2017

Kenora Rainy River Youth Justice Service Collaborative

Trauma-Informed Agency Protocol

Version 2.0

Contents

Kenora Rainy River Youth Justice Service Collaborative

Trauma-Informed Agency Protocol

1.0 Overview

It is the protocol of agencies and community service providers involved with the Kenora Rainy River Youth Justice Service Collaborative that they are informed about the prevalence and effects of psychological trauma, signs and symptoms of trauma exposure response in their own workforce. Agencies and community service providers commit to put this knowledge into practice to avoid re-traumatizing those involved in the youth criminal justice system and promote pathways to resiliency and recovery. The protocol includes self-evaluation resources for agencies to gauge how trauma-informed they are and guides to further develop trauma-informed practice within their organizations.

1.1 Purpose

The purpose of the Trauma-Informed Agency Protocol is to:

- Promote the understanding that trauma experiences are common and are predictors of increased risk of physical and behavioural health issues, and that trauma can be triggered by a wide range of experiences; however, response to trauma is unique and individual for each person;
- Mitigate the effects of trauma exposure response in system workers;
- Improve awareness that the inter-generational, historical, cultural trauma experienced by some First Nations, Inuit, and Métis (FNIM)[1] populations are a distinct form of complex trauma; also referred to as Indigenous throughout this document.
- Establish universal screening for mental health and substance use in youth justice populations to assist trauma recovery through a strengths-based approach;
- Increase access to effective and appropriate services for those who have experienced trauma by improving system navigation and referrals.

1.2 Rationale

Trauma experiences are now known to be far more common than previously thought. Youth justice populations report higher rates of trauma exposure than the general population (Wolpaw & Ford, 2004). Indigenous populations are also found to have higher rates of trauma exposure than

[1] When referencing statistics in this document, FNIM is defined using Statistics Canada's (2010) definition of Aboriginal, "those people who reported identifying with at least one Aboriginal group, that is, North American Indian, Métis or Inuit, and/or those who reported being a Treaty Indian or a registered Indian as defined by the Indian Act of Canada, and/or those who reported they were members of an Indian band or First Nation".

the general population (Northwest LHIN, 2009). The Indigenous population in Kenora and Rainy River districts respectively are 36% and 22% of the total population, compared to 2% for the province of Ontario (Statistics Canada, 2013a, 2013b, & 2013c). Further, male FNIM youth in Ontario are incarcerated at a rate that is five times higher than the general youth population, and FNIM females at a rate that is ten times higher (Rankin & Winsa, 2013). The high percentage of FNIM youth in the region coupled with the overrepresentation of FNIM youth in the justice system, suggests that many justice-involved individuals in the region will have experienced trauma.

A shift towards a more trauma-informed youth justice system allows system partners to develop common trauma-informed processes, practices, and policies. For service providers, the anticipated outcomes include an increased number of appropriate mental health and addictions referrals, improved communication among service providers, increased service collaboration, improved continuity of care, and improved trauma recognition and response. For youth and families, anticipated long-term outcomes include improved behavioural and mental health, decreased substance use, decreased contact with the justice system, decreased severity of youth justice incidents, and increased overall well-being. At the system level, the projected outcomes of a more-trauma informed approach are reduced pressure and financial strain on human service systems and reduced victimization. System partners will need to take a coordinated collaborative approach to system education, training, and funding proposals. The intent of these efforts is to influence policy and practice change at the agency, system, and ultimately, the provincial government level, and act as a catalyst for a paradigm shift in the approach to youth justice.

1.3 Applicability

Member agencies of the Kenora Rainy River Youth Justice Service Collaborative who provide justice, mental health, and/or substance use services for the youth and/or adult sectors. Inclusion of adult agencies is intended to encourage continuity of service philosophy between sectors and a more seamless transition from youth to adult serving systems. Other sectors who provide services to justice-involved youth outside of the justice system proper are also included, i.e., education, child welfare, primary health care. In addition, the protocol includes agencies that provide services to victims of crime. This protocol and its components initially focussed on the Kenora area with the intent to scale-up to additional communities in the Northwest region.

1.4 Definitions

1.4.1 Individualized

Treatment strategies, services, and other supports that are customized to suit the particular needs and strengths are individualized, including consideration given to their lived experience and resilience.

