; we need to be curious and understanding in order to interpret what is being said to us.

- The breadth of publications and presentations on these topics is noted in the appendix.

8. The relationship you have with a child is the most important component of any treatment process.

- Although we never wrote about this "treatment model", or in fact, thought it was anything special, this tenet morphed into a description of the model as "relationship-based"
- While we have on occasion used behavioral techniques to encourage change, those methods were not used consistently. It was about "whatever worked" and had more to do with understanding the behavior of a client based upon what happened to him or her before the child came to Wood's Homes than simply trying to control it. Understanding what happened required empathy and an ability to accept stories and traumas without judgment.

9. Certain behaviours (such as self-harm) require creative, well thought out and matter of-fact interventions.

- Note the number of times and how long ago Wood's Homes was interested in understanding self-harm and suicidal behavior, how to quell it and reach what was underneath.
- Note – there has only been one completed suicide (in a residential program) at Wood's Homes in 33 years.

10. Diagnoses for children should be avoided whenever possible. Medications should be carefully considered.

- Until Premier Klein mandated that all children who were admitted into a special school needed to have a particular diagnosis, Wood's Homes avoided diagnosing children unless it was absolutely necessary.
- Medications have always been carefully considered and over-medication is always a worry. We lobby for less is more, whenever that is possible.

11. Non-deliberative forms of therapy (art, recreation, drama, for eg) often work better for the very troubled child than traditional talk therapy

- Wood's Homes hired its first art therapist in 1986 and has had one ever since
- We have done drama therapy in one form or another since 1986 as well. (Summer Stock existed for over 20 years and Nexus – a work experience program funded by the federal government – (HRSDC) that used drama to teach employment skills existed for 4 years as well.)
- We used music, the wilderness, camping trips, hiking and the outdoors in general to help kids self-regulate and express their feelings.

12. Early intervention and follow-up are significantly important parts of treatment

- In 1984, Wood's Homes was basically a residential treatment service. Over a ten year period, many early intervention programs were started (Stabilization, CRT (Community Resource Team), Eastside and Exit) in order to catch people before they fell
- We knew from a decade of experience that not everyone had BIG problems – sometimes it was "everyone needs a little help sometimes" – we started many of our outreach, early access and prevention programs like Eastside – to catch people before the big problems were created.
- Wood's Homes has always had a special concern for emerging adults. In 1984, the Hillhurst program was a harbinger for Supported Independent Living and often assisted young men and women moving out on their own – offering a place to come back to for Sunday dinners and doing laundry (for eg)
- Since 1993 (for about 20 years), during the times of A"isokina , Eaglemoon Lodge and even Catalyst, we funded a "travelling team" that went out to Indigenous communities to transition a young person home after treatment, pick up a child that was resistant to coming or meet with parents that were nervous, help with a community training session or offer support.
- Wood's Homes had major involvement in the early days of a program called Bridging the Gap. This partnership program was intent on assisting young people transitioning to adulthood..
- To this day, young people return to us to either tell us how they are doing or ask for help.

13. Connections with Indigenous people to learn their rituals and traditions are not just important for the Indigenous clients we serve but also for other non-indigenous clients as these processes have great meaning.

- Both CEO's were honoured with Native names
- Our connections with indigenous groups has been long-standing with programs Wood's Homes offered (Eagle Moon Lodge, A'isokina, Canadiana (Our 6 year solvent use program), Summit Lodge, Lone Pipe, etc.). We also developed and operated the Northern Network of Services residential program with the community and child welfare for youth in Whitehorse, YK from 1990-1998.
- We had yearly powwows and organized many traditional events in conjunction with elders. We have a new Tipi – (that replaces the old one). We created a sweat lodge at the Bowness Campus.
- For about 10 years we funded a "Travelling Team". This team ventured out to Indigenous Communities to transport children, pick them up, provide liaison services and offer training and education programs to various parts of Canada.
- We helped the Couchiching Band in Northern Ontario consider starting a program for young people.
- We hire indigenous staff, have an new Indigenous Liaison person
- Training and consciousness raising of our staff has been occurring for decades.
- When we offered live-in programs for Indigenous youth, there was always a traditions room.
- Our standpoint has always been that we can offer therapeutic skill that can be melded into traditional practices. But we cannot help alone.

14. In order to "never turn anyone away" we must look diligently for gaps in service delivery and find ways to fill these gaps with programs that clients need. We cannot wait for people to ask.

- Many Wood's Homes programs were started because there was a need. Usually we were trying to fill this need inside an existing program. The more that need grew, the harder it was to do this and so a new program would be started. Most of these programs were successful – meaning that funding could be found eventually if the need was consistent. Some were not.

15. What happened to people before they came to a door at Wood's Homes was of the utmost importance. This idea was adapted from what we imagined as important in our "orphanage days"

- We always ask "What happened to you?"
- We also ask "What does that mean for you?" "Why are you doing that?" and "How does that feel?"
- Our case management format was put in place in 1985. Over the years it has changed to fit the needs of different types of programs but the assessment review/discharge formats all contain histories and important demographics as well as the importance of knowing how to make a good hypothesis.
- We use these same "what happened to you" questions in supervision with our staff - this is the reflective/reflexive model of supervision that is used and has been in place for over 30 years.

16. Education and preparing oneself to be a citizen of the world needs to be a major focus for all troubled children.

- Children want to go to school, learn and be successful. Even if they have troubles that get in the way of these things, it behooves us to help them reach these often unidentified goals and overcome the hopelessness that can accompany feeling stupid and unsuccessful.

17. All parents want to be good parents to their children; some do not know how and need help that is nonjudgmental and yet firm. Some children are challenging to care for and if one feels they cannot go on – there needs to be someone else to step in and fill the gap as best they can.

- The importance of family has always been top of mind at Wood's Homes.
- We always advocated for family finding during times inside child welfare when families were seen as unimportant or even damaging to children. Often this was not a popular stance.
- We often had to remind parents who brought their children to Wood's Homes doors that they needed to be involved too. Sometimes parents did abandon their child at one of our programs – regardless of our interventions.
- There have been many years over the past 30 in which the child was the identified problem and that was an accepted fact. Not at Wood's Homes.

18. Organizational culture is an important part of a therapeutic service as staff members are understandably affected by their clients. A consistent approach to reflective supervision has been in place since 1984 for all staff members.

- It is understood that staff members also need a place to consider what happened to them when a client interacts with them. Working with clients who have significant mental health issues and behavioral challenges is provocative, often frightening and aggravating. Staff members are expected to be professional, therapeutic, caring and careful, all at the same time and this can often be upsetting and difficult. A place to talk about "what happened" and "how I feel about it" in order to determine what is to be done next, is very important to the well-being of the client and also the staff member. This is what supervision at Wood's Homes is all about. It is not just about accountability.
- Retreats, training, supervision, encouragement to try new things – these events and activities have been standard fare for all staff – front-line and management.
- An EAP program has been in place at Wood's Homes for almost 30 years.

MORE RECENTLY

For the past 22 years, while ensuring that the premises outlined above were maintained and even improved, other foci also were added to this Wood's Homes model:

19. Leadership

- Over the past 20+ years, Wood's Homes focused on improving supervisory and leadership practices by introducing trainings for all management levels and emerging leaders. Succession planning was always top of mind.
- Trainings introduced mindfulness, creativity, emotional intelligence, supervisory practices, supervision of supervision and the concept of inspiration in supervision.
- Alignment with staff turnover and retention was also front and centre.

20. The voices of children:

- We must listen to the ideas, worries, suggestions and concerns of children as much as we listen to their parents, caregivers and the referral sources that bring them to wood's Homes. Often they teach us more that any class or training session can do.

21. Risk Management, Mindfulness and Sensory Integration:

- Wood's Homes staff are trained in non-violent crisis interactions and have been since the late 1980's. This occurred with Dr Perry and then we embraced CPI, created our own method of non-violent crisis intervention and now use TCI.
- Many other trainings in risk management occur – (Tattered Teddies, ASIST, First Aid and CPR, Emotional and Psychological First Aid etc.) on a regular basis.
- We have a 24 hour on-call service that has been in place for over 30 years. This service was recently revamped to ensure staff and on-call service providers(the management team) are cared for, listened to and have the ability to make changes when needed.
- In 2000, a donation was given to Wood's Homes for the creation of a multi-sensory space (now called the Magic Room). Once the success of this intervention was grasped, others have been created in various parts of the organization and in different ways. These rooms offer a calming space.
- Previous to this creation, Wood's Homes always utilized ways for self-soothing and calming – massage, hypnosis, EMDR – as well as the non-deliberative forms of therapeutic intervention already noted above. We even utilized mindfulness techniques in management meetings and when planning leadership training. One could say that these techniques were used the category of "whatever works". They were definitely used before they were "hip" – as they are now.
- Although diagnoses are still given at Wood's Homes and there are many more psychiatrists involved with assessing children and youth who were in hospital or need to be, we still hold that diagnosis does not identify a young person. It is the interventions that hopefully arise from the diagnosis that help staff, the parents and the child to get on with life healthily and happily.
- After 1995 we decided not to compete with other organizations in our own backyard or compare ourselves and our programs to others. We decided to assess our own abilities in all areas and determine if others could do particular work better – if so, we would support them. We also decided to aspire to quality service, evidence-informed or promising practices and hold ourselves in every program to a higher standard. We focused on quality improvement, nothing less than excellence in service and a national reach.

22. Clinical and operational models and approaches for all programs and department areas

- This initiative began in the late 1990's, with the creation of program frameworks. Then, models of practice were written but these became unwieldy and we discovered staff were not reading or using these documents – as they were intended to be used. Approaches were then written that outline - in a more succinct and user-friendly way – the clinical activity for each program area.
- The intent of these exercises was to ensure all staff understood what the program did, who was referred to the program and for what problems, how the program worked, what interventions were used to assist with the problem, what evidence underpinned these interventions and finally what results were expected/desired.
- Over the 20+ years of this initiative, most programs have reviewed and revamped their approaches many times and kept up with the literature that promotes change.
- In 2013, the departments were also required to produce operational approaches. These outline how the Human Resources, Finance, IT, etc. departments work with others and promote the values of Wood's Homes.
- It should be noted that all approaches are reviewed and approved by the Quality Improvement Committee of the Board.

23. Healing Environments

- Wood's Homes has always valued the power of environment – clean and welcoming facilities: staff offices that are very user-friendly, spaces for children and youth, family-focused spaces, opening up our space to the communities in which we reside.
- For the past 15 years, Wood's Homes has become interested in the power of place and its healing capacity. This is evident in the new buildings created at Bowness and Parkdale and will be evident in the new residential space presently in its visioning stage.

24. Family-centred care

- Although Wood's Homes has had a focus on family as important members of a therapeutic alliance for many years, more robust attention was given to family connection in all programs over the last 20 years. For example: we set about to finding family for all young people residing in residential settings; we performed therapy over the Internet and visited families in remote parts of Canada; we asked young people who came to any of our Street Services about their families and offered a multitude of ways to connect with them (email, Skype, bus tickets); we began to offer Kinship services; we spent considerable energy connecting children in foster homes and their foster parents with biological parents and now offer Collaborative Service Delivery in both Calgary and Lethbridge.
- We have always taken the standpoint that the parent knows the child best and is the best resource for ideas for change.
- We continued to expect family involvement when a young person was referred to Stabilization (even when someone was resistant. We are gently persistent!)
- We offer programs funded by Health that have always involved parents.
- We opened the Whole Family Treatment Program with no government contract funding.
- Our accreditation process (with Accreditation Canada) investigates family centred and people centred care. In that process we are seen as leading the pack – with our years of Exemplary Standing and Leading Practices.
- The board has a Youth and Parent Advisory Committee that hears the voices of children and their parents in new ways each year and makes suggestions to the organization for ways to act upon their suggestions.
- We have a strong focus on stakeholder satisfaction and seek out feedback for improvements from all family members.

25. Continued creation of programs to fill gaps in service and better serve clients

- In the past, we created programs when there was a perceived gap in services. This is how Exit, Eastside, CRT, etc. came to be. In the more present day, we continue to do the same thing – more often with others now. Some examples are:

    - We entered into a partnership with Vecova to offer services for emerging adults with disabilities. This became the jumping off point for our now Temple programs.
    - We entered into a partnership with Horizon Housing – so that we could offer Housing First philosophy programs for emerging adults struggling with mental health and addiction issues. This is our New Horizon Program which will expand again into Inglewood;
    - We created a medical clinic at Exit (CATS clinic) for very vulnerable youth that has now been in place for 10 years under Dr. April Elliott and her band of doctors and nurses.
    - We grew our Foster Care program through a connection with CBI (Canadian Back Institute) so that we could help children earlier and also transition some of them into adulthood with caring people behind the scenes.
    - We wanted to offer Collaborative Services for the same reasons and also so we could work in stronger partnership with Children's Services
    - We developed the Youth Culinary Arts and LEAD (Linking Employment Abilities and Development) programs as we saw that the young people who needed our help were under-educated and under-employed.
    - We expanded our therapeutic services for street-involved youth by Eastside offering REACH therapeutic services. We also now offer services at Eastside in a variety of different languages.
    - In partnership with the CBE, we now offer work experience classrooms for students.
    - We offer distance programs when requested (Ft McMurray, Lethbridge and Ft Smith, NWT, Canmore, Strathmore). We adjust to the needs and challenges of those communities (the fire, changing demographics, etc)
    - Whole Family Treatment became a reality when we received a corporate donation. The beginning results are promising and the program is well used.
    - We offer telephone and chat after-hours crisis assistance to the University of Calgary Counselling Services, SAIT and Mt Royal – in partnership with the Distress Centre.
    - We now offer chat, text and email counselling via CRT and Eastside.
    - We also can offer quicker access to a variety of assessments (that often take months to acquire elsewhere)
    - The new Inglewood Campus offers many opportunities – for combining services, inviting the community into the organization, offering better facilities for programs that are currently "making do" and opening up opportunities for even more partnership work with others.

- There are still a few gaps – maybe there always will be – areas that we would like to become proficient in (such as addiction and substance use/misuse, eating disorders, children with autism spectrum disorders) or receive adequate funding for (recreation, FASD respite and assessment)

26. Developmentally appropriate practice

- While Wood's Homes has always been interested in "what happened" to any client before they came to our doors, new programs such as Collaborative Service Delivery, Kinship, Foster Care and Home Connections have offered us greater opportunities to learn about and understand child development, the effect of trauma on the brain and psyche and new ideas for intervention as a result.
- With the development of Temple programming for young people with complex psychiatric issues and developmental challenges, we have learned even more about the developmental trajectories and the importance of "beginning where the client is". As well, we are learning to be compassionate, patient and understanding of how these challenges can be lifelong struggles and how to help those young people enter adulthood with better coping skills.

27. Research, data collection and finding out what matters

- "Research" at Wood's Homes started with a simple process – counting up the number of "incidents" issues" or events that occurred in a week in every program. By doing this and being persistent about collecting this data, refining it and then giving aggregate and specific results, we learned about the power of data.
- Many of the categories we created in those early days (1996) are still used today. Some examples are: the number of restraints, the number of violent episodes, number of running away episodes, drug use, self-harming behaviour, the use of relief staff, compliments and complaints (to name just a few).
- We started with what mattered to us - what we wanted to know, what we thought needed to change or we needed to understand and this information morphed into actions of all kinds – some reported or referenced already
- A Research Department was created with one person and a few volunteers. This grew into a strong partnership with the University of Calgary – particularly with the Faculties of Social Work and Nursing – and less so, Psychology - and now the Wood's Homes Research Chair in Children's Mental Health as of April 2017. This took 10 years at least to fund. The Research Chair is unusual as it focuses on the application of knowledge – it is about putting theory into practice and helping staff and family members to understand, combat and manage mental health issues of all types – eventually with ideas and interventions to try.
- We have a remarkably robust data base that can be used to find out the answers to many questions not yet asked.
- We are also not afraid of finding out that some things do not work, that clients are not improving, that programs need to close or change. We welcome ideas for improvement and can bite the bullet when need be – just as we can start a program even when there is little financial support. It is all about client need and client success.

28. Quality Improvement

- Wood's Homes has had a Clinical Advisory Council for almost 30 years. This group – under a variety of different names - consists of professionals from social work, psychology, nursing and now law who give advice about clinical issues the organization faces every day.
- The Quality Improvement Committee of the board reports on these quality reviews, decisions, issues, etc and provides oversight and good counsel for many thorny issues.
- The Strategic Plan process for Wood's Homes has been in place for 30 years – being reviewed every 5 years. As part of the Strategic Plan work and accountability, business plans are created for all programs and defended in June. This process audits quality services in the 4 strategic plan goal areas- client, program, community and financial.

29. Client success

- Wood's Homes is focused on one thing – improvement of client functioning.
- We built our definitions of success based upon client need, child welfare desired outcomes, the reduction of risky behaviours, resilience, understanding developmental stages and the effects of trauma on human beings.
- We always ask "what does success look like – for this child, this family, this program?" and then we set about to find out if what we are doing works – wanting to discover if that "success" – however defined, is reached. Sometimes it is a very slow and difficult process. But then again, we are used to never giving up.
- When a program does not work, we are not afraid to say so and change it.

30. Diversity

- Over the past 20 years, our clientele and our staff complement have both become very diverse.
- We have had to learn about the customs, practices and struggles of clients from many countries – starting in some cases, from zero. We have been taught many things by both staff and clients who are involved in a wide variety of gender identity issues. We have increased our sensitivity to indigenous issues and offered our therapeutic services to meld with Indigenous practices in order to help clients in many ways.
- In 1996 we created values that demanded an appreciation of differences – not settling for just tolerance or acceptance, and we have held ourselves to that standard over the years. We consider "diversity" to mean any kind of difference (gender, faith, size, disability, culture, mental health or illness – to name just a few) and we emphasize with all of our staff the need for people to listen to others experiences and help others feel heard, respected, appreciated, cared for and free from judgment.

31. The end of restraints

- In 1995/1996, the CEO decided that restraining children and youth was just adding to the trauma already being experienced by the client. She wanted the entire organization to become a "no restraint" place.
- This was a lot harder to do than to say. It took a great deal of time, major philosophical debates and a lot of data collection, training and encouragement of other ways to handle violent and scary behaviour.
- The CEO used ideas from the Andrus Children's Centre (and Sandra Bloom's work developing the Sanctuary Model) to spearhead this idea and the collection of data over the years of this implementation.
- As a result, we have data that shows the trajectory of this "no restraint" journey and some analysis of the challenges we experienced that goes back almost 20 years. We have published some of these results and presented our process as well. We know we have had an effect on others making similar changes and encouraging them to stay the course for a long haul.
- We are not yet at 100% no restraints. But we are close.

32. Trauma-informed practice

- Over the past 3 years, Wood's Homes has been learning about trauma-informed practices. Staff at all levels have been involved in learning about the CARE model, the Sanctuary Model and NMT.
- In the Catalyst Program – some years ago – the Sanctuary Model was initiated as a pilot Project and continues, in part to this day.
- Many of our staff have taken training (and in some, are trainers) in NMT (Neurosequential Model of Treatment), the Palix Foundation's "Brain Story", ARC (Attachment, Regulation, Competence), TCI (Therapeutic Crisis Intervention), ACES (Adverse Childhood Experiences), Signs of Safety, Triple P Parenting, Mothers in Mind.
- We have reviewed our own practices, documents and approaches; updating them as needed. We can clearly see how trauma-informed practice wisdom and knowledge gives us language for what we have been doing over these past years and enhances what we are already doing.
- Wood's Homes has its own trauma-informed document that is the result of a comprehensive review of the literature and Wood's Homes practices.