1.4.2 Psychological trauma

The occurrence of Psychological trauma is when an individual is overwhelmed by their experience of an event or from enduring conditions. The individual's ability to integrate his or her emotional experience is compromised and can result in a sense of helplessness. Trauma can be triggered by a wide range of experiences, including single events such as an accident, natural disaster, unexpected loss, or victimization through personal or property crime. Or, trauma can be triggered by multiple or repeated events, such as war, poverty, family or community conflict, or neglect and/or abuse. A person can experience trauma directly or indirectly and still be psychologically impacted. Trauma experiences are predictors of increased risk of prolonged emotional, physical, and behavioural health problems. An individual's inability to cope can result in inappropriate mental health diagnoses, substance use issues, self-harm, criminal or violent behaviour, and family conflict, among other things. Trauma responses can be further defined as follows:

1.4.2.1 Acute trauma response

– An immediate response to a situation where an individual experiences extreme, disturbing or unexpected fear, stress, pain, or loss. A single event can lead to long-term trauma responses.

1.4.2.2 Chronic trauma response

– A response to trauma exposure over long periods of time. Responses can range from fear, guilt, and shame, to loss of trust in others, and a reduced ability to tolerate normal stress. Each traumatic event or circumstance can serve as a reminder of previous traumatic events, so the negative effects accumulate and reinforce the impact of the previous trauma.

1.4.2.3 Complex trauma response

– The wide-ranging, long-term impacts of children's exposure to multiple traumatic events, often of an invasive, interpersonal nature. These events are severe and pervasive. They usually begin early in life, and disrupt many aspects of a child's development and the very formation of a self. These traumatic events often occur in the context of the child's relationship with a caregiver, and can interfere with the child's ability to form a secure attachment bond.

Complex trauma can have devastating effects on a child's physiology, emotions, ability to think, learn, and concentrate, impulse control, self-image, and relationships with others. Complex trauma is linked to a wide range of problems that can present and persist across the life span, including chronic physical conditions, addiction, depression and anxiety, self-harming behaviours, and other psychiatric disorders. Changes in the brain and in emotional development can result in self-initiated isolation, and/or the inability to get or remain connected to potentially supportive people, further impacting the individual.

1.4.2.4 Cultural trauma

– An attack on the fabric of a society, including its norms, social mores, values, belief system, way of life, traditions, and language, affecting the essence of the community and its members.

1.4.2.5 Historic trauma

– The cumulative exposure of traumatic events, such as colonization, dispossession and dislocation that negatively impact an individual and continue to affect subsequent generations.

1.4.2.6 Inter-generational trauma

- When trauma is not resolved, subsequently internalized, and passed unwittingly through behaviours and thought systems from one generation to the next.

1.4.3 Re-traumatization

Individuals may be unintentionally traumatized or re-traumatized in agency or provider settings when psychological trauma is not recognized or addressed. Re-traumatization can be triggered by the use of seclusion or restraint, or less overtly, by a lack of sensitivity to the potentially triggering impact of words, appearance, or behaviours of service providers or those in positions of authority. Re-traumatization can also occur when the physical environment may compromise an individual's

feelings of comfort and safety. What may appear to be an over-reaction may in fact be associated to a previous trauma that is being triggered by a current event, circumstance, or surroundings.

1.4.4 Trauma-informed practice

A philosophy that facilitates identification of trauma responses in individuals, and is used to ensure that clients and service providers are supported appropriately so as not to cause re-traumatization is considered to be trauma-informed practice. This practice differs from trauma-specific interventions which are treatment-focused clinical programs designed to lessen the impacts or symptoms of traumatic experiences on an individual. Trauma-specific interventions can augment trauma-informed practice, but trauma-informed agencies can be established without them.

1.4.5 Trauma exposure response

A stress reaction that may be experienced by individuals who are exposed to trauma through their work (sometimes referred to as “vicarious trauma”). Primary response workers such as police, paramedics, or child welfare workers involved in apprehensions may be exposed to trauma directly through their work. Workers can also be impacted through disclosures of images and events by individuals seeking help. Service providers may experience long lasting changes in how they view themselves, others, and the world. Trauma exposure response can develop into posttraumatic stress disorder (PTSD) and can affect the lives and careers of even those with considerable training and experience.

1.4.6 Universal precautions

Assuming that all individuals may have experienced trauma and have symptoms from this exposure, they are not immediately obvious. Trauma is an almost universal experience in the general population with even higher rates of trauma exposure reported in youth justice populations. This necessitates that a universal precaution approach be used with the understanding that while not all clients will have a trauma background, service providers need to be informed and ready to recognize and support those who do.

2.0 Protocol Components

This part of the protocol identifies our mandate, statement of values and guiding principles, mission, and vision.

2.1 Mandate

The Kenora Rainy River Youth Justice Collaborative connects justice-involved youth with appropriate mental health and addiction services through coordinated efforts by agencies in the Kenora Rainy River Districts in order to give youth and their caregiver's access to services and options that limit escalation in the justice system.