33. Ethics

- There is also a major focus on ethics and ethical decision-making at Wood's Homes. It is the nature of the work – being around for over 100 years, dealing with complicated problems and upset people, having sometimes no good choice and sometimes many – choosing the best one for the most people is the real key.
- Organizational Ethics have been taught using Dr. David Thomas – since 1995.
- Our accreditation process investigates ethical dilemmas and how they are handled in every program area.
- The CEO gives workshops on ethics and ethical decision-making.
- We use advisors for the very complicated issues we have had to face.
- We review all of these complicated decisions – either after the fact (root cause analysis) or prospectively – looking for potential pitfalls we may face. These reviews are written up and done by someone at arms-length with skill in a particular area. All are reported to the board.

SEEING AHEAD

This collection of points make up the foundation of the Wood's Homes Therapeutic Treatment Model. It has been in place for over 30 years. As noted, over the years, each program and department has created their own approach to providing excellent service that utilizes all or most of these components.

As the years pass, this approach will be reviewed and consulted, revamped and adapted to changing times and needs of clients, the organization, the staff and society as a whole.

Where we came from and how we made these therapeutic model components is important to understand. There are keys to future success hidden inside the stories and decisions made by others in the past, the risks they took to provide service and create innovations.

This document offers the past and present day context for those who prepare the way ahead.

WOOD'S HOMES

WORKING FOR CHILDREN'S MENTAL HEALTH

SINCE 1914

TRAUMA-INFORMED CARE

• *Practice Guide* •

2018

AN INTRODUCTION

For the most part, the clinical work done at Wood's Homes is treating the impact of developmental trauma (exposure to early, ongoing or repetitive events involving neglect, abandonment, various kinds of abuse, witnessing violence or abuse). Developmental trauma generally happens within a child's care giving system and interferes with healthy attachment and development. Developmental trauma can create lifelong difficulties with physical and mental health; educational and occupational success and social and intimate relationships.

Wood's Homes operates from a Trauma-Informed Care approach while supporting the developmental and family-centered lenses through which interventions are provided in its work with children and families. Wood's Homes recognizes that all behavior has meaning and that behaviors are, more often than not, the result of what happened to those we work with. As Bloom (2013) would assert, "it is not what's wrong with you, it's what happened to you".

This guide was developed for the purpose of supporting the implementation of trauma informed care into everyday practice. The guide aims to provide important theory and concrete strategies supported by evidence-informed practices. An important goal is to build on what is already working while refining existing practices, assessment and interventions through the lens of trauma informed approaches.

Key information sources, from a search of practice protocols and interventions, include Alberta Children's Services, Alberta Health Services, the Calgary Board of Education, the British Columbia Trauma-Informed Practice Guide (2013), the Centre on the Developing Child at Harvard University and the Neurosequential Model of Therapeutics. (See reference list attached.) This document was prepared by the Trauma-Informed Working Committee consisting of: Nidia Celis, Susan Gardiner, Jeremy Barham, Amy Hojabrolsadati, Kathleen Rhodes and Chloe Westelmajer. Acknowledgment is also given to Dr. Jane Matheson for editorial assistance.

UNDERSTANDING TRAUMA

DEFINITIONS

Trauma: Experiences that overwhelm an individual's capacity to cope. There are a number of factors affecting the magnitude, complexity, frequency and duration, and whether it occurs from an interpersonal or external source.

Single Incident Trauma: An unexpected and overwhelming event such as an accident or natural disaster, a single episode of abuse or assault, a sudden loss, or witnessing violence.

Complex or Repetitive Trauma: Related to ongoing abuse, domestic violence, war, etc. Often involving being trapped emotionally or physically.

Developmental Trauma: Results from exposure to early, ongoing or repetitive trauma (as an infant, child or youth) involving neglect, abandonment, physical abuse or assault, sexual abuse or assault, emotional abuse, witnessing violence or death, coercion or betrayal, which often occurs within the caregiving system and interferes with healthy attachment and development (Van Der Kolk, 2014)

Historical Trauma: Is the emotional and psychological wounding over the lifespan and across generations emanating from massive group trauma, i.e. genocide, colonialism (residential schools) slavery and war. Intergenerational trauma is an aspect of historical trauma

Intergenerational Trauma: Describes the psychological or emotional effects that can be experienced by people who live with trauma survivors.

EFFECTS OF TRAUMA

Research has shown that traumatic experiences can have a devastating impact on a child's physical, emotional, cognitive and social development. Perry (2006), asserted that traumatic events in childhood increase risk for a host of social, (i.e. teen pregnancy, drug abuse, school failure, victimization and antisocial behavior), neuropsychiatric, (i.e. PTSD, stress disorder, dissociative disorders, and conduct disorders) and other medical problems (i.e. heart disease, asthma) (Perry, 2006).

According to Perry, (2006) there are adaptive changes in cognition, affect, behavior, neurophysiology and physiology that occur in response to trauma. These changes are an **adaptive response** for coping with the trauma experience. Supporting the needs of children affected by trauma requires having an understanding of the **adaptive responses to threat** present during the traumatic experiences.

These physiological adaptations that people develop in response to trauma and perceived ongoing threats produce an underlying state of "emotional dysregulation". **Emotional dysregulation** refers to an emotional response that is poorly modulated, and does not fall within the conventionally accepted range of emotive response. This difficulty controlling or regulating emotional reactions or behaviours can result in **hyper arousal and hyper vigilance**, in which an individual seems to overreact frequently to situations; or **listlessness and dissociation**, in which the individual seems numb and disconnected in stressful or dangerous situations.

*Children with trauma experiences tend to be more easily **triggered** into crisis mode by everyday events and are significantly less likely to be able to think their way to more rational solutions.*

To protect itself, the body uses increased energy to respond in one of three ways:

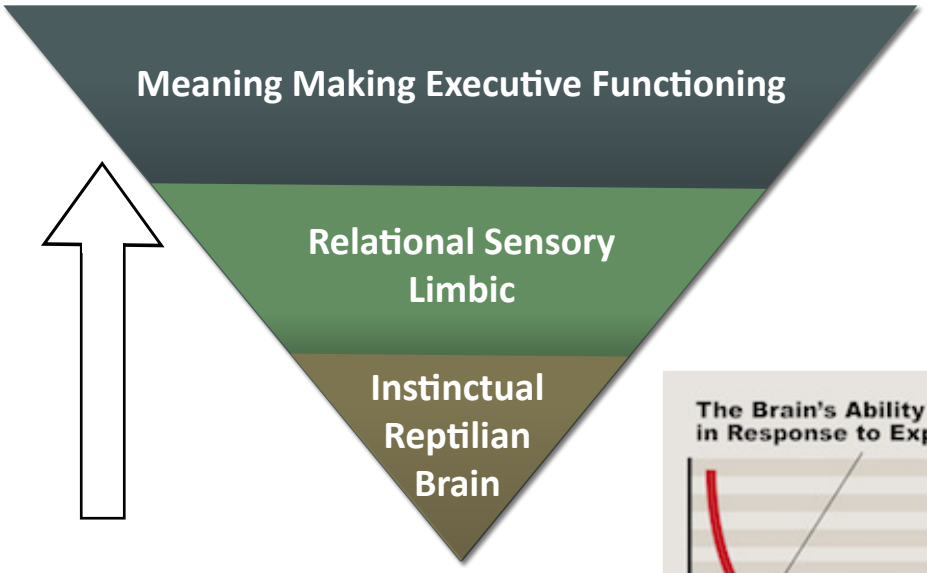
- **FIGHT** (physiological arousal): Aggression, irritability/anger, trouble concentrating, hyperactivity or silliness.
- **FLIGHT** (withdrawal and escape): Social isolation, avoidance of others, sitting alone in class or at recess, running away.
- **FREEZE** (stilling and constriction): Constricted emotional expression, stilling of behaviour, over compliance and denial of needs, slowness.

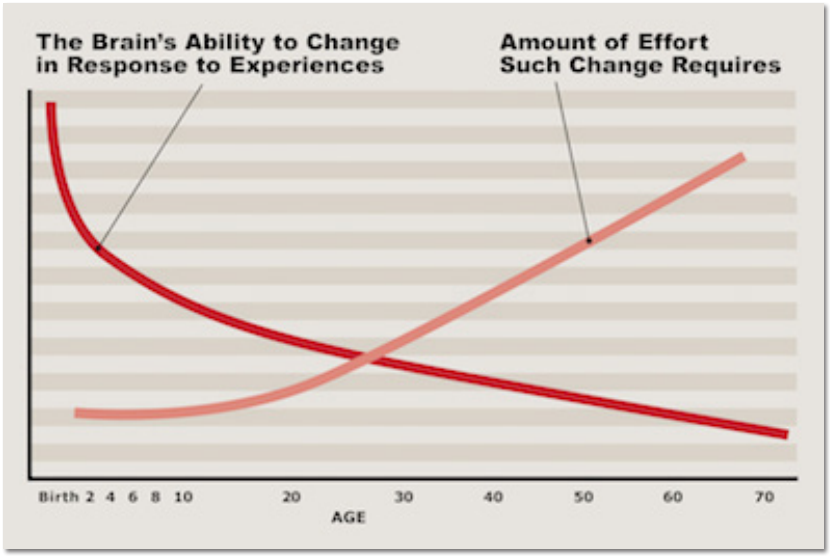
A trigger is a reminder of past traumatizing events. Traumatic triggers can come in many forms and many things can be a possible trigger for someone. Part of the clinical work with people who have suffered trauma is in changing our frame of mind so that we always keep front and centre that survivors' unusual or worrisome responses to seemingly neutral events and interactions with people may reflect a trauma response. Survivors may have adopted long-term patterns that reflect their efforts to adapt to a traumatizing life. We also work to hold in mind that this behavior and these patterns reflect strategies that survivors have developed to keep themselves safe—that is, they reflect strength and resiliency. Perry (2010) asserts *"kids can do well if they can, if they can't, something is getting in the way. Your understanding determines your solution and the goal is to engage them differently."*

DEVELOPMENT, TRAUMA AND THE BRAIN

Development is dynamic, and tasks build on themselves with success and mastery at a given stage, laying the foundation for potential success and efficacy at a later one. **Brains are built over time, from the bottom up**. The basic architecture of the brain is constructed through an ongoing process that begins before birth and continues into adulthood. Simpler neural connections and skills form first, followed by more complex circuits and skills. In the first few years of life, 700 to 1,000 new neural connections form every second. After this period of rapid proliferation, connections are reduced through a process called **pruning**, which allows brain circuits to become more efficient. (Harvard University Centre on the Developing Child, 2016).

Early experiences affect the development of **brain architecture**, which provides the foundation for all future learning, behavior, and health. Just as a weak foundation compromises the quality and strength of a house, adverse experiences early in life can impair brain architecture, with negative effects lasting into adulthood.





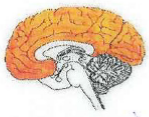
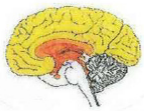
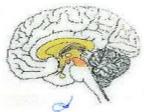
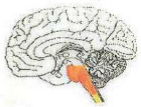
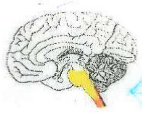
The early years are the most active period for establishing neural connections, **but new connections can form throughout life and unused connections continue to be pruned**. The first years of life are a very busy and crucial time for the development of brain circuits. The brain has the most plasticity, or capacity for change, during this time, which means it is a period of both great opportunity and great vulnerability. Brains never stop developing—it is never too late to build new neural circuits—but when establishing a strong foundation for brain architecture, earlier is better.

Traumatized children tend to have overactive stress responses: aggressive, impulsive and needy, they are easy to upset and hard to calm, they can overreact to small changes. Self-regulation in many forms is altered, i.e. intense affect; difficulty identifying and expressing emotion. Hyper arousal, a need for control; fear, shame, terror, numbing, denial and dissociation are just some of the responses identified in the face of stress. The brain must adapt radically to survive and this often looks like adaptive misbehavior in response to a perceived threat.

Experiencing stress is an important part of healthy development. Activation of the stress response produces a wide range of physiological reactions that prepare the body to deal with threat. However, stress becomes toxic when these responses remain activated at high levels for significant periods of time, without supportive relationships to help manage them. This can impair the development of neural connections, especially in the areas of the brain dedicated to executive functioning or higher-order skills. Toxic prolonged activation of the stress response system without supportive adults to help (i.e. accumulation of adverse childhood experiences such as neglect, abuse or severe maternal depression, extreme poverty or community violence), can weaken the architecture of the developing brain. A major ingredient in the brain development process is the serve and return interaction between children and their parents and other caregivers in the family or community. The interactions between genes and experience shape the developing brain. Experience reinforces the use of certain circuits. Brain circuits are reinforced by repeated use, enhancing development in those areas or determining pruning (Harvard University Centre on the Developing Child, 2016). Perry (2010) asserts that when under threat, the mind and body respond in adaptive ways, making changes in the state of arousal; thinking (cognition) and body physiology (e.g., an increase heart rate, muscle tone, rate of respiration).

When responding to threat it is important to appreciate that *a person in fear moves along the arousal continuum* – from calm to alert, to alarm, fear and terror – *and in that movement different areas of the brain control mental and physical functioning.* Fig. 4 (Perry, 2010)

How Children Respond To Perceived Threat

How they feel inside	Calm	Arousal	Alarm	Fear	Terror
Their reasoning ability	Abstract thinking	Concrete thinking	Emotional	Reactive	Reflexive
Part of the brain they can access	Neocortex Cortex 	Cortex Limbic 	Limbic Midbrain 	Midbrain Brainstem 	Brainstem Autonomic 
Their sense of time	Extended future	Days or hours	Hours or minutes	Minutes to seconds	No sense of time
How they cope: Arousal (Fight)	Rest	Vigilance	Resistance (crying)	Defiance (tantrums)	Aggression
Dissociation (Flight)	Rest	Avoidance	Compliance (robotic)	Dissociation (fetal rocking)	Fainting

Perry, B.D., et. al. (1995). Childhood trauma, the neurobiology of adaptation, and "use-dependent" development of the brain: How "states" become "traits. Infant Mental Health Journal, Vol. 16, No. 4. Winter 1995.

The stronger the threat, the more 'primitive' the thinking and behaving becomes. When a traumatized child is in a state of alarm they will be less capable of connecting the thinking brain in their response. He or She becomes more anxious, focusing on 'non-verbal' cues such as tone of voice, body posture and facial expressions (Perry, 2009).

Another key understanding to the work with traumatized children is that their baseline is a low state of fear. Responses then would show hyper arousal or dissociative adaptations, thereby highlighting the importance of offering interventions that allow them to move along the arousal continuum.

Several studies have documented various aspects of the negative impact of developmental trauma and other adverse childhood experiences. Perry (2009) underscores the importance of questioning what happened and how to understand where gaps in development might have occurred, then offering therapeutic activities that support development where it's needed. The Adverse Childhood Experiences study is also helpful.

WHAT IS TRAUMA INFORMED CARE?

The foundations of a Trauma-Informed Care approach for Wood's Homes start with the importance of understanding the mechanisms affecting current functioning given the effect of toxic stress and early childhood adverse experiences on child development and outcomes (Perry, 2006; Van Der Kolk, 2014).

"Trauma-Informed Care" seeks to create safety for clients by understanding the effects of trauma and its close links to health and behavior. To be trauma-informed is to understand clients and symptoms in the context of life experience, appreciating that some of those symptoms may be efforts at coping, and offering spaces that limit the potential for further harm (Brown, Baker & Wilcox, 2012; Butler, Critelli & Rinfrette, 2011). "Trauma specific care", on the other hand, provides treatment for the particular trauma history and its impact.

DEVELOPMENT, TRAUMA AND THE BRAIN

- Recognize the impact of trauma and understand potential opportunities to offer support
- Have a working knowledge of the signs and symptoms of trauma in clients and others involved in the system of care
- Ensure physical, emotional and cultural safety is offered through the continuum of interventions and interactions for both clients and staff
- Seek and offer opportunities for choice, collaboration and connection while working with children, families and other professionals
- Understand and integrate policies, procedures and practices of the organization in everyday work with clients

IMPORTANCE OF A TRAUMA-INFORMED APPROACH

Wood's Home's and our major funders such as Alberta Children's Services, Alberta Health Services and the Calgary Board of Education are committed to a philosophy of care which takes into consideration the impact that toxic stress, trauma, grief and loss can have on child development and a cumulative mental health risk.

Traumatic events can happen to everyone; it's part of the human experience. People who have experienced trauma are at higher risk of being re-traumatized. Lack of knowledge and understanding about the impact of trauma can get in the way of providing the most effective care and intervention.

Child-serving agencies such as health, mental health, education, child welfare, and criminal justice are tasked with providing safe and healthy environments for children and adolescents. As many children who come into contact with these systems have experienced significant trauma, there is increased awareness of the need to have a systematic approach using evidence-based services to address the impact of trauma.

The purpose of a trauma-informed care approach is to develop a caregiver's capacity to improve outcomes for infants, children and youth. Caregivers who use a trauma-informed approach often report positive changes in their ability to meet the child's emotional and behavioural needs. It is important to consider:

- Our ability to respond to the needs of children in developmentally appropriate manner improves with this model.
- Knowledge of age and stage appropriate developmental expectations allows for experiences that promote healthy attachment and developmental opportunities.
- The importance of responsive relationships and interactions -"serve and return" –between children of all ages, and their caregivers, build strong brain architecture and provides a solid foundation for healthy development.
- Knowledge about how Adverse Childhood Experiences can derail a child's healthy development is helpful.
- There is greater awareness about how "toxic stress" weakens the architecture of the developing brain, and prolonged exposure to traumatic events can lead to toxic stress for a child, leading to possible life-long problems in learning, behaviour, physical and mental health.
- Understanding that trauma impairs the child's ability to trust and relate to others is important.
- Many Indigenous people are impacted by intergenerational trauma, and intervention services should be provided in a culturally sensitive manner.
- Traumatic experiences may be associated with grief and loss in children and families. Significant loss has the potential to threaten a child's sense of identity, safety, mastery and control.

- Grief is a normal response to loss, and it presents differently for each individual. As such, different experiences, developmental age, stage and capacity create a different set of needs and processes for each person.
- Caregivers who understand the grieving processes in childhood and adolescence are more likely to respond to these needs, offering safety and understanding.

With these considerations in mind, Wood's Homes recognizes the widespread impact of trauma. Potential paths for healing can be explored by educating staff to recognize the signs and symptoms of trauma in clients as well as in themselves.

Wood's Homes aims to build safety and trust while offering choice and control in a compassionate environment. A central belief of trauma-informed care is that people can recover, a key point in supporting clients. This requires an honoring of their experience and building hope based on the individual's resilience.

IMPLEMENTING TRAUMA-INFORMED CARE: THE SANCTUARY AND NEUROSEQUENTIAL MODELS

TRAUMA-INFORMED CARE AND OUR ORGANIZATION

A commitment to trauma-informed care requires that people receiving services will encounter service providers who are sensitive to the impact of trauma. To that end, and building on the work of the past 25 years, Wood's Homes investigated the power and potentials of two trauma focused models – Sanctuary and Neurosequential. The Sanctuary Model originated in a psychiatric hospital in New York in the early 1990's out of a sense that restraints and seclusion did not result in change and maybe made things worse for people who had suffered traumatic events. In addition, there was concern for clients who did well in the program but not so well on discharge. Most trauma-informed work has essentially started with efforts to reduce and then prevent restraints. From there, the capacity to work differently with clients and within the organizations that do this work was developed.