2.2 Statement of values and guiding principles

We believe in:

- **Being Trauma-Informed –** Recognizing the prevalence of trauma, how trauma affects all individuals in the system, including its own workforce, recognizing the historic trauma experienced by First Nations communities over the last several centuries, and putting this knowledge into practice
- **Collaboration & Partnership –** Encouraging cooperation and collaboration between interconnected system partners to facilitate system change
- **Community & Inclusion –** Bringing families, communities, and cultures together
- **Resilience –** A belief in capacity to respond to adverse conditions, and acknowledging there are individual responses to diversity through creative individual and community solutions
- **Ethics & Integrity –** Measuring our success and accountability to each other and the broader community in time-sensitive ways
- **Safety –** Identifying risks and enhancing protective factors for all

Mandate

The Kenora Rainy River Youth Justice Collaborative connects justice-involved youth with appropriate mental health and addiction services through coordinated efforts by agencies in the Kenora Rainy River Districts in order to give youth and their caregivers access to services and options that limit escalation in the justice system.

2.3 Mission

Our mission is defined as follows:

Create an integrated service system built on a foundation of trauma-informed practice, to continue to educate, support, and promote collaboration around learning and working together, to acknowledge the significant issues of loss in all systems, and to develop a unified voice.

Mission

To create an integrated service system built on a foundation of trauma-informed practice, to continue to educate, support, and promote collaboration around learning and working together, to acknowledge the significant issues of loss in all systems, and to develop a unified voice.

2.4 Vision

Our vision statement encompasses what we imagine to be our ideal future state.

Within 5 years, a systemic shift to a trauma-informed youth justice system that recognizes individual, family and community response to trauma while fostering resiliency, where young people and their families are meaningfully supported, and where organizations work together in collaborative and culturally-responsive ways.

Vision

Within 5 years, a systemic shift to a trauma-informed youth justice system that recognizes individual, family, and community response to trauma while fostering resiliency, where young people and their families are meaningfully supported, and where organizations work together in collaborative and culturally-

3.0 Goals and Objectives

This protocol commits organizations to the process of transitioning to a more trauma-informed youth justice system, and clarifies service provider roles and responsibilities from all sectors. The guiding protocol is responsive to the distinct and varying needs of youth justice clients, with particular attention to Indigenous youth. This is accomplished by cross-sectoral training and education in trauma-informed practice, adoption of a common mental health and addictions screening tool, and creation of a system navigation map for service providers, clients, and families.

3.1 A more trauma-informed youth justice system

It is the goal of the Service Collaborative to transition to a more trauma-informed youth justice system over the next five years. A more trauma-informed youth justice system will support:

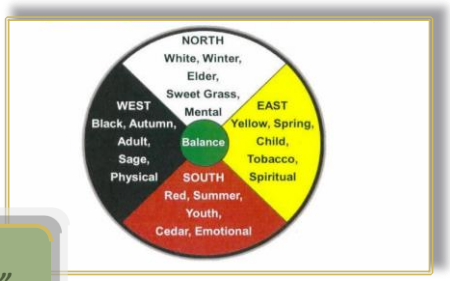
- Education and training in trauma-informed practice;
- Cross-sectoral training groups – Indigenous, mainstream, frontline, management;
- Common language and approaches between agencies and sectors;

- The capacity of organizations and individuals to recognize and support justice-involved youth exhibiting trauma exposure response;
- The capacity of organizations and individuals to recognize and support youth justice system workers exhibiting trauma exposure response;
- Improved self-care for trauma-exposed workers within the system.

3.2 Improved cultural awareness

It is the goal of the Service Collaborative to ensure that all providers are knowledgeable about the history of colonization, and the direct and inter-generational impacts it has had on indigenous populations. Service providers can support justice-involved indigenous youth by:

- Acknowledging and recognizing the cultural, historical, and inter-generational trauma experienced by many Indigenous individuals and communities;
- Improving their capacity to support traditional ways of knowing and forms of healing, while also recognizing that the choice to engage in traditional ways rests with the individual;
- Embracing the "two-eyed seeing"[2] or "double understanding" model, where different healing approaches are seen as complimentary and parallel, and each explored to respond to individual needs;
- Increasing their ability to be culturally competent in their practice;
- Being aware that many workplace practices and tools have not been culturally-adapted for Indigenous populations;
- Recognizing that healing is individual and people must be able to guide their own healing journeys.