Over the past 25 years, the Sanctuary Model has evolved into an organizational approach to managing trauma. It is an operating system for organizations that is trauma sensitive and evidence informed and assists organizations to both function well and provide effective treatment. It provides a common language and way of thinking about all human behavior. It represents a shift from “What is wrong with you?” to “What has happened to you?” (Bloom, 2013)

THE FOUR PILLARS OF THE SANCUTARY MODEL

Trauma Theory

What happens to people who are exposed to adversity and chronic stress? There is rapidly developing neuroscience that is just starting to be integrated into our understanding of the impact of trauma. It is critical to have a clear understanding of how trauma and toxic stress impact our clients and our staff doing difficult work.

Sanctuary Commitments

Sanctuary commitments are guiding principles related to trauma recovery. These principles are actually organizational practices put in place to prevent trauma exposure and mitigate its impact. Included are commitments to growth and learning, emotional intelligence, open communication and social responsibility as examples.

The S.E.L.F. Model

This acronym represents the four interactive and key aspects of recovery from bad experiences. S.E.L.F. represents four key domains of change and healing; Safety, Emotional Management, Grieving Loss and Future Orientation.

Sanctuary Tool Kit

The Sanctuary Tool Kit consists of a range of practical skills that help deal with difficult situations and build common practice.

The Sanctuary Model is helpful in developing organizational strength and is used to inform our trauma-informed care practice. A core idea is that we must start with understanding ourselves and how we manage difficult situations in order to provide effective care.

In an effort to promote general awareness of trauma-informed care, staff and leadership teams need to increase knowledge related to individual and systemic responses to trauma. Wood's Homes uses a comprehensive reflective supervisory process throughout the entire organization (as well as ongoing training) in order to ensure quality service provision. Areas where knowledge has been increased are:

- Understanding gender influences
- Language and communication skills
- De-escalation strategies
- Emotional modulation techniques and vicarious trauma manifestations and effects
- Focusing on self-care and resilience.

Regular reflexive supervision and staff meetings include opportunities for knowledge exchange on working with trauma. Staff are encouraged to discuss issues associated with defining and implementing appropriate personal and professional boundaries. This model of supervision is, in part, devoted to helping staff understand their own stress reactions.

Some questions we ask staff to consider, as outlined in the British Columbia Trauma-Informed Practice TIP guide (2013), while collaborating in supervision involve:

1. What are my underlying assumptions about the experience of those with trauma and how do people recover?
2. What particular responses or behaviours of those I'm assisting might trigger me? How do I know when it's happening? How will I respond?
3. How do my cultural background and personal experiences of diversity influence my interactions with others? What am I bringing to the relationship?
4. There may be some experiences in my life which could influence my ability to provide trauma-informed care. Do I have awareness of this? How am I responding?

In supervision, or while supporting on call, it is critical to stop and think about what the most appropriate response would be, given the factors involved. Questions to guide these conversations might include:

- What am I feeling now?
- What does this young person feel, need, or want?
- How is the environment affecting the young person?
- How do I best respond?

THE NEUROSEQUENTIAL MODEL OF THERAPEUTICS (NMT)

There has been considerable work in our field directed towards effectively working with clients who have trauma histories. The Neurosequential Model of Therapeutics was developed by Dr. Bruce Perry and is a "developmentally sensitive, neurobiology-informed approach to clinical problem solving. (Perry, 2006) It has three components including training/capacity building, assessment and intervention planning based on therapeutic, educational and enrichment activities where needs and strengths are utilized. The Neurosequential Approach is an important framework to address, "What has happened to this client?"

In the Neurosequential Model of Therapeutics Perry, (2006) outlines three core clinical questions, useful to support teams for assessment and intervention planning:

1. Are the child's difficulties due to a lack of appropriate developmental stimulation?(Meaning the neural networks that mediate function are present but are under developed) If so, offering developmentally appropriate experiences, repetition and consistent dosing would allow development to increase and continue.

2. Are the child's difficulties due to abnormal organization of the brain? (The neural networks responsible for the function are present but disorganized or abnormally organized). If this is the case, providing developmentally appropriate experiences and increasing levels of repetition would allow development to occur.

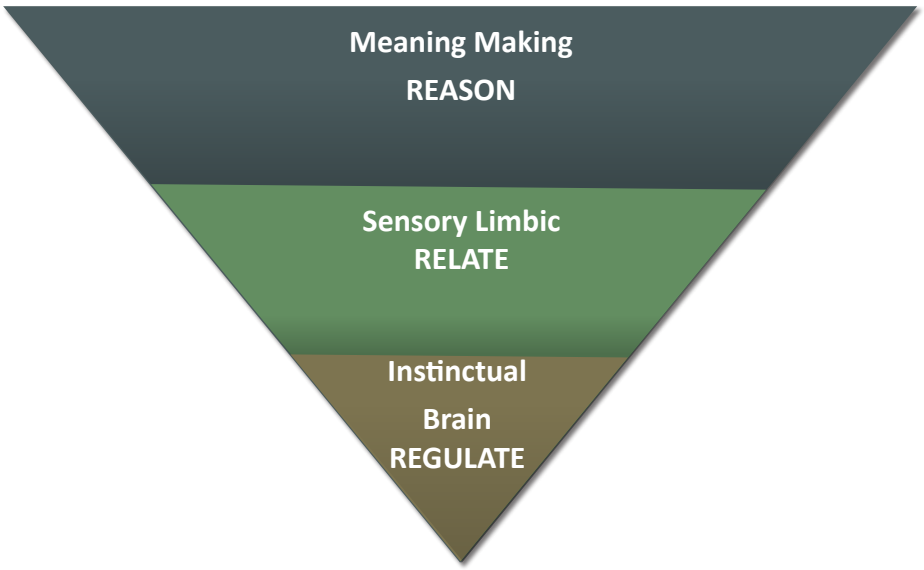
3. Are the child's difficulties due to a lack of necessary neural "material" to mediate the function? (Due to genetic, epigenetic or toxic factors the neural networks underlying the function are absent) In this case, a combination of specialized assessment related to understanding the medical, health and psychological impacts and then careful intervention planning based on the unique needs of the child.

Thinking about the child in light of these questions, and in the context of their experience, is valuable when selecting interventions consistent with the child's age and developmental stage. Some of the most commonly utilized interventions in the provision of trauma specific services are Attachment Regulation Competence (ARC) framework and Therapeutic Crisis Intervention System (TCI). (see later in this paper)

NMT Trauma-Informed Interventions are then provided in the context of *relational regulation*. Perry (2006) states providing **dosing** of regulation is most effective in targeting the developmental needs of children with trauma experiences. Dosing is defined as "Providing stimulation or input to specific parts of the brain for the purpose of improving functioning" (Perry, 2006). Doses of regulation ought to be provided at least once per hour, and should be defined based on prior research around 'what are the things that help the child regulate and stimulate their body? Interventions are then based on observations of "what works."

Perry (2006) contends that in order to be more successful, a sequence of engagement and therapeutic activities respectful of the specific developmental stage and physiological needs of the child must be considered. In this sense a sequence of engagement would begin with *Regulating* activities, followed by *Relating* emotionally to the child's experience and then attempting to Reason and discuss if possible or necessary.

From this point of view, every behavior is understood as the result of a person moving up the arousal continuum or just as a maladaptive behavior that ultimately needs to be "managed". With this in mind, interventions ought to be developmentally sensitive and responsive to the current emotional state of the individual.



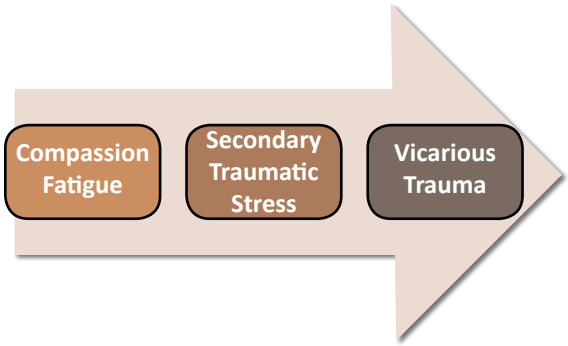
WORKING WITH PEOPLE AFFECTED BY TRAUMA

Trauma-informed practice is an overall way of working, rather than a specific set of techniques or strategies. Providing trauma-informed care means recognizing that different types of support may need to be offered for different circumstances. In preparing for trauma-informed practice, staff need to consider factors such as self-awareness, vicarious trauma, trauma awareness and the power of language. (TIP Guide, 2013).

Self-Awareness: When it comes to experiences of trauma, the distinction between practitioner, or anyone providing some level of support or service, and those accessing care may become blurred. Many practitioners have experienced and/or witnessed varying degrees of trauma themselves, and have been exposed to repeated stories of trauma and abuse; for this reason. Consequently, self-awareness is a critical component of this work.

It is essential that staff utilize supervision, practice self-reflection, know themselves well, and recognize what they bring to the interaction—their own story, diversity, culture, beliefs about recovery, triggers, and vulnerabilities. Trauma-informed supervision provides ongoing support to build self-awareness. Central beliefs of supervision are similar to those of practitioner toward client: people can recover and learn from mistakes, interventions and approaches are grounded in hope and honour an individual's resilience.

Vicarious Trauma: This term is understood as the cumulative and transformative effect on the helper working with survivors of traumatic life events. The impact of vicarious trauma occurs on a continuum.



FACTORS INFLUENCING VICARIOUS TRAUMA	PROTECTIVE FACTORS IN MANAGING VICARIOUS TRAUMA
Role	Mindful Self-Awareness
Level of Exposure	Active Optimism
Degree of Support	Countering Isolation
Personal Experiences of Trauma	Empathetic Engagement
Personal Life Support	Holistic Self-Care

Trauma Awareness: being trauma aware does not mean the practitioner has to be a trauma expert. However it's important that the practitioner has working knowledge of the trauma response and its effects which will inform practice in many levels, with the goal of helping clients make links between current adaptations and past experiences. Trauma may have different meanings in different cultures and responses to trauma may also be expressed differently. Cultural competence is an important component of trauma-informed care.

The Power of Language: Operating from a trauma-informed lens requires a shift in thinking and language. It is easy for behaviours and responses to be misunderstood and labeled in stigmatizing and deficit-based ways. Trauma-informed practice is a way of understanding trauma responses as a way of coping and adapting to the overwhelming impact of trauma. It is, in fact, a normal response to abnormal events. This re-frame empowers individuals as it de-stigmatizes their experience.

FROM **Deficit Perspective**	**TO** **Trauma-Informed & Strengths-Based**
What is Wrong?	What has happened?
Symptoms	Adaptations
Disorder	Response
Attention Seeking	The individual is trying to connect in the best way they know how
Borderline	The individual is doing the best they can, given their experiences
Controlling	The individual seems to be trying to assert their power
Manipulative	The individual has difficulty asking directly for what they want
Malingering	Seeking help in a way that feels safer

Adapted from Royal College of Nursing 2008, pg. 18 [54] (TIP guide 2013)

HISTORICAL TRAUMA AND INDIGENOUS CHILDREN, YOUTH AND FAMILIES

The following section was taken verbatim from the Executive Summary of a document prepared for PolicyWise and written by LaBoucane-Benson, P., Sherren, N., Yerichuk, D. (2017). The document is titled, "Trauma, Child Development, Healing and Resilience: A review of literature with focus on Aboriginal peoples and communities. The following is edited from the Executive Summary, pages 3 to 17.

"Historical trauma refers specifically to the inter-generational impact of colonization on Indigenous peoples. In the 1990s, the mental health issues suffered by Indigenous people in Canada were first conceptualized as post-traumatic stress disorder (PTSD).

Later researchers briefly began developing the concept of 'residential school survivor syndrome,' but then settled on the term historical trauma to create a definition that included the larger historical contributing processes. The most recent definition includes four aspects:

1. "Colonial injury to Indigenous peoples by European settlers who 'perpetrated' conquest, subjugation, and dispossession.

2. Collective experience of these injuries by entire Indigenous communities whose identities, ideals, and interactions were radically altered as a consequence.

3. Cumulative effects from these injuries as the consequences of subjugation, oppression, and marginalization have 'snowballed' throughout ever-shifting historical sequences of adverse policies and practices by dominant settler societies.

4. Cross-generational impacts of these injuries as legacies of risk and vulnerability were passed from ancestors to descendants in unremitting fashion until 'healing' interrupts these deleterious processes."

The current definition is useful in underscoring the past and present colonial conditions that cause and perpetuate intergenerational trauma. However, every First Nation, Métis and Inuit communities will have unique experiences of colonization due to significant diversity of culture, geographic location and other specific historical encounters or events. To understand the nuanced effects of colonization and how it informs our understanding of historic trauma and healing, we must dive deeply into specific culture and experiences.

Beginning in 1820, Indigenous children were removed from their families and communities and placed in state-funded Industrial Boarding Schools. By 1930 there were 80 Residential Schools operating across Canada, and this system continued for rest of the twentieth century, with the last school closing in 1996.

Residential school policies were based on the Euro-Christian beliefs that Indigenous peoples were: primitive; godless and heathen; child-like and unable to care for themselves; and savage. As such, government assumed that Indigenous children would fail to succeed if they remained under the influence of their families. The ultimate goal of the residential school system was to fully assimilate Indigenous people, eradicating all Indigenous culture, language and spirituality.

Students were forbidden to speak their First language and the practice of Indigenous spirituality and culture was deemed morally and ethically wrong and was therefore also prohibited. If children dared transgress these rules, they received punishments, which ranged from shaming to physical violence. As a result, if any of the children did go home, they struggled to communicate with their family and were unaware, suspicious, or afraid of customs/rituals that had historically strengthened and reaffirmed relationships between family and community members.

For 176 years, children were placed either in day-schools or residential schools for the entire school year. Undernourished children with depressed immunities that were living in overcrowded dormitories lead to the spread of disease among the children, which resulted in a high death rate among students.

Further, many Indigenous families have, over may generations, been subjected to overwhelming acculturation stress; in addition, children have grown up in environments where they have been left alone to manage normal developmental stress, as well as overwhelming external stresses such as racism, neglect and poverty.

Neuroscience has mapped the toxic stress response, which occurs when children experience frequent, intense, and long-lasting threats in the absence of adequate adult support. Experiences like abuse, neglect, or living with a caregiver who is not able to provide appropriate serve-and-return interactions, as is the case when a caregiver has an addiction or untreated mental health problem, produce toxic stress in children. This type of experience releases large amounts of stress hormones into the body which can damage developing brain circuits and peripheral systems over time. In short: toxic stress is detrimental to healthy brain development, which effects the adult's capacity to navigate and pursue healthy, productive lifestyles. For Indigenous children living with the burden of historic trauma, toxic stress has deeply affected brain and skill development

Generations of residential school graduates were survivors of trauma, abuse and neglect, burdened with significant psychological issues that impaired their ability to create healthy relationships with spouses and children. Survivors entered adulthood without an understanding of the roles and responsibilities of parents, or how to care for and nurture children of their own.

Healing from historic trauma is a learning process that includes activities that foster reclaiming the relationships-based world view. At its core, healing is a movement from isolation, despair, and hopelessness to belonging and deep responsibility to all living beings within the web of relationships. Healing programs and services are experiential educational processes that teach history, culture, and connectedness, and mobilize sacred knowledge in the "recapturing of the life force."

Healing programs are often framed as the beginning of a lifelong healing journey that involves personal and collective decolonization. Often, programs will combine traditional teachings ceremony and activities with history lessons on colonization and the impact on Indigenous people throughout Canada and North America. Learning colonial history provides context for historic-trauma-informed behavior. As such, there are three conditions for the building and maintaining of family and community resilience and for healing from the effects of historic trauma:

- reclaiming an interconnected relationships-based worldview and legal tradition;
- reconciliation of damaged relationships; and
- recovering the power to respectfully self-determine

ADVERSE CHILDHOOD EXPERIENCES AND RESILIENCE

ADVERSE CHILDHOOD EXPERIENCES

Many children and families involved in Wood's Homes programs have experienced chronic exposure to "toxic stress" due to living in seriously difficult and disadvantaged circumstances. Research initiated by Dr. Vincent Felitti and Dr. Robert Anda, has shown that Adverse Childhood Experiences (ACES) are associated with later psychological and physical dysfunction. (Fig 1) The outcomes of their research showed there is a significant relationship between the number of ACES and many of the different types of problems seen in clients and families, such as early drug use, addictions, promiscuity, teen pregnancy, depression, suicide attempts, life dissatisfaction, school failure etc. Although there is indeed a significant relationship between ACES score and these problems, it is not a strict linear relationship; rather ACES constitute risk factors.

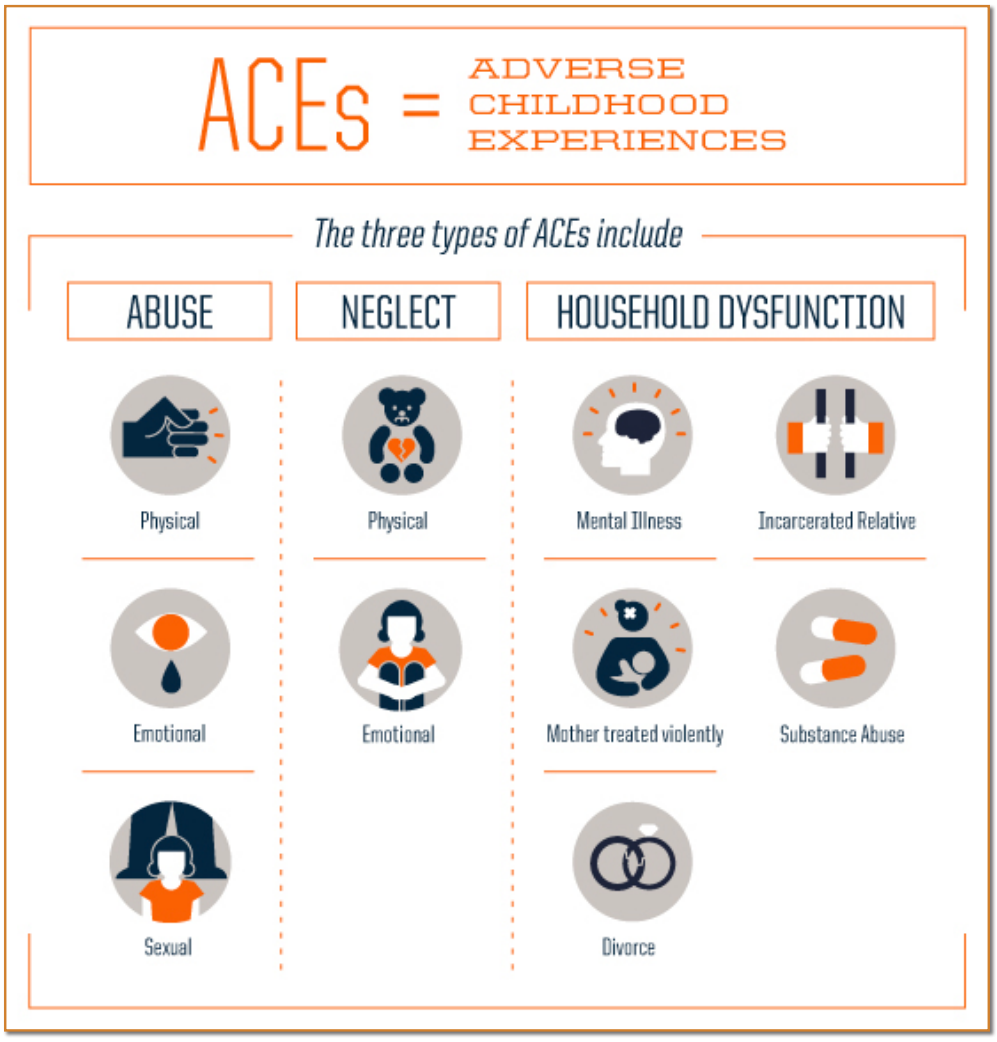


FIG. 1

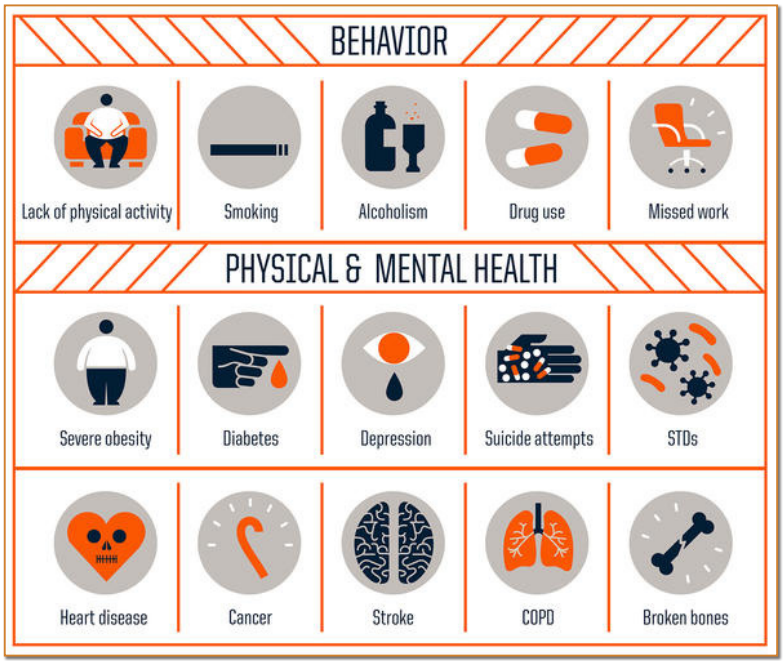


FIG. 2

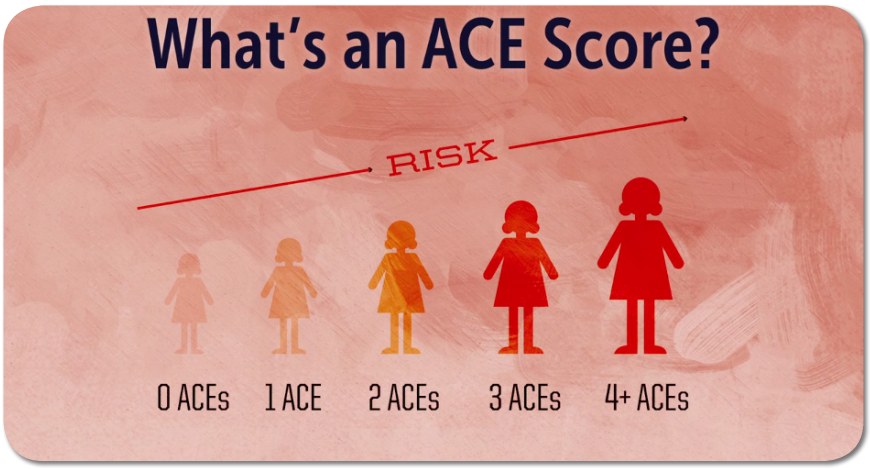
Felitti et al, (1998) found that early adverse experiences tend to be co-occurring and interrelated, which in turn are associated with greater number of health risk behaviours and difficulties in general functioning, including mental health and medical conditions throughout the life span. Complicated experiences eliciting anxiety, confusion, fear and anger result from exposure to challenging, upsetting and often dangerous experiences over extended periods of time within the child-caregiver system, beginning in early childhood. (Fig 2)

Whether it is early in life as a result of child abuse, neglect; or later in life such as accidents, natural disasters, war, sudden loss, etc. trauma can be devastating. Experiences like this can interfere with a person's sense of safety and self-efficacy as well as the ability to regulate emotions and navigate relationships.

Trauma is pervasive, it can be life changing especially for those who have faced multiple traumatic events. Trauma is an intense event that threatens the safety or security of an infant, child or youth, but it may also result from prenatal stress (e.g., Fetal Alcohol Exposure, brain injury). In the presence of toxic stress, trauma impairs the child's ability to trust and relate to others, therefore affecting their ability to form attachments.

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 drugs**
- **3.9 times more likely to have chronic obstructive pulmonary disease.**



Research has identified that clients with high ACE scores tend to experience significantly more co-occurring mental health difficulties, such as depression, sexual dysfunction, dissociation, anger, suicidality, self-harm, as well as substance use problems and addictions, than people experiencing mental health problems without trauma histories (TIP Guide, 2013).

In the provision of services, Trauma-Informed Care as a philosophy of care does not require disclosure of trauma. Trauma-Informed Care assumes clients may have experienced trauma and therefore may benefit from services that promote safety, trust, choice and control which are provided with compassion.

Wood's Homes has developed screening processes for children and adults utilizing the Adverse Childhood Experience Questionnaire. It's important to understand how each program completes these screenings and how this information informs interventions with clients, in order to understand staff's role and the interventions undertaken. The hope is that there are opportunities for staff to understand the impact of trauma on development and current functioning, determine the subjective ways their clients experience and cope with trauma, consider the possible associations and make connections that support mental and physical health concerns experienced by these clients and their unique trauma histories. Each program will identify how this might work in the overall provision of care.

Of utmost importance is that responses on each of the Adverse Childhood Experience questionnaire items are interpreted in the context of the client's current presentation and situation. While it is not possible to change the number of ACES a person has experienced, doing an assessment and identification of protective factors would enhance the possibilities of increasing those protective factors, thereby preventing an increase on ACE scores and promoting resilience.

THE ROLE OF RESILIENCE

Resilience has been regarded as the ability to bounce back from stress and adversity and take on new challenges. It's the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress. Research indicates that resilience has a significant impact on our physical and mental health, our relationships with others, and our ability to be successful. Several critical abilities are associated with resilience. These include: emotional regulation, impulse control, causal analysis, empathy, maintaining realistic optimism, self-efficacy, and reaching out, among others (Haggerty, Lonnie, Garmezy and Rutter 1996).

Research suggests that the way we think about challenges and adversity influences whether or not we handle setbacks in a resilient manner. Thinking skills that help us respond resiliently to daily adversity and stress can be learned (Haggerty et al. 1996).

A central belief of trauma-informed practice is that people can recover, and the approach is grounded in hope and the honoring of each individual's resiliency. As Ungar asserts: "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 in culturally meaningful ways." (Ungar, 2008)

Protective experiences and coping skills have the power of counterbalancing significant adversity. Building on resilience provides opportunities for more positive outcomes in children. One way of building up resilience is, from a strength based approach, to assess what capacity for resilience is already available in the life of a person and adapt the environment to provide supports that fit his or her needs. The assessment of risk and resilience should go hand in hand. While it is important to consider severity and chronicity of risk factors, resilience is built overtime and influenced by a variety of factors, including the individual's temperament, personality, cognitive capacity and self-regulation; as well as, the environment which can also be a contributor for either risk or protection.

In assessing resilience, the work of the Resilience Research Centre is relevant as it conceptualizes resilience from a social ecological perspective. This ecological perspective suggests that interventions must involve those in the helping role, as well as family, peers and community.

The Child and Youth Resilience Measure (CYRM), identifies individual, relational, communal and cultural resources available to individuals that may bolster their resilience (Ungar, 2005). The Child and Youth Resilience Measure is one way of assessing risk and resilience regarding current functioning during intervention planning.

When planning interventions, input from the clients, and family or other extended supports is critical. When understanding the effects of adversity and resilience, it is important to consider the developmental age and stage of clients at the time of the trauma, the available supports and resources, as well as the client's capacity to use supports. Connecting this knowledge with the understanding of the impact trauma can have on brain development, facilitates an understanding of the adaptive nature of behaviour in coping with life experience.

RELATIONAL PRACTICE

Building positive and appropriate relationships is one of the most important aspects of providing Trauma-Informed Care. Attachment then becomes an important consideration. Attachment is defined as an enduring form of "emotional" relationship with a specific person, which brings safety, comfort, soothing and pleasure; the loss of which or the threat of this loss can evoke intense distress.

The interactions between genes and experience shape the developing brain. Brain circuits are reinforced by repeated use, enhancing and developing specific functions and skills or determining what cells get pruned to open space for newly developed ones. A major ingredient in this developmental process is the **serve and return** interaction between children and their parents and other caregivers in the family or community. In the absence of responsive caregiving—or if responses are unreliable or inappropriate—the brain's architecture does not form as expected, which can lead to disparities in learning and behavior. (Harvard University Centre on the Developing Child, 2016).

Research has shown that a solid and healthy or secure attachment with a primary caregiver is a protective factor that contributes to the emergence of healthy relationships with others, while poor or insecure attachment with the primary caregiver appears to be associated with a number of emotional and behavioural difficulties later in life (Perry, 2010).

Although early experiences have an effect on shaping the brain, research now also suggests relationships also have the potential to be protective and reparative to the brain (Perry & Dobson, 2010). The Attachment, Regulation and Competence framework (ARC) (Kinniburgh, Blaustein & Spomazzola 2005), offers opportunities for establishing predictable routines, and reconnections with attentive, attuned, and committed caregivers. A solid therapeutic relationship provides more opportunities for children to do better.

ARC notes that in the therapeutic relationship with clients, caregivers and staff practice *management of their own affect*, while being **Present, Attentive, Attuned and Responsive** –on 'PAAR' - to the needs of each client. Relationally rich environments offer more opportunity for serve and return interactions enhancing the development of the brain.

FAMILY-CENTRED TRAUMA-INFORMED CARE

Wood's Homes, as stated in its policies, recognizes the importance of family engagement in supporting positive outcomes of treatment for children and youth, while addressing the impact of trauma for parents and caregivers as a component of treatment. Inherent is the belief that the most effective approach to ensuring the health, well-being and safety of a child or young person, and encouraging permanency, is to provide services that engage, involve, strengthen, and support all family members

- Parents have the ability and responsibility to decide what is important to them and their family.
- Supports should focus on the positive aspects and strengths of families.
- All families have the capacity to develop competence.
- Services have the responsibility to create opportunities for competencies to be manifested.
- Families must acquire a sense of control and attribute change to their own efforts.
- Availability and acceptance are important in engaging families in the change process (Kalafat, 2004).

Trauma-informed providers of service at Wood's Homes aim to make every effort to involve family members and personal supports in the development of goals and plans while creating a safe environment that fosters choice, collaboration and connection. Adopting a trauma-informed lens allows staff to view aggressive or hostile client responses as coping strategies resulting from the individuals' life experience.

This lens also supports clients in a non-judgmental way; placing priority on the individual's safety, choice and control in a culture of non-violence, learning and collaboration. Both Family-Centred Care and Trauma-Informed Care approaches are informed by the developmental age and stage of the different client groups and services are tailored to the specific needs of clients

TOOLS AND INTERVENTIONS

Wood's Homes utilizes a variety of tools and intervention techniques in the services offered to children and families, starting with the focus on building strong working relationships with clients. Perry (2006) asserts that much of what is therapeutic does not occur in the context of one hour of conventional therapy, but in matching therapeutic activities to the specific developmental stage and physiological needs of the child (Perry, 2006).

This therapeutic process begins with assessment. Careful developmental assessments are completed in order to understand what has happened to the client and when it happened.

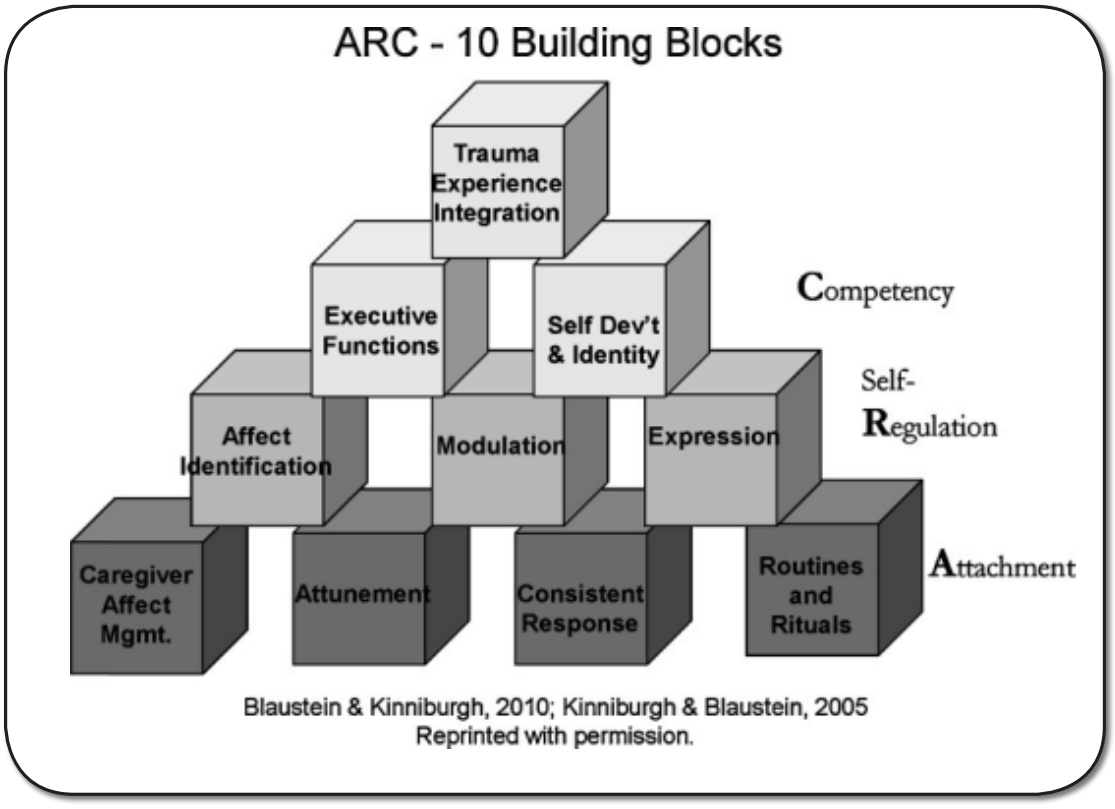
Developmental assessments are key to a thorough understanding of the trauma history and are important to understanding the unique impact for each individual.

THE ATTACHMENT, REGULATION AND COMPETENCY FRAMEWORK

The ARC Framework was developed by Kristine Kinniburgh and Margaret Blaustein, from the Justice Resource Institute (JRI) Trauma Center, and in cooperation with the National Traumatic Stress Network (NCTSN), for the purpose of treating traumatized children and adolescents who have experienced trauma. The model was developed as a component-based framework, meaning there is no specific order or structure. This flexibility allows for the development of individualized treatment plans.

The framework focuses on three specific areas; Attachment, Regulation and Competence. Each area targets several "building blocks". Specific strategies are used for each building block depending on the degree of impairment and resilience factors. (Fig 7). The ARC framework is informed and grounded in attachment theory, child development theory, traumatic stress theory, and resiliency theory. (Kinniburgh & Blaustein, 2005).

Interventions focus on the individual, family and system levels via a range of treatment modalities including: groups, family therapy, parent workshops, and home-based treatments. (Kinniburgh & Blaustein, 2005).



Blaustein & Kinniburgh, 2010; Kinniburgh & Blaustein, 2005
Reprinted with permission.

Based on the understanding that trauma may derail healthy development and that trauma does not occur in a vacuum, thus, service provision shouldn't either. Effective interventions go beyond formal, office-based therapy. Consequently, the ARC framework offers opportunities to:

1) To develop a safe caregiving system, thus focusing on Attachment

2) Enhance the individual's ability to regulate and tolerate experience, focusing on Self-Regulation

3) Offer support to master an array of tasks crucial to resilient outcomes, targeting Competency all within the context of the individual current presentation and experiences.

Ultimately the goal for the children and families we work with is the building of resources, both internal and external, which promote ongoing healthy development and positive functioning across various domains of competency, such as social connections, academic engagement and community involvement (Blaustein & Kinniburgh, 2010).

Using ARC as a framework, allows for countless opportunities to develop creative interventions. Examples of potential goals, when using the ARC framework, are listed briefly in the chart below. However more in depth explanations of activities and additional activities are described in Blaustein & Kinniburgh's (2010): *Treating Traumatic Stress in Children and Adolescents.*

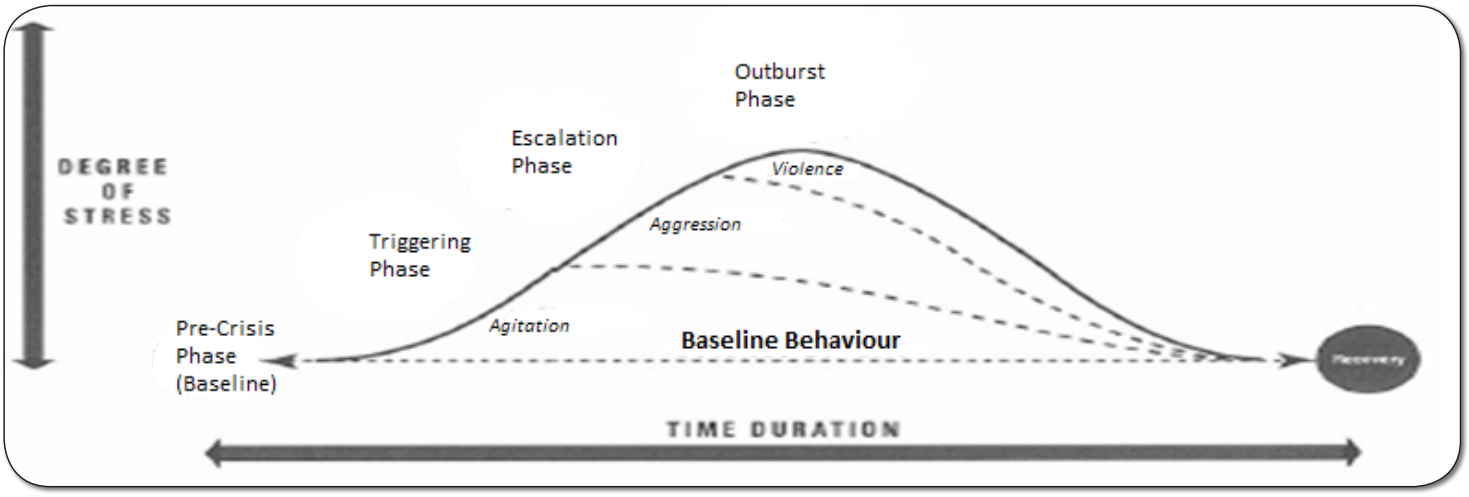
GOAL	CAREGIVER ROLE	EXAMPLES OF ACTIVITIES & INTERVENTIONS
Caregiver Management of Affect	Understanding of the crucial role they play in child development	1. Psycho-education about the nature of trauma and normalization of caregiver's response 2. Building Caregiver self-monitoring skills 3. Building of caregiver affect management skills 4. Enhancing caregiver supports
Attunement	Develop skill in accurately reading children's cues and responding appropriately	1. Psycho-education about the role of child vigilance 2. Psycho-education about traumatic triggers and their expression 3. Building an understanding for children's communication (becoming a feelings detective) 4. Building reflective listening skills
Consistent Response	Offers an environment where responses can be easily predictable for the child	1. Assessment of key intervention targets for building consistent response 2. Consider trauma experience, typical parenting practices may trigger strong responses in children with dys-regulated emotions 3. Consider and teach classic behavioural parenting techniques (limit setting, praise, positive reinforcement) combined with education around the role of the trauma response 4. Implement strategies framing them as "experiments" no one parenting technique will be successful for all children
Routines and Rituals	Increasing predictability in routines to build a sense of safety thus reducing high levels of arousal	1. Psycho-education in terms of age appropriate routine and structure for the day 2. Transitions can be a potential for difficulty 3. Address routine and structure in all key settings identified
Affect Identification	Attunement Skills: mirror and reflection of child experience	1. Provide psycho-education about the human alarm response and trauma triggers 2. Support in building a feelings vocabulary 3. Normalize the experience of mixed emotions 4. Teach children how to be a feelings detective: identify emotions in self and others 5. Educate about the connection between emotions and body sensations, thoughts and behavior 6. Link the emotional experience to internal and external factors