"Learning together as a way of working together."
Colin Wasacase, Service Collaborative member and Elder

3.3 Universal screening (GAIN-SS – CAMH-modified version)

Many Service Collaborative agencies have signed on to the 5-year group licence for use of the Global Appraisal of Individual Needs - Short Screener CAMH-Modified Version (GAIN-SS). Use of the GAIN-SS by as many agencies as possible in the system will result in:

- Consistency in screening across sectors;

[2] The concept of two-eyed seeing "…refers to learning to see from one eye with the strengths of Indigenous knowledges and ways of knowing, and from the other eye with the strengths of Western knowledges and ways of knowing ... and learning to use both these eyes together, for the benefit of all" (Institute for Integrative Science and Health, n.d.). See http://www.integrativescience.ca/Principles/TwoEyedSeeing/ for more discussion of this concept.

- Screening results that can be shared among agencies with appropriate consent to reduce the need for multiple screenings of individual clients;
- A common screening tool that can be used as a measure over time;
- More appropriate referrals made using a valid, reliable screener;
- Screening for cognitive impairments.

3.4 Improved system navigation and referrals

A Youth Justice and Mental Health and Addictions Systems Map has been developed and launched for the Kenora area and agencies are encouraged to use the Inter-Agency Referral Form. The navigation map and referral form are an important part of the protocol because:

- The map outlines where justice and mental health and addictions sectors intersect;
- It identifies intersection points and local services available at each point;
- There is a description of services and agency contact information on back of map to assist service providers and youth and families with system navigation;
- Those agencies providing cultural services will be highlighted;
- The map will be available to agencies and court staff who work with justice-involved youth and mirror an adult-system map for consistency;
- The existing referral form will be amended to ensure appropriate referrals are made to youth mental health, addictions, and justice services;
- A common referral form will create a common pathway to care for justice-involved youth.

4.0 Monitoring and Evaluation

Monitoring and evaluation of the protocol occurred during implementation and then annually thereafter. Only with proper monitoring will we be aware of our progress. One Service Collaborative meeting per year will be dedicated to the evaluation of progress and gauge agency commitment to the protocol. Agencies will be accountable to the larger Service Collaborative body for adherence to the protocol and its components.

5.0 References

Institute for Integrative Science and Health. (n.d.) *Two-eyed seeing.* Cape Breton University. Retrieved from: http://www.integrativescience.ca/Principles/TwoEyedSeeing/

Northwest LHIN. (2009). Integrated health services plan 2010-2013. Local Health Integration Network report, Thunder Bay, ON. Retrieved from: http://www.childrenscentre.ca/Resources/Articles/LHIN%20Health%20Services%20Plan%202010-2013.pdf

Rankin, J. and Winsa, P. (2013, March 3). Unequal justice: Aboriginals caught in the justice system trap. The Star.Com. Retrieved from: http://www.thestar.com/news/insight/2013/03/03/unequal_justice_aboriginals_caught_in_the_justice_system_trap.html

Statistics Canada. (2013a). *Kenora, DIS, Ontario (Code 3560) (table)*. National Household Survey (NHS) Profile. 2011 National Household Survey. Statistics Canada Catalogue no. 99-004-XWE. Ottawa, ON. Released September 11, 2013. Retrieved from: http://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/index.cfm?Lang=E

Statistics Canada. (2013b). *Ontario (Code 35) (table)*. National Household Survey (NHS) Profile. 2011 National Household Survey. Statistics Canada Catalogue no. 99-004- XWE. Ottawa, ON. Released September 11, 2013. Retrieved from: http://www12.statcan.gc.ca/nhs-enm/2011/dp- pd/prof/index.cfm?Lang=E

Statistics Canada. (2013c). *Rainy River, DIS, Ontario (Code 3559) (table)*. National Household Survey (NHS) Profile. 2011 National Household Survey. Statistics Canada Catalogue no. 99-004-XWE. Ottawa, ON. Released September 11, 2013. Retrieved from: http://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/index.cfm?Lang=E

Wolpaw, J. W. and Ford, J. D. (2004). *Assessing exposure to psychological trauma and post-traumatic stress in the juvenile justice population. Report of the National Child Traumatic Stress Network Juvenile Justice Working Group.* Retrieved from: http://www.nctsn.org/sites/default/files/assets/pdfs/assessing_trauma_in_jj_population.pdf

The following documents were also consulted in preparation of this document:

Clark, Gina. (2015). *Developing a trauma-informed youth justice system in Kenora Rainy River: Recommendations and Next Steps.* (Master's project, University of Victoria). Retrieved from UVicSpace: http://dspace.library.uvic.ca/bitstream/handle/1828/6158/Clark_Gina_MPA_2015.pdf?sequence=1&isAllowed=y

Oregon Health Authority. (2014). *Trauma informed services* (Oregon Health Authority Addictions and Mental Health Division Policy No. AMH-060-1607, version 1.0). Retrieved from: http://www.oregon.gov/oha/amh/trauma-policy/Trauma%20Policy.pdf