Modulation	Source of physiological organization; importance of modeling; provision of safety through limits and routines.	1. Building an understanding of degrees of feelings 2. Using activities to increase and decrease arousal in order to help children to comfortably tolerate and move through arousal states 3. Develop a feelings "toolbox" with specific skills and strategies directed toward the energy of the emotion
Affect Expression	Provide children with skills that help them effectively and safely share emotional experience with others	1. Identification of safe communication resources 2. Effective use of resources including how to "pick your moment" and initiate conversation 3. Effective non-verbal communication strategies (physical space, boundaries, tone of voice, eye contact) 4. Verbal communication skills, including the use of "I statements" 5. Building a repertoire of self-expression strategies
Self-Development	Source of unconditional positive regard; alteration of negative working models of self; resource for formation of coherent narrative	1. Exploration and celebration of the "unique self" including personal attributes, likes and dislikes, values, opinions, family norms, culture 2. Exploration of the "positive self", which involves building internal resources and identifying strengths and successes 3. Exploration of the "cohesive self" which emphasizes the examination of the self across multiple aspects of experience. I.e. self before and after trauma; self with parents and self with others; self on the outside and self on the inside 4. Exploration of the future self, involving a building of the child's capacity to imagine the self in the future and to explore possibilities
Executive Functioning Skills	External organization; modeling of calm approach to problem solving; support for developing of agency	1. Development of a sense of agency: the knowledge that he or she has the ability to make an impact in the world. Agency develops as we try, we do, and we choose 2. Development of problem solving skills 3. Building awareness of the contrast between acting and reacting 4. Building youth awareness of choice
Trauma Experience Integration	Reflective and supportive context. Child is able to process and explore experience and integrate it.	1. Drawing from the skills addressed within the nine blocks, define the steps intended to support children in building a coherent and integrated understanding of self and the capacity to engage in present life

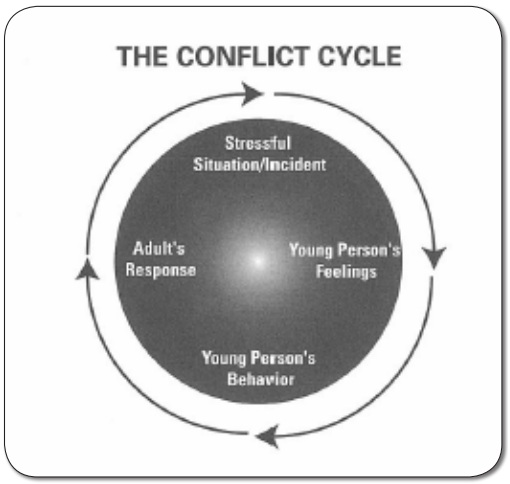
* Adapted by Nidia Celis from, Attachment, Regulation, Competence Handbook Blaustein, M. & Kinniburgh, K., (2010)

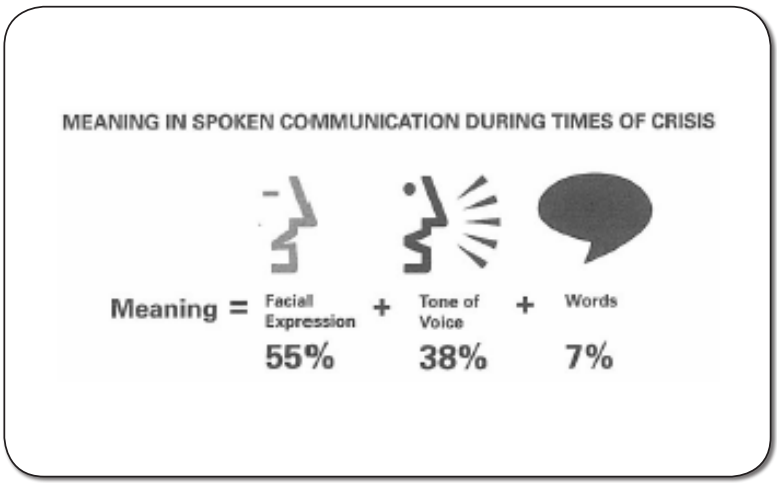
THERAPEUTIC CRISIS INTERVENTION

The Therapeutic Crisis Intervention (TCI) training program for child and youth care staff presents a crisis prevention and intervention model designed to teach staff how to help children learn constructive ways to handle crises.



Addressing stressors early reduces full escalations from occurring. It's important to remember that the stronger the threat, the more 'primitive' the thinking and behaving becomes. A child will be more anxious focusing on 'non-verbal' cues such as tone of voice, body posture and facial expressions (Perry, 2014). Consistently practicing being on PAAR would allow early detection of these responses and needs.





During stressful situations, when behaviours start escalating, adults may try to take control of the situation by "correcting" the behaviour through directive statements, threats, demanding compliance or giving consequences. These interactions often generate resistance, foster resentment, damage relationships, and escalate situations. Looking at this from the point of view of the **arousal continuum**, this 'correcting intervention' can create more fear, thereby creating a sense of lack of control for the individual and threatening their safety and ability to remain calm. Thoughtful reflection on how this cycle occurs with each child/youth can be helpful in implementing change in interventions to reduce escalations.

THERAPEUTIC CRISIS MANAGEMENT

Using Therapeutic Crisis Management techniques (see the pyramid diagram), intervening from least intrusive to most intrusive offers support that matches the Stress Model of Crisis Interventions. There are six levels of interventions in this model (fig. 5). These events move from the bottom up beginning with self-awareness of responses and triggers in a **continuum of self-reflecting while intervening.**

SELF-AWARENESS: Four questions

1. What am I feeling now?
2. What does this young person feel, need, or want?
3. How is the environment affecting the young person?
4. How do I best respond?

ACTIVE LISTENING

OARS (Open ended questions, Affirmations, Reflections, and Summaries). Using OARS helps to identify and validate feelings, which in turn reduces defensiveness, promotes change while communicating that we care and understand. It is an effective ***co-regulation strategy*** that helps young people "talk out rather than act out." It maintains the thinking brain as engaged in state of alertness and not fear.

BEHAVIOUR SUPPORT TECHNIQUES

Behavior Support Techniques can be helpful in offering safety when the part of the brain driving behaviors is fear driven, when interactions are less rational and more primitive. The main purpose of this intervention is to soothe and offer safety while attempting to calm the child.

1. **Managing the Environment,**
2. **Prompting,**
3. **Caring Gesture,**
4. **Hurdle help,**
5. **Redirection and Distractions,**
6. **Proximity,**
7. **Directive statements,**
8. **Time away**

FIG. 5

EMOTIONAL FIRST AID

Emotional First Aid is a quick intervention designed to get the child/youth through a tough situation and back to expected behaviours and activities. It can set the stage for a more comprehensive processing of the event by conducting a Life Space Interview. Among the specific objectives of emotional first aid are: assistance while an individual drains off frustration, support for the management of fury, panic, and/or guilt, and maintenance of communication during difficult periods. Timing and relevance are also very important considerations in terms of when to use these interventions.

CRISIS CO-REGULATION

The immediate objective in a potentially violent situation is to make the situation safe.

What to Think - 4Qs, positive self-talk, lower own stress.

What to Do -Take a deep breath, step back, give space and time.

What to Say- Say very little, minimal encouragement, understanding responses.

LIFE SPACE INTERVIEW

The Life Space Interview is a tool to teach self-management and values. After a stressful event, and always in situations where a restraint has occurred, a Life Space Interview is completed by staff with the child/youth. This must be done when the child/youth is at the Baseline stage of Stress Model of Crisis. The following steps must occur in order as listed below to be most successful:

I - Isolate the conversation
E - Explore the young person's point of view
S - Summarize the feeling and content
C - Connect feeling to behaviour
A - Alternative behaviours discussed
P - Plan developed / Practice new behaviour
E - Enter young person back into routine

CONCLUSION

This guide was produced in order to assist all staff working with clients in all Wood's Homes Programs to help children, youth and their families with mental health challenges. This document outlines the basis of trauma-informed practice as it is connected to the Wood's Homes therapeutic model of practice.

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WEB RESOURCES

Aces too High
https://acestoohigh.com/

Attachment, Regulation and Competency Framework
http://arcframework.org/

Centre on the Developing Child
http://developingchild.harvard.edu/

Centers for Disease Control and Prevention
https://www.cdc.gov/violenceprevention/acestudy/index.html

Child Trauma Academy
http://childtrauma.org/

Children's Resilience Initiative
https://www.resiliencetrumpsaces.org/resilience-trumps-aces/aces

Heart-Mind Online
http://heartmindonline.org/resources/a-parents-guide-to-self-regulation

Info Trauma
www.info-trauma.org/

KidsLINK
http://kidslinkcares.com

The National Child Traumatic Stress Network
http://www.nctsn.org/

Tools of the Mind
https://toolsofthemind.org/learn/resources/

The Child and Youth Resiliency Measure (CYRM)
http://www.resilienceresearch.org/files/CYRM/Child%20-%20CYRM%20Manual.pdf

APPENDIX 1

Adverse Childhood Experience (ACE) Questionnaire
Finding your ACE Score
While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household 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?
Yes No If yes enter 1 _____
2. Did a parent or other adult in the household often …
Push, grab, slap, or throw something at you?
or
Ever hit you so hard that you had marks or were injured?
Yes No If yes enter 1 _____
3. Did an adult or person at least 5 years older than you ever…
Touch or fondle you or have you touch their body in a sexual way?
or
Try to or actually have oral, anal, or vaginal sex with you?
Yes No If yes enter 1 _____
4. Did you 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?
Yes No If yes enter 1 _____
5. Did you 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?
Yes No If yes enter 1 _____
6. Were your parents ever separated or divorced?
Yes No If yes enter 1 _____
7. Was your mother or stepmother:
Often pushed, grabbed, slapped, or had something thrown at her?
or
Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
or
Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
Yes No If yes enter 1 _____
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
Yes No If yes enter 1 _____
9. Was a household member depressed or mentally ill or did a household member attempt suicide?
Yes No If yes enter 1 _____
10. Did a household member go to prison?
Yes No If yes enter 1 _____

Now add up your "Yes" answers.
This is your ACE Score.

APPENDIX 2

The Child and Youth Resiliency Measure (CYRM) is a measure of the resources (individual, relational, communal and cultural) available in the following website http://www.resilienceresearch.org/files/CYRM/Child%20-%20CYRM%20Manual.pdf

WOOD'S HOMES

WORKING FOR CHILDREN'S MENTAL HEALTH

SINCE 1914

'DUTY OF CARE' AGREEMENT

WHAT DOES A *DUTY OF CARE* MEAN FOR EMPLOYEES OF WOOD'S HOMES?

Duty of care is the **responsibility** or **duty** to take reasonable **care** to avoid acts or omissions that could expose people, for whom there is a **responsibility**, to a reasonably foreseeable risk of injury.

Duty of care is defined simply as a legal obligation to: always act in the best interest of individuals and others; not act or fail to act in a way that results in harm; act within your competence and not take on anything you **do** not believe you can safely **do**.

It is **important** to address **duty of care** in the induction process. Each person has a **duty** to ensure their action, or failure to take action, does not harm others. This needs to be reinforced for everyone wanting to work at Wood's Homes. It is part of the occupational health and safety responsibilities and obligations for employers and employees. This means that employers are responsible to make this duty sensible and reasonable in itself to those he or she is hiring.

IMPORTANT THINGS TO KNOW AND UNDERSTAND ABOUT THE WAY OF THE WORLD AT WOOD'S HOMES:

You are eager to work at Wood's Homes, with children and families in some capacity. We are happy to hear this. Along with the above need to fully embrace a duty of care for our clients, it is important to understand that your therapeutic role is very important. You are a treatment specialist in some way – not a babysitter or a disciplinarian. As such, you will be called upon every day to use the knowledge and skills you already have and now bring to your position to benefit and understand the challenges of all clients who come to the doors of this children's mental health centre. **I understand that this is both a challenge and a responsibility.**

_____
Initials

Children and adults who come to the doors of Wood's Homes come with past experiences of trauma, abuse, abandonment, neglect, domestic violence, etc. They often come with disabilities that hamper good thinking processes and an inability to regulate their emotions as well. You will experience the pain and upset these clients feel and it will often be scary. Threats, spitting, hitting, damaging property, swearing, running away, lashing out are only a few examples of how these feelings are manifested. It is the job of all employees to understand that this is pain being expressed by seriously troubled children. It is our job to pay attention to it, listen to it, protect it and manage these behaviours and the feelings beneath them with respect, kindness, forgiveness and safety for both yourself and the client. **I am fully aware of how these behaviours are manifested and I am open to understanding their deeper meaning.**

_____
Initials

Wood's Homes offers training for all staff in a wide variety of ways to handle disruptive and aggressive behaviours. We also expect that you are coming to this position with some practical and theoretical knowledge and skill that we expect you to use well. One must remember that when feelings are expressed with or toward you that it is not about you – it is about the client. **I feel I am able to maintain a therapeutic stance in all situations, ask for help when I am unsure, and will be aware of my own actions and reactions when faced with perceived anger or danger.**

_____
Initials

This job demands more curiosity, and less control. What our clients do and say are keys to their future mental health and it is our job to encourage the expression of both their experience and their emotions. When a client feels safe with a staff member, often he or she will have to bear the brunt of many an outburst. This is uncomfortable and confusing most of the time. But curiosity is key – as well as being able to stand back and realize that while the outbursts may be directed at you, you are not the real ultimate target and must remain neutral and try to take advantage of the opportunity to use your professional skills – it is the unknown for the client that is key. **I will be curious.**

_____
Initials

The time for you to understand your own reactions to clients and learn about what their behaviours mean is in supervision. The way to get the most out of this process is to be open to not knowing, asking for advice, taking a few calculated chances, making mistakes and talking responsibility for oneself when things do not work out. **I will be transparent, open and curious during supervision.**

_____
Initials

I have read and understand the contents of this document.

_____ _____

Employee Signature **Date**

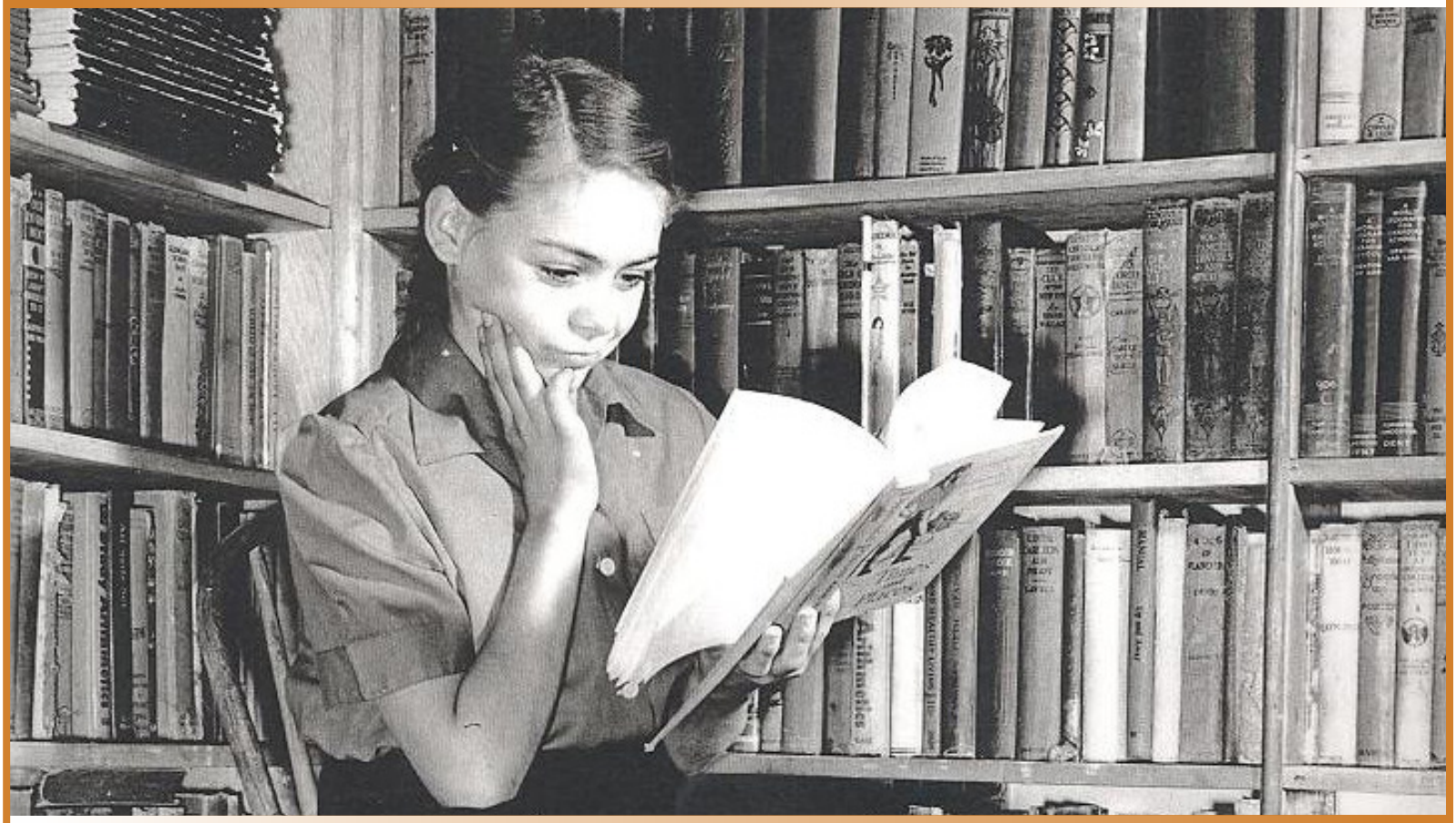
_____

Employee Name (please print)

WOOD'S HOMES

WORKING FOR CHILDREN'S MENTAL HEALTH

SINCE 1914



Wood's Homes

Publications, Presentations, Teaching and the Blog

woodshomes.ca

Publications, Presentations, Teaching and the Blog

At Wood's Homes, we pride ourselves on our culture of learning and are committed to both growing and sharing our knowledge and resources. As the issues and hurdles our clients face become more complex, it is important that all those in the field of mental health remain dedicated to learning and developing effective treatment and interventions.