Appendices

1.0 Trauma Resources

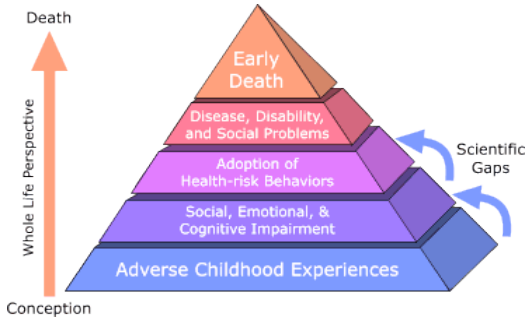
1.1 ACE Study and Resources

The effects of childhood trauma experience as predictors of future physical, mental and behavioural health was well documented in a foundational study on the subject. The Adverse Childhood Experiences (ACE) study examined the linkage between childhood abuse, neglect, and other adverse experiences, as predictors of increased health and behavioural problems as the person ages (Middlebrooks & Audage, 2008). Over 17,000 adults participated in the original study which surveyed exposure to 10 categories of adverse childhood experiences as indicated in the table below:

Categories of adverse childhood experiences used in ACE study	
Abuse	Household Dysfunction
• Emotional • Physical • Sexual	• Mother treated violently • Household substance abuse • Household mental illness • Parental separation or divorce • Incarcerated household member
Neglect	
• Emotional • Physical	

Categories of adverse childhood experiences as used in ACE study. Adapted from Middlebrooks & Audage, (2008), *The effects of childhood stress on health across the lifespan,* Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

As reported by Middlebrooks and Audage (2008), findings revealed that adverse childhood experiences are much more common than previously thought, with almost two-thirds of participants reporting at least one ACE event. High ACE scores are related to increased numbers of co-occurring health and behavioural problems in adolescence and adulthood, and an increased risk of involvement with the justice system (Baglivio et al., 2014). For more information on the ACE study and collecting ACE scores:



- http://health-equity.pitt.edu/932/1/Childhood_Stress.pdf (Middlebrooks & Audage study)
- http://acestudy.org/
- http://www.cdc.gov/violenceprevention/acestudy/
- http://acestoohigh.com/
- http://acestoohigh.com/2014/08/20/florida-study-confirms-link-between-juvenile-offenders-aces-rates-much-higher-than-cdcs-ace-study/
- http://www.journalofjuvjustice.org/JOJJ0302/JOJJ0302.pdf (Baglivio, et al. study)
- http://www.ifapa.org/pdf_docs/ACES_Handout.pdf (stress and early brain growth)
- https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime?language=en (TED talk by Dr. Nadine Burke Harris)

1.2 Trauma-Informed Agency Self-Evaluation Checklist

The table below outlines Harris and Fallot's (2009) key domains to consider when designing an agency culture of trauma-informed practice. Of the six domains, only one sub-domain mentions trauma-specific clinical interventions. More consideration is given to having procedures and policies in place that are consistent with their five guiding principles of trauma-informed practice: safety, trustworthiness, choice, collaboration, and empowerment. These principles apply to both clients and employees. Also key is administrative level support for trauma-informed practice and education, and human resources practices that support trauma-related concerns. A shared philosophy about trauma among staff, clients, and administration, is the foundational piece necessary on which to build a trauma-informed service system.

Key domains to be considered when designing cultures of trauma-informed practice	
Domain	Key questions
☐ **Domain 1** **Program procedures and settings**	To what extent are program activities and settings for clients and staff consistent with five guiding principles of trauma-informed practice: safety, trustworthiness, choice, collaboration, and empowerment?
☐ **Domain 2** **Formal services policies**	To what extent do the formal policies of the program reflect an understanding of trauma survivors' needs, strengths, and challenges? Of staff needs? Are these policies monitored and implemented consistently?
☐ **Domain 3** **Trauma screening, assessment, service planning, and trauma-specific services**	To what extent does the program have a consistent way to identify individuals who have been exposed to trauma, to conduct appropriate follow-up assessments, to include trauma-related information in planning services with the client, and to provide access to effective and affordable trauma-specific services?
☐ **Domain 4** **Administrative support for program-wide trauma-informed services**	To what extent do program or agency administrators support the integration of knowledge about violence and abuse into all program practices?
☐ **Domain 5** **Staff trauma training and education**	To what extent have all staff members received appropriate training in trauma and its implications in their work?
☐ **Domain 6** **Human resources practices**	To what extent is trauma-related concerns a part of the hiring and performance review process?

Key domains to consider when designing cultures of trauma informed care. Adapted from Harris, M. and Fallot, R. D., (2009, July), Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from: https://www.healthcare.uiowa.edu/icmh/documents/CCTICSelf-AssessmentandPlanningProtocol0709.pdf

More detailed agency self-evaluation resources based on Harris and Fallot's six domains can be found at:

- https://www.healthcare.uiowa.edu/icmh/documents/CCTICSelf-AssessmentandPlanningProtocol0709.pdf - The Self-Assessment and Planning Protocol is divided into the six domains. The planning protocol addresses both service-level, and administrative or system-level changes. In each domain, there are guiding questions for a collaborative discussion of a program's activities and physical settings, followed by a list of more specific questions and/or possible indicators of a trauma-informed approach.
- http://www.theannainstitute.org/TIPSASCORESHEET.pdf - The Trauma-Informed Program Self-Assessment Scale allows agencies to gauge and score to what extent program activities and settings are consistent with the five guiding principles of trauma-informed practice.

1.3 Trauma-Informed Resources

1.3.1 Websites

Aboriginal Healing Foundation http://www.ahf.ca/

Manitoba Trauma Information and Education Centre http://trauma-informed.ca/

National Center for Trauma Informed Care and Alternatives to Seclusion and Restraint http://www.samhsa.gov/nctic

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

- Titles available in the National Child Traumatic Stress Network's Current Issues and New Directions in Creating Trauma-Informed Juvenile Justice Systems, brief series:

Resources for mental health and juvenile justice professionals:

In Trauma-Informed Juvenile Justice Roundtable: Current Issues and New Directions in Creating Trauma-Informed Juvenile Justice Systems (2013) (PDF), Carly B. Dierkhising, Susan Ko, and Jane Halladay Goldman, staff at the National Center for Child Traumatic Stress, discuss the Juvenile Justice Roundtable event, describe the current issues and essential elements of a trauma-informed JJ system, and outline possible new directions for the future.

In Trauma-Informed Assessment and Intervention (2013) (PDF), Patricia Kerig, Professor at the University of Utah, discusses how trauma-informed screening and assessment and evidence-based treatments play integral roles in supporting traumatized youth, explores the challenges of implementing and sustaining these practices, and highlights practice examples for integrating them into a justice setting.

In The Role of Family Engagement in Creating Trauma-Informed Juvenile Justice Systems (2013) (PDF), Liane Rozzell, founder of Families and Allies of Virginia Youth, discusses the importance of partnering with families, explores strategies for doing so, and emphasizes ways that justice settings expand their outreach to supportive caregivers by broadening their definition of family.

In Cross-System Collaboration (2013) (PDF) , Macon Stewart, faculty at the Center for Juvenile Justice Reform (CJJR), outlines practice examples for continuity of care and collaboration across systems, a vital activity for youth involved in multiple service systems, drawing from the CJJR's Crossover Youth Practice Model.

In Trauma and the Environment of Care in Juvenile Institutions (2013) (PDF), Sue Burrell, staff attorney at the Youth Law Center, outlines specific areas to target in order to effectively implement this essential element, including creating a safe environment, protecting against re-traumatization, and behavior management.

In Racial Disparities in the Juvenile Justice System: A Legacy of Trauma (2013) (PDF), Clinton Lacey, Deputy Commissioner of the New York City Department of Probation, outlines the historical context of racial disparities and highlights how systems can move forward to reduce these racial disparities, including by framing the issue so that practical and pro-active discussion can move beyond assigning blame.

Assessing Exposure to Psychological Trauma and Posttraumatic Stress in the Juvenile Justice Population (2014) (PDF)
This factsheet explores the importance, clinical considerations and approaches to assessing for psychological trauma and post-traumatic stress with youth in the juvenile justice population. It addresses challenges that are unique to assessment within the juvenile justice environment.

Screening and Assessment in the Juvenile Justice System Speaker Series
This series describes the utility of screening and assessment for trauma in juvenile justice settings, specific instruments that are used or can be used in juvenile justice settings, how to best utilize data derived from screening and assessment, and recommendations for agencies and practitioners interested in implementing trauma-informed screening and assessment.

Testifying in Court about Trauma: How to Prepare
Offers guidance to clinicians called upon to testify as an expert witness for a client's court case. From understanding a subpoena, confidentially, and the therapist-client privilege to preparing yourself, your client, and his/her caregivers for your court appearance, this fact sheet lays out ethical considerations, describes how to navigate conversations with your consumers, and gives you self-care tips to use for a court appearance.

Testifying in Court about Trauma: The Court Hearing
7-page fact sheet to help those preparing for a court hearing. In addition to a case example, it defines legal terms, delineates the types of cases in which clinician testimony might be required, explains the roles of "expert" witness and "fact" witness, describes how to testify effectively (with specific talking points), charts behaviors traumatized children may display and possible contributing facts from a trauma perspective, tells your rights as a witness, presents a checklist to use prior to the hearing day, and gives self-care tips for managing anxiety during the hearing.