2018

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Stewart, J. (2015, March 02). Capturing the moment 2: reaching new heights in single session therapy and walk-in services [Blog post]. Retrieved from https://woodshomesfamilies.wordpress.com/?s=Capturing+the+moment+2%3A+reaching+new+heights+in+single+session+therapy+and+walk-in+services

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Wood's Homes communications team. (2015, February 20). Top 10 tactics for taming a toddler [Blog post]. Retrieved from https://woodshomesfamilies.wordpress.com/?s=Top+10+tactics+for+taming+a+toddler+

Weeks, K. (2015, February 18). Moving on: youth from evergreen takes a new step [Blog post]. Retrieved from https://woodshomesfamilies.wordpress.com/?s=Moving+on%3A+youth+from+evergreen+takes+a+new+step

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2014

PUBLICATIONS

Aielo, A., Carter, C., Johansson, B., MacLaurin, B., McCay, E., et al., (Submitted), Dialectical Behavior Therapy as a Catalyst for Change in Street-Involved Youth: A Mixed Method Study, Submitted to Children & Youth Services Review, April, 2015

Allan, K., Blackstock, C., Chabot, M., Fallon, B., Fluke, J., MacLaurin, B., & Sinha, S. (2015), Exploring alternate specifications to explain agency-level effects in placement decisions regarding Aboriginal children: Further analysis of the Canadian Incidence Study of Reported Child Abuse and Neglect, Child Abuse & Neglect, In Press, Corrected Proof, Available online 2 May 2015

Badry, D., Lee., C., MacLaurin, B. & Sieppert, J., (2014) Editorial – Balance Required When examining the Child Welfare System, AASCF Journal for Services for Children and Families, Volume 7, p. 7-10

Badry, D., Fuchs, D. & MacLaurin, B. (accepted – 2015 release). A Comparative Response in Child Welfare and Social Work Practice between Children and Youth with Developmental Disabilities and Fetal Alcohol Spectrum Disorder. Fudge Schormans, A. & Stoddart, K. Social Work, Intellectual and Developmental Disabilities in Canada, Waterloo: Wilfrid Laurier Press.

Balser, A., Johansson, B., & Smith, A. (2015), A Renewed Perspective of Group Care and Residential Treatment: An Orientation Towards Therapeutic Group/Residential Care, Part One: Setting the Context: Establishing Value in the Service System and Initiating the Construct of Therapeutic Group/ Residential Care, AASCF Journal Special Edition Reconstructing Residential Care, Special Edition, p. 17-33

Daoust, G., Fields, J., Lee, C., MacLaurin, B. (2014). Supporting Victims of Child Abuse: An interdisciplinary approach to supporting children impacted by child abuse. Report prepared for the Sheldon Kennedy Child Advocacy Centre. Calgary, AB: University of Calgary.

DeMone, M., MacLaurin, B., & Yoo, H. (Submitted) Differential response and traditional protection investigation: A comparison of two child welfare investigation streams. Journal for Services to Children and Families. Edmonton, AB.

DeMone, M., MacLaurin, B., & Yoo, H. (Accepted) Differential response and traditional protection investigation: A comparison of two child welfare investigation streams [Extended Abstract]. Journal for Undergraduate Research, University of Calgary, Calgary, AB.

DeMone, M., MacLaurin, B., & Yoo, H., (Accepted) Children aged 0-5 years investigated by child welfare in Alberta: Child, family, household and case risk factors [Extended Abstract]. Journal for Undergraduate Research, University of Calgary, Calgary, AB.

DeMone, M., MacLaurin, B., & Yoo, H. (Submitted) A comparison of two cohorts among child welfare investigations in Alberta: Child, caregiver, household and case risk factors. Journal for Services to Children and Families. Edmonton, AB.

DeMone, M., MacLaurin, B., & Yoo, H. (Accepted) Factors associated with investigations involving intimate partner violence and other forms of maltreatment: child, family, household, and case characteristics [Extended Abstract]. Journal for Undergraduate Research, University of Calgary, Calgary, AB.

Enns, R., Fallon, B., Feehan, R., MacLaurin, B., Sinha, V., Trocme, N., & Yoo, H. (2015) Characteristics of child investigations with noted caregiver cognitive functioning concern in Alberta in 2008 [Fact Sheet]. Canadian Child Welfare Research Portal. Montreal, QC.

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Gardiner, S., MacLaurin, B. & Reeves, J., (2015) Outcomes-based Service Delivery (OBSD): The Process and Outcomes of Collaboration, in Dorothy Badry, Don Fuchs, H. Monty Montgomery & Sharon McKay (Eds.), Reinvesting in Families: Strengthening Child Welfare Practice for a Brighter Future – Voices from the Prairies, Regina: University of Regina Press

Goodman, D., MacLaurin, B., et al., (2014) Characteristics of Investigations with Noted Child Functioning Concern of FAS/FAE in Alberta in 2008, [Fact Sheet]. Canadian Child Welfare Research Portal. Montreal, QC

MacLaurin, B., Trocme, N., et al., (2014) Alberta Incidence study of Reported Child Abuse and Neglect (AIS-2008): Select Findings, AASCF Journal for Services for Children and Families, Volume 7, p. 31-41

MacLaurin, B, & Yoo, H. (Submitted) Factors associated with kinship foster care placements in Alberta. Journal for Services to Children and Families. Edmonton, AB.

MacLaurin, B., & Yoo, H.J. (2015) Factors Associated with Placement Decision Making: Associated Factors – Extended Abstract, Journal for Undergraduate Research 4(2), University of Calgary, Calgary, AB

MacLaurin, B., Yoo, H. (Submitted) Formal child welfare placement decision-making; child, family, case and maltreatment factors. Journal for Services to Children and Families. Edmonton, AB.

Matheson, Jane (2014). The research department at Wood's Homes: The little engine that could. Evidence to Practice – *Wood's Homes Journal. Vol. 1* (1), Fall 2014, pp 2-4.

Matheson, Jane (2014). Cat's Cradle: Managing and (maybe even) enhancing the complexities and diversity of groups in human service organizations. In Pelech, W., Ring, K., & LaRocque. *Unity in Diversity: Embracing the Spirit of Group Work*. Whiting & Birch: London. In Press.

McElheran, N., Stewart, J., Soenen, D., Newman, J., & MacLaurin B. (2014). Walk-in single session therapy at the Eastside Family Centre. In Michael F. Hoyt and Moshe Talman (Ed.), *Capturing the moment: single session therapy and walk-in services*. UK: Crown House Publishing.

PRESENTATIONS

Barham, J. & McAllister, A. (2014 October). The Phoenix Program: A Canadian Perspective on Residential Treatment of Adolescents with Sexually Abusive Behaviours. *ATSA Conference*, San Diego, CA.

Bergen, H., Fournier, B., Gardiner, S., & MacLaurin, B. (2014 October). Innovations in Outcome-Based Service Delivery (OBSD) in Alberta. *Prairie Child Welfare Consortium*, Regina, SK.

Eagletale, H., Coleman, R. (2014 June). Beyond beads and feathers: understanding the profound impact of historical trauma and its effect on aboriginal identity, mental health, family and community. *Wood's Homes 100 Year Speaker Series*. Calgary, AB, Canada.

Johansson, B.; & Rhodes, K. (2014 May). The Long and Winding Road Leading to Residential Treatment. *AASCF Group Care Research Symposium*, Red Deer, AB.

Matheson, Jane (2014). Cat's Cradle: Managing and (maybe even) enhancing the complexities and diversity of groups in human service organizations. *Annual Symposium of the International Association for Social Work with Groups*. Calgary, AB.

MacLaurin, B., Fournier, B. and Gardiner, S. (2014) Context and Evidence for Service Innovation: Outcomes Based Service Delivery. *Child Intervention Research Forum*. Edmonton, Alberta, Canada.

McElheran, N., Stewart, J., Soenen, D., Newman, J., & MacLaurin B. (2014). Walk-in single session therapy at the Eastside Family Centre. In Michael F. Hoyt and Moshe Talman (Ed.), *Capturing the moment: single session therapy and walk-in services*. UK: Crown House Publishing.

Reeve, E., McPhee, D., & Kopeck, C. (2014 September). Who you gunna call???: The 411 on schools, hospitals and helpers. *Wood's Homes 100 Year Speaker Series*. Calgary, AB, Canada.

Ward, S., & Hick, A. (2014 June). Eaglemoon Lodge: outcomes used to measure functioning and resiliency in indigenous youth with complex histories of abuse. *American Professional Society on the Abuse of Children*. New Orleans, LA.

2013

PUBLICATIONS

Fallon, B., MacLaurin, B., Trocmé, N., & Vine, C. (2013), Children Abused, Neglected and Living With Violence; An Overview, in Allagia, R., Vine, C., (Eds), Cruel but not Unusual Punishment, 2nd Edition, Waterloo: Wilfred Laurier Press

Gardiner, S., MacLaurin, B., & Reeves, J. (in press) Outcome-Based Service Delivery (OBSD): Trends, Initial Results and Implications. Dorothy Badry, Don Fuchs, Monty Montgomery, Sharon McKay (Eds.), Reinvesting in Families: Securing a Brighter Future, Prairie Child Welfare Research Consortium

Kontrimas, M., Navia, D., & Newman, J. (2013), Understanding Running Away Through the Lived Experience of Youth in Care. Journal for the Services to Children and Families Vol. 6, p.8-16.

MacLaurin, B., McElheran, N., Newman, J., Stewart, J., & Soenen, D. (in press), Walk-in Counselling at The Eastside Family Centre, in Michael Hoyt & Moshe Talmon (Eds.) Capturing the Moment: SST and Walk-In Services, Bethel, CT: Crown House Publishing Company LLC

MacLaurin, B., & Worthington, C. (2013), Promoting Health for Homeless and Street-Involved Youth: Use and Views of Services of Street-Involved Youth in Calgary, in Gaetz, S., (Ed.), Youth Homelessness in Canada: A Reader, Toronto: Canadian Homelessness Research Network

PRESENTATIONS

Afflick, K., & Stewart, J. (2013, February) Self-Harm by Adolescents. *Presentation offered by the Alberta Youth Justice Committee in High River, AB to the community of High River*.

Afflick, K., Jeske, V., Lai, S. & Willford, A. (2013, January). All About Crisis: Theory and Practice at Wood's Homes. *The Alberta Association of Services for Children and Families: Annual Learning Symposium*, Edmonton, AB.

Asels, J., & Westelmajer, C. (2013, April). Journey to the summit: 25 years of trials and tribulations. Presented at the Massachusetts Adolescent Sex Offender Coalition (MASOC), Boston, MA.Bobele, M, Hackney, L.

Britton, C., & Padilla, P. (2013, June). Next Steps: Outcomes in Transition. Wood's Homes Research Symposium. Calgary AB

Brodziak, J., Gardiner, S., McCord, C. MacLaurin, B., & Reeves, J., (2013), Outcome-Based Service Delivery: Trends, Implications and Results, Alberta College of Social Work Annual Conference, Calgary, AB, 2013 March

de Vries, T., & Stewart, J. (2013, January). Depression and Anxiety: For You and Your Loved Ones. *Presentation offered by the Pastoral Care Committee at the Wild Rose United Church*, Calgary, Alberta.

Enns, R., Feehan, R., & MacLaurin, B. (2013), Service Outcomes for Children Investigated for Maltreatment in Alberta, Alberta College of Social Work Annual Conference, Calgary, AB, 2013 March

de Vries, T., & Stewart, J. (2013, January). Depression and Anxiety: For You and Your Loved Ones. Presentation offered by the Pastoral Care Committee at the Wild Rose United Church, Calgary, Alberta.

Enns, R., Feehan, R., & MacLaurin, B. (2013), Service Outcomes for Children Investigated for Maltreatment in Alberta, Alberta College of Social Work Annual Conference, Calgary, AB, 2013 March

Gardiner, S.; McCord; C.; Morkin, T.; and Richards, A. (2013, January) Making New Ground: Discovery, Joining and Implementation of Collaborative Practice. Presented at the Alberta Association of Services for Children and Families, Edmonton, Alberta

Gardiner, S., Koester, L., MacLaurin, B., & Ogundimu, S., (2013),From Research to Practice, Wood's Homes 3rd Annual Research Symposium - Outcome Measures: Measuring Success and Challenges, Calgary, AB, 2013 June

Johansson, B., Kontrimas, M., Navia, D., Newman, J., & MacLaurin, B., (2013), Shifting Towards a Research Oriented Approach in Clinical Settings, Alberta College of Social Work Annual Conference, Calgary, 2013 March

Johansson, B., Kontrimas, M., Navia, D., Newman, J. & MacLaurin, B., (2013), Understanding Running Away Through the Lived Experience of Youth in Care, Alberta Association of Services for Children and Families: Annual Learning Symposium, Edmonton, AB, 2013 January

MacLaurin, B. & Worthington, C., (2013), Characteristics of Street-Involved Youth with Previous or Current Child Welfare Involvement, Wood's Homes 3rd Annual Research Symposium - Outcome Measures: Measuring Success and Challenges, Calgary, AB, 2013 June

Kontrimas, M., & Starchuk, A. (2013) Evaluating Treatment and Program Outcomes using CAFAS: the Exceptional Needs Program, Wood's Homes 3rd Annual Research Symposium – Outcome Measures: Measuring Success and Challenges, Calgary, AB, 2013 June

MacEcheran, C., & Weeks, K. (2013) Stigma and Mental Health Survey Results: A Wood's Homes Perspective, Wood's Homes 3rd Annual Research Symposium. Calgary, AB, 2013 June

McElheran, N., Oakander, M., Park, H., : (March, 2013): Walk-in follow up Round Table. Presented at the Inaugral International Symposium on Single Session and Walk-in Services, Phillip Island, Victoria, Australia

Mangubat, L., & Ward, S. (2013, January). A strategy of transition from residential care to community based care for aboriginal children: Aftercare begins at admission. *Mental health disorders: Challenges with youth, aboriginal communities & the criminal justice system*. Presented at the AASCF Conference, Edmonton, AB.

Matheson, J. (2013, February). Successes and challenges with engaging the community in a research mandate. *Alberta Centre for Child, Family and Community Research, Research Symposium*, Edmonton AB.

Matheson, J. (2013, June). Turning a big ship around is harder than one thinks: Ten years of restraints. *Wood's Homes Research Symposium*. Calgary AB

McDonald, M.; McMechan, L. (2013, June) Roofs for Youth: A partnership program addressing the issue of youth cycling between homelessness and involvement with the criminal justice system. Presented at the Homeless Hub, Markham, Ontario

Navia, D., (2013), Understanding Running Away Through the Lived Experience of Youth in Care, *Wood's Homes 3rd Annual Research Symposium - Outcome Measures: Measuring Success and Challenges*, Calgary, AB, 2013 June

Newman, J., & Stewart, J. (2013, June). Evolution of Outcome Tracking at Eastside Family Centre, Wood's Homes 3rd Annual Research Symposium – Outside Measures: Measuring Success and Challenges, Calgary AB.

Oakander, M. & Park, H. (March 2013): Eastside and Beyond: Community Connections and Networks. Presented at the Inaugral International Symposium on Single Session and Walk-in Services, Phillip Island, Victoria, Australia

Oakander, M., & Park, H. (November 2013): Finding strengths: the use of solutons focused therapy. Presented at Foothills Hospital to medical residents.

Stewart, J. (2013, October). The Anxious Teen: Parents as experts, professionals as consultants gathering information, strategies, and tools. Presented as part of *Understanding Issues Teens Face Today: Free Education Sessions for Parents/Caregivers and those who work with teens.* A partnership between the Shawnessy Library and South Calgary Health Centre.

Thompson, D. & MacLaurin, B., (2013), National Outcome Matrix of Child Welfare Outcomes, Council for Quality Assurance, Calgary, AB, 2013 April

Walsh, B. (2013, May). Key components of creating "great places to work". Presentation and panel guest. Pathways to Business Health Symposium, Calgary, AB

Ward, S., & Mangubat, L. (2012, January). "Healing the Spirit that Weeps" Intensive Treatment for First Nations youth dealing with the complexities of addiction and at-risk behaviors. *Mental health disorders: Challenges with youth, aboriginal communities & the criminal justice system*. Presented at the AASCF Conference, Edmonton AB.

TEACHING

Matheson, J., Lawson A., Johansson, B., McElheran N., Neuls D., & Westelmajer C., Park, H., (2013) Children's Mental Health SOWK 555. Half course in Undergraduate Program, Faculty of Social Work, University of Calgary, AB.

Matheson, J., (2013) Clinical Supervision, Half course in Distance MSW Leadership Program, Faculty of Social Work, University of Calgary, AB.

Matheson, J., (2013). Practice Skills in Leading and Supervising in Human Service Organizations SOWK 679. Half course in Distance MSW Leadership Program, Faculty of Social Work, University of Calgary, AB.

Matheson, J., (2013). Maximizing Staff Supervision SOWK 679. Half course in Distance MSW Leadership Program, Faculty of Social Work, University of Calgary, AB.

2012

PUBLICATIONS

Johansson, B., MacLaurin, B., Matheson, J., & Navia, D., (2012), Measuring Outcomes for Child and Family Mental Health Services: Development of the Wood's Homes Outcome Measurement (WHOM) Canada's Children, Vol. 18 (3), pp. 29

MacLaurin, B., O'Brien, D. & Miklos, T., (2012), Using Evidence to Inform Practice, Journal for Services to Children and Families, Learning Our Way Special Edition #1, p. 53-58

MacLaurin, B. & Worthington, (2012), Street Involved Youth in Canada, in Winterdyk, J., & Smandych, R., (Eds), Youth at Risk and Youth Justice: A Canadian Overview, Don Mills: Oxford University Press

Matheson, J. (2012) The Power and Potential of Social Work Supervision. Alberta Association of Services for Children and Families Learning Our Way Journal, Volume 1, p39-52.

Rogan, D. & MacLaurin, B., (2012), Getting Our Message Across, Journal for Services to Children and Families, Vol. 5, p. 18-22

PRESENTATIONS

Caneus, C., McDonald, J., Basi, T. & MacLaurin, B., (2012), Wood's Homes- The Catalyst Program Serving Youth with Complex Mental Health Needs, Wood's Homes 2nd Annual Research Symposium, Calgary, 2012 June

Gardiner, S., Reeves, J. & MacLaurin, B., (2012), Outcome Based Service Delivery: Trends, Implications and Results, Reinvesting in Families: Securing a Brighter Future: Prairie Child Welfare League Consortium, Edmonton, 2012 May

Gardiner, G., Reeves, J. & MacLaurin, B., (2012), Outcome-based Service Delivery: Trends, Implications and Results, Wood's Homes 2nd Annual Research Symposium, Calgary, 2012 June

Gardiner, S., Reeves, J. & MacLaurin, B., (2012), Outcome-based Service Delivery: Trends, Implications and Results, Strengthening Today - Building Tomorrow - 3rd Annual AASCF Conference, Edmonton, 2012 January

Johansson, B., Jones, A., Sjoblom, E. & Navia, D., (2012), What Does Research and Practice Say About Mental Health Treatment and Services for Children? Strengthening Today - Building Tomorrow - 3rd Annual AASCF Conference, Edmonton, 2012 January

Johansson, B., Navia, D. & Sjoblom, E., (2012), Evaluating Client and Program and Client Outcomes Using the Child and Adolescent Functional Assessment Scale: The Exceptional Needs Program, Prairie Child Welfare Consortium, Edmonton, 2012 May

Kopeck, C., Bergh, H. & Starchuk, A. (2012). Practicing an Inclusive Biopsychosocial Framework within Residential Treatment. Providing a framework for adolescent residential treatment focusing on balancing interventions in the following areas: biological/puberty; psychological/cognitive and social redefinition. Seminar presented at the 4th annual Strengthening Today, Building Tomorrow Conference hosted by the Alberta Association for Children and Families, Edmonton.

Kopeck, C. & Starchuk, A. (2012). Practicing an Inclusive Biopsychosocial Framework within Residential Treatment. Providing a framework for adolescent residential treatment with a focus on Family Centered Care. Seminar presented at the National Child and Youth Care Conference, Canmore.

MacLaurin, B., (2012), A Call to Action for Vulnerable Youth: Key Note Address, United Way - Pushing the Limits Conference, Calgary, 2012 October

MacLaurin, B., (2012), *Taking Up the Challenge of Advocacy*, Government of Alberta - Children's Advocate Symposium, Calgary, 2012 February

Mangubat, L., & Foreman, J. (2012, March). A strategy of transition from residential care to community based care for aboriginal children: Aftercare begins at admission. *Mental health disorders: Challenges with youth, aboriginal communities & the criminal justice system*. Presented at the National Mental Health Conference, Winnipeg, MB.

Navia, D. & Viens, J. (2012), Evaluating Client and Program and Client Outcomes Using the Child and Adolescent Functional Assessment Scale: The Exceptional Needs Program Wood's Homes 2nd Annual Research Symposium, Calgary, 2012 June

Penner, C. (2012, May). *The Catalyst Program: Serving youth with complex mental health needs*. Poster board presented at the 3rd National Symposium on Child and Youth Mental Health, Calgary, AB.

Walsh, B. (2012, October). Key components of creating "great places to work". Presentation and panel guest. Pathways to Business Health Symposium, Edmonton, AB

Weeks, K., Raivio, E. & MacLaurin, B., (2012), The Exceptional Needs and Stabilization Programs: Partnerships with Wood's Homes and Alberta Health Services (CAAMHP), Child Welfare League of Canada , Calgary, AB, 2012 October

Worthington, C. & MacLaurin, B., (2012), The Calgary Youth, Health and the Street Study: A CBR Case Study, University of Victoria Social Dimensions of Health Colloquium, Victoria, 2012 February

TEACHING

Matheson, J., (2012). *Maximizing Staff Supervision* SOWK 679. Half course in Distance MSW Leadership Program, Faculty of Social Work, University of Calgary, AB.

Matheson, J., (2012). Practice Skills in Leading and Supervising in Human Service Organizations SOWK 679. Half course in Distance MSW Leadership Program, Faculty of Social Work, University of Calgary, AB.

Matheson J., Johansson B., McElheran N., Westelmajer C., Neuls D., Lawson A. Park H. (2012) Children's Mental Health SOWK 555. Half course in Undergraduate Program, Faculty of Social Work, University of Calgary, AB.

2011

PUBLICATIONS

Lawson, A., Gardiner, S., Johansson, B., & MacLaurin, B., (2011), Wood's Homes - University of Calgary Faculty of Social Work Innovative Partnership, in Leveille, S.,Trocmé, N., Brown, I. & Chamberlain, C., (Eds)., Research Community Partnerships in Child Welfare, Montreal: Centres of Excellence in Child Welfare

Gardiner, S., & Hachkowski, A. (2011). Outcome Based Service Delivery: Launching, Learning and Looking Forward. Journal for Services to Children and Families, 4, 16-21.

MacLaurin, B., Budgell, D., (2011), Differences Between Runaway and non-Runaway Youth Investigated for Maltreatment in Canada, Journal for Services to Children and Families, Vol. 4 (1), p. 4-10

PRESENTATIONS

MacLaurin, B., Worthington, C., Tutty, L., et al., (2011), Predictors of Homelessness: The Hart Tool, Vancouver Homeless Community Forum, Vancouver, 2011 November

MacLaurin, B. & Worthington, C., (2011), Calgary Youth, Health and the Street Study, Government of Alberta, Calgary, 2011 September

Matheson, J. & Johansson, B., (2011) Quality Control Data: A Ten Year Report, *Wood's Homes Research Symposium*. Calgary AB.

Miklos, T., O'Brien, D. & MacLaurin, B., (2011), Using Evidence to Inform Practice, Learning Our Way: Alberta Association of Services to Children and Families, Edmonton, AB, 2011 November

Park, H. (October, 2011) Loss as part of life: Presentation to genetics residents at Foothills Hospital.

Park, H. (October, 2011): Walk-in Therapy: Presented to Tele-health, Calgary Health Services.

Park, H. (March, 2011): Trial and Error by Design: Presented at the Winds of Change conference in Toronto, Ontario.

TEACHING

Matheson, J., (2011). *Maximizing Staff Supervision* SOWK 679. Half course in Distance MSW Leadership Program, Faculty of Social Work, University of Calgary, AB.

Matheson, J., (2011). Practice Skills in Leading and Supervising in Human Service Organizations SOWK 679. Half course in Distance MSW Leadership Program, Faculty of Social Work, University of Calgary, AB.

Matheson J., Johansson B., McElheran N., Westelmajer C., Neuls D., Lawson A. (2011) Children's Mental Health SOWK 555. Half course in Undergraduate Program, Faculty of Social Work, University of Calgary, AB.

2010

TEACHING

Matheson, J., (2010). *Maximizing Staff Supervision* SOWK 679. Half course in Distance MSW Leadership Program, Faculty of Social Work, University of Calgary, AB.

Matheson, J., (2010). Practice Skills in Leading and Supervising in Human Service Organizations SOWK 679. Half course in Distance MSW Leadership Program, Faculty of Social Work, University of Calgary, Calgary, AB.

Matheson J., Johansson B., McElheran N., Westelmajer C., Neuls D., Lawson A. (2010) Children's Mental Health SOWK 555. Half course in Undergraduate Program, Faculty of Social Work, University of Calgary, AB.

2009

PUBLICATIONS

Matheson, J. (2009), Making Sense of Partnerships in the Nonprofit Sector: Do we really know what we are doing? Lessons Learned. Journal for Services to Children and Families. (October, 2009) (pp.9-17).

PRESENTATIONS

Matheson, J. (2009), *The voice on the skin – Managing self-multilative behaviours in residential programs*.

McDonald, M., and Elliott, A.,Dr. (2009 February) Growing Home National Conference: Results of medical services provided to at risk adolescents in a downtown drop in storefront service known as Exit Community Outreach a program of Wood's Homes. Results presented at the University Of Calgary Faculty Of Social Work.

2008

PUBLICATIONS

Harper-Jaques, S.; McElheran, N.; Slive, A.; Leahey, M. (2008). A Comparison of Two Approaches to the Delivery of Walk-in Single Session Mental Health Therapy. Journal of Systemic Therapies. (Winter 2008) (pp. 40-53).

Slive, A.; McElheran, N.; Lawson, A. (2008). How Brief Does It Get? Journal of Systemic Therapies (Winter 2008) (pp. 5-22).

Charles, G., Matheson, J. (2008), The use of involved neutrality with self mutilative behaviour among young people in residential settings. Residential Treatment for Children and Youth Vol. 24 (4) (pp. 299-313)

PRESENTATIONS

Capitol Hill Staff. (2008) *High Fidelity Discovery Writing* to Wood's Clinical Group, Calgary, AB, 21 April 2008.

Capital Hill Staff. (2008) *Capitol Hill Program*, Our Lady of Lourdes, Calgary, AB, 27 February 2008.

Capitol Hill presented (2008) with CRT to High Fidelity Meeting at Hull, 18 November 2008.

Capitol Hill Staff. (2008) Booth at the High Fidelity Fare at Mount Pleasant Community Centre, Calgary, AB, 19 June 2008.

Capitol Hill Program was presented to the Flex House, 31 March 2008.

Capitol Hill staff, (2008) presented their program to Enviros, 8 July 2008.

Caneus, C.; Casey, A. (2008) (frontline staff) Staff Training, This was part of the aftercare plan for a youth who left Phoenix and was discharged to Crossroads, Crossroads Group Home in Edmonton, AB, 29 December 2008.

CRT Staff. (2008) Calgary Health Region Rural South, Parent Support Association and Wraparound Services, Calgary, AB, 2008.

CRT Staff. (2008). Training Sessions, Victim's Assistance and the Distress Centre, Calgary, AB, 2008.

CRT Staff. (2008) Resource fairs at Jack James, Sir John A Mac Donald, Radisson Park, Mt. Royal College and Sunridge Mall, Calgary, AB, 2008.

Oakander, M., Park, H. *Eastside Family Centre: Origins and Current Practice* (2008) presented to Peter Lougheed Short Stay, Brief Counselling and Transitions Group Teams, Calgary, AB, 6 May 2008.

Eastside Staff. (2008) Eastside Family Centre Walk-In program, PLC group with Manager of PLC Emergency and the Manager of the Sunridge Gallery, September 2008.

Hackney, L. (2008) A Tour of Eastside Family Centre for three Simon Fraser Junior High School Teachers, Calgary, AB, May 2008.

Hackney, L. (2008) *Eastside Family Centre Walk-In Services*, NE/SE Community Resource Centres: Heart of the NE, North of McKnight/Macho and Downtown, Calgary, AB, May 2008.

Matheson, J. (2008) *The voice on the skin – Managing self-multilative behaviours in residential programs*, December 2008.

Matheson J. (2008) *Keeping Ahead of the Game - One Organization Tackles the Transition to Adulthood*, IFCW World Forum, Early Intervention and Prevention - Children in Wales, Cardiff, Wales, October 2008.

Neuls, D. (2008) Phone presentation on *Eagle Moon Lodge* to NT Health and Social Services Lawyer and legal representative for Eagle Moon Lodge youth, 4 September 2008.

Neuls, D. (2008) Presentation to Trail Cross and Wood's to Elders in Fort Smith, Fort Smith, AB, 15 July 2008.

Neuls, D. (2008)Presentation to University of Calgary Practicum Advisor on Eagle Moon Lodge, 28 August 2008.

Neuls, D. (2008) Presentation on Eagle Moon Lodge and substance abuse treatment to Tsu Tina staff starting new solvent program, Calgary, AB, 12 June 2008.

Neuls, D., (2008) *Eagle Moon Lodge Presentation*, Community Conferencing Session at CYOC, 10 April 2008.
Presentation of Evergreen Framework to Calgary Child and Family Services, Calgary, AB April 2008.

McElheran, N., & Park, H. (2008) *Eastside Family Centre Walk-In Model,* to mental health therapists from the David Thompson Health Region, Calgary, AB, 2008.

Reimer, C. (2008) Training Session to new staff at the Phoenix program, weekly, for approximately 3 months in 2008.

Reimer, C. (2008) Presented at 5-trainings of Residential 101 and also led 5 CAFAS trainings, 2008.

Reimer, C. (2008) *The Goals of Misbehaviour*, Wood's Homes Foster Parents, Calgary, AB, 24 May 2008.

Reimer, C. & Winfield, T. Training to a new wrap-around program which was supporting a former Phoenix client, 28 April 2008.

Reimer, C., Winfield, T. (2008) *The Flight of the Phoenix*, ACSW Conference, Edmonton, AB. 13-15 March 2008.

Smith, B. (2008) presented at three parent council meetings, Calgary, September 2008.
Street Service Presentation (2008), IODE Provincial Conference – Banff Park Lodge, Banff, AB, 12 April 2008. Street Services Presentation (2008), National Conference on Youth Homelessness in Toronto, 20 November 2008. Street Services Presentation (2008) to Nova Chemicals, Calgary, 23 October 2008

Tetreault, J., McCormick, J., & Nielsen, P., (2008), *Transition to Home for Youth with Complex Mental Health Issues: A Partnership between a Community Agency and a Health Region*, 16th European Congress of Psychiatry, Nice France, 2008 April.

Tetreault, J., McCormick, J., Nielsen, P. and Cawthrope, D. (2008) *Transition to home for youth with complex mental health issues: A partnership between a community agency and a health region*. A poster presentation at the 16th European Congress of Psychiatry, Nice, France, 5-9 April 2008.

Winfield, T., & Reimer, C. (2008) *Treatment Issues Sexually Abusive Adolescents Face While in Treatment*, Hull Services, Calgary, AB, 6 October 2008.

Winfield, T. & Caneus, C. (2008) Trained staff at Elk Island Boys Ranch. This was part of the aftercare plan for a youth who left Phoenix and was discharged there, Edmonton, AB, 9 September 2008.

Winfield, T. (2008) *Training session on the Phoenix Program Clinical Model and on the Cycle of Abuse*, Phoenix Program, Calgary, AB, September – November 2008.

2007

PUBLICATIONS

Gardiner, S., McDonald, M., Cooke, S., & the Research Department of Wood's Homes (2007). *Children at risk of sexual exploitation: Facts and beliefs*. The Welfare of Canadian Children: The Child Welfare League of Canada (2007) (pp. 117-125).

Matheson, J. (2007). Canada's Children (Book review). *Winter's Children* by Germaine Dechant. For the Child Welfare League of Canada (2007).

PRESENTATIONS

Babin, A. (2007) *Street Services*, St. John's Ambulance and United Way, Calgary, AB, 21 March 2007.

CRT Staff. (2007) *CRT and the Eastside Family Centre*, PAA Annual Conference, Calgary, AB, May 2007.

Hackney, L. (2007) *Evergreen Program Model – Clinical Implications and Repair of Early Attachment Damage*, Oak Hill Boys Ranch, 23 March 2007.

Hackney, L. (2007) *Evergreen Program Model –Clinical Implications and repair of Early Attachment Damage*, Calgary Young Offender Centre, Calgary, AB, 7 May 2007.

Matheson, J. (2007)Two day workshop to Wood's Homes staff, Calgary, AB, October 2007.

Matheson, J. (2007) was a Facilitator at Symposium on Children's Mental Health – sponsored by CWLC in Toronto, ON, September 2007.

Matheson, J. (2007) Two 1-day workshops in the *Fundamentals of Supervision*, ACSW conference in Calgary, AB, March 2007.

McCormick, J., and Lawson, A. (2007) *The Calgary and Adolescent Functional Assessment Scale as a Performance Indicator of Outcomes for Youth in Residential Treatment*. A poster presentation at the 2007 Canadian Symposium of Child and Family Services Outcomes, Vancouver, B.C. , 5-6 February 2007.

McCormick, J. and Lawson, A. (2007) *The Child and Adolescent Functional Assessment Scale as a Performance Indicator of Outcomes for Youth in Residential Treatment*, 2007 Outcomes and Best Practices in Creating Social Change, Calgary, AB, 25-26 April 2007.

Neuls, D. (2007) *Eagle Moon Lodge Program*, Oak Hill Treatment Centre, Calgary, AB, 23 March 2007.

Neuls, D. (2007) *Eagle Moon Lodge Program*, Kasohkowew Child Wellness Society, Hobbema, AB, 16 November 2007.

Neuls, D. (2007) *Behavioural Theory and Interventions*, Eagle Moon Lodge staff, Calgary, AB, March 2007.

Neuls, D. (2007) Phone presentation *Eagle Moon Lodge*, to staff from Community Living BC, Calgary, AB, 13 July 2007.

McElheran, N., & Park, H. (2007) *Eastside Family Centre Walk-In Model*, David Thompson Health Region, Calgary, AB, Fall 2007.

Pupp, S. (2007) *Attachment Issues*, Wood's Homes Foster Parents, Calgary, AB November 2007.

Reimer, C. (2007) Training of staff at the Phoenix program weekly for approximately 4 months 2007, Calgary, AB, 2007.

Reimer, C. (2007) 1-hour training to new staff at the Phoenix program weekly for approximately 4 months, Calgary, AB, 2007.

Reimer, C. (2007) Presented at 5 trainings of Residential 101 and also led 5 CAFAS trainings, Calgary, AB, 2007-2008. Reimer, Candace. Presented at 5-trainings of Residential 101 and also led 5 CAFAS trainings, Fall 2007.

Reimer, C., & McCormick, J. (2007) *The Child and Adolescent Functional Assessment Scale as a Performance Indicator of Treatment Outcomes for Youth in Residential Treatment*, Outcomes & Best Practices In Creating Social Change Conference, Calgary, AB, October 2007.

Tetreault, J., & Nielsen, P., (2007). *A Partnership Evaluation: Evaluating Outcomes*, Banff Alberta, May 2007.

Tetreault, J., McCormick, J., Nielsen, P. and Cawthrope, D. (2007)*Transition to home for youth with complex mental health issues: A partnership between Calgary Health Region and Wood's Homes.* A poster presentation at Banff International Conferences on Behavioural Science, Banff, Alberta, 18/21 March 2007.

Westelmajer, C., & Hackney, L. (2007) *Behavioural Issues in Adolescence*, University of Calgary – Healthy Minds – Managing Children's Mental health Issues in Mental Health Care, Calgary, AB, February 2007.

Winfield, T. (2007) 2-hour training at Altadore to support a transition there for one of our youth, Calgary, AB, December 2007.

2006

PUBLICATIONS

Lawson, A., Gardiner, S., Johansson, B., & MacLaurin, B. (2006). Addressing the effects of child maltreatment through the lens of domestic violence: Wood's Homes Habitat Program. *Canada's Children, Spring 2006*, (pp. 68 – 71).

PRESENTATIONS

Castle, T. (2006). Presented at the Aboriginal Mental Health Conference outlining drug/alcohol treatment using the medicine wheel as the core of treatment.

Hackney, L. (2006). Assisted in organizing a citywide conference and was one of the presenters as well.

Hackney, L. (2006). *Challenges Faced in Program Model Design*, RBI at the CHARPP conference

Hackney, L. (2006). *Effects of Abuse and Trauma on Child Development*, three times at Wood's and once at a professional development day for four of the city's treatment schools, Calgary, AB, 2006.

Matheson, J. (2006) *The use of story and storytelling in therapeutic practice* – Nanaimo, BC

Matheson, J. (2006) *Storytelling; The voice on the skin: Managing self-mutilative behaviours in adolescents,* Wilma Hansen Professional Development Day (Keynote)

Matheson, J. (2006) *Fundamentals of Social Work Supervision*, 2-day Workshop in at ACSW Conference

2005

PUBLICATIONS

Gardiner, S. & McDonald, M. (2005). Lessons Learned from the Protection of Children Involved in Prostitution. Canada's Children, Fall 2005, (pp.37 – 41).

Hackney, L. & MacMillan, K. (2005). Relational-based Interventions: Creating change through connection. Canada's Children, Fall 2005, (pp.8 – 11).

Hackney, L. (2005). Promoting Resilient Development in Children Receiving Care. Canada's Children, 11(3).

Matheson, J., Este, D., Rogers, G., Lawson, A. and Tynchryshyn, D. (2005) Making Sense of Partnerships in Nonprofit Child and Family Service Organizations in Calgary, AB University of Calgary, AB

PRESENTATIONS

Hackney, L. (2005). Relationship Based Interventions, Phoenix Program, Calgary, AB, 2005.

Hackney, L. (2005). Mental Health Diagnosis

Westelmajer, C. & Hackney, L. (2005). The Effects of Abuse and Maltreatment

2004

PRESENTATIONS

Bartel, W., & Hackney, L. (2004). *Clinical Diagnosis*
Hackney, L. (2004). As part of the clinical group, assisted in organizing a citywide conference and was also a presenter, Calgary, AB, 4 June 2004.
Hackney, L. (2004). *Promoting Resilient Development in Children Receiving Care*, CWLC conference, 16-17 August 2004.
Matheson, J. (2004.) *How are we doing?*, Making Connections, Alberta Teachers Association
Matheson, J. (2004) *Proposal Writing*, Senior Management Team at Wood's Homes, Calgary, AB, 2004.
Zaura, T., & Hackney, L. (2004) *How to Talk with Parents*

2003

PUBLICATIONS

MacMillan, K.M., & Harpur, L.L. (2003). An examination of children exposed to marital violence accessing a treatment intervention. *Journal of Emotional Abuse*, 3(1/2).
Wittig, P.G., Tilton-Weaver, L., Patry, B.N., & Mateer, C.A. (2003). Variables related to job satisfaction among professional care providers working in brain injury rehabilitation. *Disability and Rehabilitation*, 25(2),(pp.97-106).