Think Trauma
This training provides an overview for juvenile justice staff of how to work towards creating a trauma-informed juvenile justice residential setting. Creating a trauma-informed setting is a process that requires not only knowledge acquisition and behavioral modification, but also cultural and organizational paradigm shifts, and ultimately policy and procedural change at every level of the facility.

Think Trauma is a PowerPoint-based training curriculum including four modules that can be implemented back-to-back in a single all-day training or in four consecutive training sessions over the course of several weeks or even months. Each module takes approximately one to two hours, depending on the size of the trainee group, and whether you elect to implement all of training materials and activities. It contains six case studies of representative youth who've been involved with the juvenile justice system.

Trauma among Girls in the Juvenile Justice System (2014) (PDF)
This fact sheet explores research on the growing number of girls in the juvenile justice system, the high rates of exposure to violence among these girls and the potential consequences of that exposure, and the special challenges and obligations this poses for juvenile justice facilities and programs.

Trauma-Focused Interventions for Youth in the Juvenile Justice System (2004) (PDF)
Due to exposure to traumatic events, many youth in the juvenile justice system have developed symptoms of traumatic stress. This factsheet explores the role of pretreatment assessment, identifies important components of trauma-focused interventions, and discusses the treatment of co-occurring disorders as well as family- and group-based interventions that may be effective with youth involved with the juvenile justice system.

Trauma Histories Among Justice-Involved Youth: Findings From the National Child Traumatic Stress Network (2013)
This study describes detailed trauma histories, mental health problems, and associated risk factors (i.e., academic problems, substance/alcohol use, and concurrent child welfare involvement) among adolescents in the juvenile justice system.

Victimization and Juvenile Offending (2004) (PDF)
This resource summarizes research exploring the high rates of adolescent victimization and the potential

consequences, including delinquency and future violence. It presents strategies for short-circuiting the cycle of victimization and subsequent violence.

Trauma in the Lives of Gang-Involved Youth: Tips for Volunteers and Community Organizations (2009) (PDF)
For youth who have been traumatized, gangs can offer an apparent sense of safety, control, and structure that is often missing from their lives. But gang involvement is also a risk factor for interpersonal and other traumas. This fact sheet defines traumatic stress, explains why trauma is so prevalent among gang-involved youth, and provides tips for community organizations and volunteers on working with this population.

Your Child and Gangs: What You Need to Know about Trauma - Tips for Parents (2009) (PDF)
Individual reactions to trauma vary dramatically. What is devastating to one child may be less so for another. A youth's subjective response to a traumatic event depends upon a number of factors, such as individual personality, coping style, previous trauma, cultural background, and environment. This fact sheet defines traumatic stress, explains the appeal of gang involvement for traumatized youth, and offers information for parents on helping their children cope.

Resources for judges and attorneys:

NCTSN Bench Card for the Trauma-Informed Judge (2013) (PDF)

Birth Parents with Trauma Histories and the Child Welfare System: For Judges and Attorneys (2011) (PDF)
This resource is part of a series of factsheets developed from the Birth Parent Subcommittee of the Child Welfare Committee. They highlight the importance of understanding the serious consequences that trauma histories can have for birth parents and the subsequent potential impact on their parenting. This particular resource was specifically developed for the audience of judges and attorneys. Click here to access the Birth Parents with Trauma Histories series.

Helping Traumatized Children: Tips for Judges (2009) (PDF)
This fact sheet for judges and other court personnel outlines the impact of trauma on children's development, beliefs, and behaviors. It is designed to help professionals in the juvenile justice and family court system become more effective in addressing the unique needs and challenges of the traumatized children and adolescents they work with.

Juvenile and Family Court Journal: Special Editions on Child Trauma
In partnership with the National Council of Juvenile and Family Court Judges (NCJFCJ), members of the Network contributed to two issues of the *Juvenile and Family Court Journal* devoted to child trauma. Articles in the spring 2006 and fall 2008 editions of the journal inform judges and other members of the juvenile and family court systems about issues they should consider when working with youth who have been exposed to trauma. Both issues can be ordered from NCJFCJ.

Service Systems Brief (vol 2, no 2): Judges and Child Trauma: Findings from the National Child Traumatic Stress Network/National Council of Juvenile & Family Court Judges Focus Groups (2008) (PDF)
This NCTSN Service Systems Brief reports the results of focus groups conducted with members of the National Council of Juvenile and Family Court Judges (NCJFCJ). The Network conducted the focus groups in order to understand how knowledgeable juvenile and family court judges are about child trauma and to identify ways to work with NCJFCJ to promote education on the issue.