PRESENTATIONS

Egers, J. and Matheson, J. (2003) *Learning to Become the world we want: work – based learning in civil society*, Tampere, Finland, 2003.
Matheson, J. and Rogers, G. (2003) *Partnerships in Nonprofit Children's Services: Panacea or Pitfall, ARNOVA*, Denver, CO, 2003.
Matheson, J. (2003) *Proposal Writing*, Senior Management Team at Wood's Homes, Calgary, AB, 2003.
Rogers, G., and Matheson, J. (2003) *Researching Partnerships in Children's Services: Choices and Challenges in using a case study approach, ARNOVA*, Denver, CO, 2003.
Matheson, J., and Egers J. (2003), Tell me a story: The Power of Story and Storytelling to teach leadership and develop a strong organizational culture, Tampere, Finland, 2003.
Matheson, J., (2003) *Poster: Voices and Hands*, Qualitative Research Institute, Banff, AB, 2003.

2002

PUBLICATIONS

Hammond, W.A. (2000) Solvent abuse: A perplexing challenge. *Canada's Children*, Summer, (pp.26-27).
Matheson, J. (2002) Aboriginal boys and substance abuse. *www.woodshomes.com*
Matheson, J. (2002) Children's Mental Health In Alberta. *Canada's Children* (in press) and in-press proceedings
Matheson, J; Este, D; Rogers, G; and Kyle, I. (2002) *Partnerships in Children's Services in Alberta: Nonprofits Seeking Clarity*. Proceedings from 9th Annual Conference on Multi-Organizational Partnerships and Cooperative Strategies

PRESENTATIONS

Matheson, J., and Este, D. (2002) *Partnerships in Children's Services in Alberta: Nonprofits Seeking Clarity*, 9th Annual Conference on Multi-Organizational Partnerships and Cooperative Strategies, 2002.
Matheson, J. (2002) *The State of Children's Mental Health across Canada*, Children's Mental Health Ontario Conference – Opening Plenary Panel, 2002.

2001

PUBLICATIONS

MacMillan, K. (2001). Review of the book: Strategies for counseling with children and their parents. *Canadian Journal of Counselling*, 35(2), (pp.190-191).

Slive, A., McElheran, N., & Lawson, A. (2001). Family therapy in walk-in mental health centres: The Eastside Family Centre. In MacFarlane, M.M. (Ed). *Family therapy and mental health: Innovations in theory and practice* (pp. 261-285). Binghamton, New York: Haworth Clinical Practice Press.

PRESENTATIONS

Matheson, J. (2001) *Self Mutilation in Adolescents*, Cochrane Family Resource Center, Cochrane, AB, 2001.
Matheson, J. (2001) *Qualitative Research and Art/Craft Forms*, Qualitative Research Class, City University. 2001.
Matheson, J. (2001) *Supervision and Leadership Training*, Team Leaders, Wood's Homes, Calgary, AB, 2001.
Matheson, J. (2001) *Making Sense of Partnerships*, Alberta College of Social Workers Annual Conference, Calgary, AB, 2001.
Matheson, J. (2001) *Metaform*, Alberta College of Social Workers Annual Conference, Calgary, AB, 2001
Matheson, J. (2001) *With a Little Help From Our Friends*, Alberta College of Social Workers Annual Conference, Calgary, AB, 2001
Matheson, J. (2001) *Social work supervision, Women's process*, Mount Royal College Counseling Department, Calgary, AB, 2001.

2000

PUBLICATIONS

Hammond, W.A. (In Press) Treatment revisited for Native adolescent solvent abusers. Accepted as a chapter in a book being published resulting from the National Research, Policy and Practice Symposium – Child Welfare 2000. *Journal of Child and Youth Care*. December.

McDonald, M., & Matheson, J. (2000). Punishment or protection: Looking both ways at bill one. *Canada's Children*, 17(1), 31 – 33. Child Welfare League of Canada.

Miller, J. K., Protinsky, H., & Slive, A. (2000). *Investigating new clinical delivery systems: walk-in single session therapy and client satisfaction*. Submitted for publication.

Soenen, D. (2000). *Re-energizing the diversity process at Wood's Homes*. Applied research for M.BA. Unpublished manuscript.

Zelt, B. (2000). *Day Treatment Services Pilot Outcome Study for Wood's Homes*. Unpublished manuscript.

PRESENTATIONS

Matheson, J. (2000) *Making Sense of Partnerships in the Non-Profit Sector: Do We Really Know What We Are Doing?*, National Healthcare Leadership Conference, Ottawa, ON, 2000.

1999

PUBLICATIONS

Hammond, W.A. (1999). *Canadian adolescent solvent abuse and attachment theory*. Unpublished doctoral dissertation, University of Calgary, AB, 1999.

Lawson, A., McElheran, N., Slive, A. (1999). *Single session walk-in therapy: A model for the twenty-first century*.

Matheson, J. (1999). *Social work supervision: women's process*

Wittig, P. G. (1999). *Variables Related to Job Satisfaction in the Field of Brain Injury Rehabilitation*. Unpublished Masters Thesis, Royal Roads University, Victoria, BC.

PRESENTATIONS

Matheson, J. (1999) *Leadership, Supervision and Social Work*, Calgary, AB, 1999.
Matheson, J. (1999) *Voices and Hands*, A presentation on social work supervision research to field instructors, Calgary, AB, 1999.
Matheson, J. (1999) *Strategic Planning and Leadership*, Integrative Field Seminar Class, University of Calgary Faculty of Social Work, Calgary, AB, 1999.
Matheson, J. (1999) *Self Mutilative Behavior in Adolescents*, Certificate Training Program, Eastside Family Center, Calgary, AB, 1999.

1998

PUBLICATIONS

Barker, C., & Bodor, R. (1998). *Reflecting accountability: Group work with male and female perpetrators of family violence.* Unpublished.

PRESENTATIONS

Matheson, J. (1998) Leadership video production with White Iron Productions, Calgary, AB, 1998.
Matheson, J. (1998) Leadership training for Managers, Wood's Homes, Calgary, AB, 1998.

1997

PUBLICATIONS

Angus, S., Sugars, J., Boltezar, R., Koskewich, S., & Schneider, N. (1997). A controlled trial of adantadine hydrochloride and neuroleptics in the treatment of Tardive Dyskinesia. *Journal of Clinical Psychopharmacology*, 17(2), (pp.88-91).
Lawson, A., McElheran, N., & Slive, A. (1997). Single session walk-in therapy model for the 21st century. *Family Therapy News*. 30(4), (pp.15-25).
McElheran, N., & Blasetti, L. (1997). *Community advisory councils*. Presented to the National Insight Conference, March. Unpublished.

PRESENTATIONS

Matheson, J. (1997) Leadership training for Managers, Wood's Homes – Calgary, Alberta.
Matheson, J. (1997) *Supervision and Social Work*, social work field instructors at the University of Calgary, Faculty of Social Work, Edmonton, AB, 1997.
Matheson, J. (1997) *Supervision and Social Work*, presented to social work field instructors Grant MacEwan College, Edmonton, AB, 1997.
Matheson, J. and MacDonald, M. (1997) *The Myths of Community Partnerships*, Chair of Child Protection Symposium, St. John's, Nfld, 1997.
Matheson, J. (1997) *Women's Ways of Working*, Canadian Association of Schools of Social Work, 1997 Learned Conference, St. John's, Nfld, 1997.
Matheson, J. (1997) *Supervision*, Faculty of Social Work Field Instructors at the University of Calgary, Lethbridge Division, 1997.
Matheson, J. and Charles, G. (1997) *Guidelines and Games: The Supervisory Playing Field* Social Work Field Instructors, Calgary, AB.

1996

PRESENTATIONS

Matheson, J. and Rodway, P. (1996) *New Wine in Old Bottles: Education and Practice Theory Principles*, Social Work Field Instructors, Calgary, AB, 1996.

1995

PUBLICATIONS

Charles, G., Dale, K., & Collins, J. (1995). The Phoenix Program: Difficult to serve adolescent sexual offender project final report. Submitted to: Family Violence Prevention Division Health Canada. Centre for the Study of Sexual and Community Violence, Wood's Homes, Calgary, AB, 1995.

Gardiner, M. S. (1995). Intervention with children who witness violence: Clinical implications for shelter based and community programs. *Directions on Child and Adolescent Therapy*, 2(2), 2-9, 1995.

Gardiner, M. S., & McGrath, F. (1995). Wife assault; A systemic approach that minimizes risk and maximizes responsibility. *Journal of Systemic Therapies*, 14, (pp.20-21), 1995.

Hammond, W.A. (1995). Cognitive factors contributing to adolescent depression. Journal of Youth and Adolescence, 24, (pp.667-683), 1995.

Slive, A., MacLaurin, B., Oakander, M., & Amundson, J. (1995). Walk-in single sessions: A new paradigm in clinical service delivery. *Journal of Systemic Therapies*.

Charles, G., & Innes, M. (1995) *Solvent abuse: Finding answers from within*. Aisokina Centre and the Centre for the Study of Sexual and Community Violence, Wood's Homes, Calgary, AB.

PRESENTATIONS

Matheson, J. (1995) *Self-Harming Behaviour,* Eastside Family Center's Single Session and Brief Therapy Certification Program, Calgary, AB, 1995.

Matheson, J. (1995) *The Parallel Journeys of Social Work and Feminism*, University of Calgary's Annual Gender Symposium, Calgary, AB, 1995.

1994

PUBLICATIONS

Malanych, S., Matheson, J., & Charles, G. (1994). Growing up with supervision. *Journal of Child and Youth Care*. December 1994.

McElheran, N., & Harper-Jaques, S. (1994). Commendations: A Resource intervention for clinical practice. *Clinical Nurse Specialist*, 8(1), (pp.7-11), 1994.

McIntyre, S. (1994). *The Youngest Profession, The Oldest Oppression*. Unpublished doctoral dissertation, Department of Law, University of Sheffield.

PRESENTATIONS

Matheson, J. (1994) *Caring in a Violent Society: Who Cares?*, Keynote Speaker: First Annual General Meeting of the Northern Network of Services, Whitehorse, Yukon, 1994.

Matheson, J. and Charles, G. (1994) *Managing Suicidal and Self-Mutilative Behaviour in Adolescents*, Whitehorse, Yukon, 1994.

1993

PUBLICATIONS

Charles, G., Coleman, H., & Matheson, J. (1993). Staff reactions to young people who have been sexually abused. *Residential Treatment for Children & Youth*, 11(2), (pp. 9-21).

Rempel, K., Hazelwood, G., & McElheran, N. (1993). Brief therapy group for mothers of troubled children. *Journal of Systemic Therapies,* 12(1), (pp.32-48).

1992

PUBLICATIONS

Charles, G., Gabor, P., & Matheson, J. (1992). An analysis of factors in the supervision of beginning child and youth care workers. *The Clinical Supervisor*, 10(1), (pp. 21-33).

Gardiner, M. S. (1992). Out of harm's way: Intervention with children in shelters. *Journal of Child and Youth Care*, 2, (pp.41-48).

Matheson, J. (1992). Working with adolescent girls in a residential treatment center. Special Issue: Feminist perspectives in child and youth care practice. *Journal of Child and Youth Care*, 7(2), (pp.31-39).

PRESENTATIONS

Matheson, J. (1992 – 1993) *Self-Mutilative Behaviour: Managing It and Understanding It in Residential Centers*, Mount Royal - Child and Youth Care, Calgary, AB, 1992.

Matheson, J. (1992) *The Rainbow Circle: Foster Parents and Biological Parents as Partners*, foster parents in Whitehorse – Yukon, 1992.

Matheson, J. and Charles, G. (1992) *Managing Self-Mutilative Behaviour, National Child Care Conference*, Victoria, BC, 1992.

Matheson, J. and Charles, G. (1992) Suicide and Self-Mutilation, Vancouver, B.C. (Invited speakers), 1994.

1991

PUBLICATIONS

Charles, G., & Matheson, J. (1991). Suicide prevention and intervention with young people in foster care in Canada. *Child Welfare*, 70(2), 185-191.

Charles, G., & Matheson, J. (1991). *Suicide prevention and intervention with children in car*e. Proceedings of the International Foster Care Education Conference, Ypsilanti, Michigan.

Charles, G., Gabor, P., Malanych, S., & Matheson, J. (1991). *Growing up in supervision: Teaching helping skills to developing professionals*. Proceedings of the Best in Care Conference, Ottawa, Ontario.

Gardiner, M. S. (1991). Putting an End to Family Violence. *Family Health, Winter 1992*, (pp.13-15).

Matheson, J., & Charles, G. (1991). *The contemporary orphan: Implications for the treatment of a permanent care population*. Proceedings of the Best in Care Conference, Ottawa, ON, 1991.

PRESENTATIONS

Matheson, J. (1991) *Crisis Intervention*, Calgary Women's Emergency Shelter and the Sheriff King Home staff, Calgary, AB, 1991.

Matheson, J. and Charles, G. (1991) *Supervision of Child and Youth Care Students*, Lethbridge, AB, 1991.

Matheson, J. (1991) *Supervision*, Calgary Women's Emergency Shelter, Calgary, AB, 1991.

Matheson, J. and Charles, G. (1991) *Supervision for Rehabilitation Practitioners*, Grant MacEwan Community College, Calgary, AB, 1991.

Matheson, J., and Charles, G. (1991) *Suicide and Self-Mutilation*, Boudreau and Jang Associates, Vancouver, BC, 1991.

1990

PUBLICATIONS

Charles, G., & Matheson, J. (1990). Children in foster care: Issues of separation and attachment. *Community Alternatives: International Journal of Family Care*, 2(2), (pp.37-49).

PRESENTATIONS

Matheson, J. and McIntyre, S. (1990) *Supervision Not Snoopervision*, Natures Youth Services, Winnipeg, MB, 1990.
Matheson, J. and Charles, G. (1990) Supervision of Child and Youth Care Staff in a Treatment Setting, Grant MacEwan Community College, Edmonton, AB, 1990.
Matheson, J. (1990) *Hemophilia - Women's Issues*, Canadian Hemophilia Society, Red Deer, AB, 1990.
Matheson, J. (1990) *Crisis Intervention*, Advent Lutheran Church Care Community, Calgary, AB, 1990.
Matheson, J. and Charles, G. (1990) *Self-Mutilation*, National Child Care Conference, Moncton, NB, 1990.
Matheson, J. (1990) *Separation and Attachment Issues for Caregivers*, Wood's Homes staff, Calgary, AB, 1990.
Matheson, J. and Charles, G. (1990) *Supervision Issues for Child Care Educators*, Western Canada Child Care Education, Lake Louise, AB, 1990.
Matheson, J. (1990) *Summer Stock*, Theatre project with troubled youth at the Provincial Canadian Mental Health Conference, Red Deer, AB, 1990
Matheson, J. and Charles, G. (1990) *The Contemporary Orphan*, Best of Care Conference, Ottawa, ON, 1990.
Matheson, J., Charles, G., Gabor, P. and Malanych, S (1990) *Supervision*, Best of Care Conference, Ottawa, ON, 1990.
Matheson, J. (1990) Child Welfare on Feasibility Study (6 months) Child Welfare Worker/Treatment Setting.

1989

PRESENTATIONS

Matheson, J. and Parry, E., Charles, G., and Wolfenson, S. (1989) *The Permanent Care Kid*, Wood's Homes Interagency Conference, Calgary, AB, 1989.
Matheson, J. and Charles, G. (1989) *Games People Play in Supervision*, Red Deer Child Care Conference, Red Deer, AB, 1989.
Matheson, J. (1989) Use of Neutrality in Intervention with Young People, Salvation Army Children's Village, Calgary, AB 1989.
Matheson, J. (1989) *Suicide Prevention and Intervention with Young People in Care*, 6th International Foster Care Education Conference, Ypsilanti, Michigan, 1989.
Matheson, J. (1989) *Issues of Separation and Loss*, British Columbia Child Care Workers Association Annual Conference, Harrison Hot Springs, BC, 1989.
Matheson, J. (1989) *Completing the Circle: Issues of Attachment*, Separation and Loss in Treatment Foster Care, 2nd North American Conference on Treatment and Foster Care, Calgary, AB, 1989.

1988

PRESENTATIONS

Matheson, J. and Charles, G. (1988) *The Treatment of Suicide and Self-Mutilative Behaviour in Young People*, 6th National Child and Youth Care Conference, Calgary, AB, 1988.
Matheson, J. and Lackstrom, J. (1988) *Adolescent Development Issues*, 6th National Child and Youth Care Conference, Calgary, AB, 1988.
Matheson, J., Martini, C., and Mickelson, B. (1988) *Summer Stock*, Arts Attack - a conference for artists - Calgary, AB, 1988.

1987

PRESENTATIONS

Matheson, J., and Slive Dr. A. (1987) *What is Community?*, Interagency Conference, Calgary, AB, 1987.
Matheson, J. and Charles, G. (1987) *Games People Play in Supervision*, Child and Youth Care Workers of Saskatchewan Annual Conference, Saskatoon, SK, 1987.
Matheson, J. and Charles, G. (1987) *Suicide Prevention with Young People*, McMahon Youth Services, Lethbridge, AB, 1987.
Matheson, J. and Charles, G. (1987) *Suicide Prevention and Intervention with Young People in Child Care Programs*, Child Care Workers Association of Alberta Annual Conference - Edmonton, AB, 1987.
Matheson, J. and Charles, G. (1987) *Suicidal and Para-Suicidal Behaviour in Children and Adolescents*, Alberta Association of Services for Children and Families, Calgary, AB, 1987.

1986

PUBLICATIONS

Perry, P.E., Charles, G.P., & Matheson, J. (1986). Separation and attachment: A shift in perspective. *Journal of Child Care*, 2(6), (pp.9-26).

PRESENTATIONS

Matheson, J. and Charles, G. (1986) *Completing the Circle: Issues of Separation and Attachment in Residential Care*, 5th National Child Care Workers Conference, Winnipeg, MB, 1986.
Matheson, J. and Charles, G. (1986) Accountability and Comprehensive Case Management, 5th National Child Care Workers Conference, Winnipeg, MB, 1986.
Matheson, J. (1986) *Completing the Circle: Separation and Attachment in Residential Settings*, Child Care Workers Association of Alberta, Annual Conference, Calgary, AB, 1986.

1985

PUBLICATIONS

Charles, G., & Matheson, J. (1985). *Separation and attachment in residential settings*. Proceedings of the Safety Net Conference. Calgary, Alberta.

PRESENTATIONS

Matheson, J. (1985) *Case Management*, Child Care Conference, Montreal, QC, 1985.
Matheson, J. and Charles, G. (1985) *Separation and Attachment in Residential Settings*, Safety Net 85 Conference, Calgary, AB, 1985.
Matheson, J. and Charles, G. (1985) Adolescence, Admission and Aftercare; Utilizing the Separation Process in Residential Child Care, with Gardiner, Child Care Workers Association of Alberta Annual Conference - Edmonton, AB, 1985.

UNKNOWN DATES

Hackney, Lee (). Alchemy for the soul. Family Tree

Hackney, Lee (). May I suggest chocolate? Family Tree

Hackney, Lee (). If you're happy and you know it. Family Tree

Hackney, Lee (). Regardless of what your children say. Family Tree

Hackney, Lee (). Why a little pot is not just a little pot anymore. Family Tree

Hackney, Lee (). How to hire a therapist. Family Tree

Hackney, Lee (). Is your child off key or are they playing the wrong tune. Family Tree

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WOOD'S HOMES
WORKING FOR CHILDREN'S MENTAL HEALTH
SINCE 1914

We never say no.
We never give up.
We never turn anyone away.