Ten Things Every Juvenile Court Judge Should Know About Trauma and Deliquency (2010) (PDF)
This technical assistance bulletin highlights crucial fact that juvenile court judges should know that they can best meet the needs of traumatized children who come into their system. A collaboration between the NCTSN and the National Council of Juvenile and Family Court Judges, this publication was funded by the office of Juvenile Justice and Delinquency Prevention.

National Coalition for Mental Health Recovery http://www.ncmhr.org/trauma.htm

National Council for Behavioral Health http://www.thenationalcouncil.org/areas-of-expertise/trauma-informed-behavioral-healthcare/

The Philadelphia Papers: Trauma-Informed Systems and Communities
https://sites.google.com/site/humanprioritiesorg/home/trauma-informed-systems-and-communities

Substance Abuse and Mental Health Services Administration http://www.samhsa.gov/

Trauma Center at Justice Resource Institute http://www.traumacenter.org/

Truth and Reconciliation Commission of Canada
http://www.trc.ca/websites/trcinstitution/index.php?p=3

Select Bibliography

Adams, E. J. (2010). Healing invisible wounds: Why investing in trauma-informed care for children makes sense. Policy brief for the Justice Policy Institute. Retrieved from: http://www.justicepolicy.org/images/upload/10-07_REP_HealingInvisibleWounds_JJ-PS.pdf

Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions. (2009). Making the links: Violence, trauma, and mental health. Canadian Women's Health Network Magazine, 11(2). Retrieved from: http://www.cwhn.ca/en/node/41607

Baglivio, M. T., Epps, N., Swartz, K., Sayedul Huq, M., Sheer, A., & Hardt, N. S. (2014). The prevalence of adverse childhood experiences (ACE) in the lives of juvenile offenders. *Journal of Juvenile Justice*, 3(2), 1-23. Retrieved from: http://www.journalofjuvjustice.org/JOJJ0302/JOJJ0302.pdf

Bédard, A. and Paletta, A. (2008). Report on "Forum on Justice System Responses to Violence in Northern and Remote Aboriginal Communities," in *JustResearch (no. 15)*, First Nations, Inuit, and Métis justice issue, 24-26. Retrieved from Department of Justice, Research and Statistics Division: http://www.justice.gc.ca/eng/rp-pr/jr/jr15/jr15.pdf

Bombay, A., Matheson, K., and Anisman, H. (2009). Intergenerational trauma: Convergence of multiple processes among First Nations peoples in Canada. *International Journal of Indigenous Health, 5(3),* 6-47. Retrieved from: http://journals.uvic.ca/index.php/ijih/article/view/12337

Bombay, A., Matheson, K., and Anisman, H. (2014). The intergenerational effects of Indian Residential Schools: Implications for the concept of historical trauma. *Transcultural Psychiatry, 51(3),* 320-338. doi: 10.1177/1363461513503380

BC Provincial Mental Health and Substance Use Planning Council. (2013, May). *Trauma informed practice guide.* Retrieved from: http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

British Columbia Centre for Excellence in Women's Health. (2010). *Coalescing on women and substance use: Trauma-informed online tool.* Retrieved from: http://www.coalescing-vc.org/virtualLearning/documents/trauma-informed-online-tool.pdf

Chauduri, B., Martin, G., and Kelley, M. L. (2009, November). *The Treatment of Intergenerational Trauma, Resiliency in First Nations Peoples and the Experience of Residential School Exposure* [PowerPoint Slides]. Presented at the National Aboriginal Health Organization Conference, Ottawa, ON. Retrieved from: http://www.naho.ca/conference/presentations/B4-HWB2-O-Chaudhuri.pdf

Fast, E. and Collin-Vézina, D. (2010). Historical trauma, race-based trauma and resilience of indigenous peoples: A literature review. *First Peoples Child and Family Review, 5(1)*, 126-136. Retrieved from: journals.sfu.ca/fpcfr/index.php/FPCFR/article/download/181/150

Ford, J. D. (2013, December 4). *Complex trauma and youth in the juvenile justice system* [PowerPoint Slides].

Ford, J. D., Chapman, J. F., Hawke, J. and Albert, D. (2007). *Trauma among youth in the juvenile justice system: Critical issues and new directions* (National Center for Mental Health and Juvenile Justice Research and Program Brief). Retrieved from: http://www.ncmhjj.com/wp-content/uploads/2013/10/2007_Trauma-Among-Youth-in-the-Juvenile-Justice-System.pdf

Harris, M. and Fallot, R.D. (2001). Using trauma theory to design service systems. *New Directions for Mental Health Services, 89*, 1-103.

Harris, M. and Fallot, R.D. (2009, July). *Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol.* Washington, DC: Community Connections. Retrieved from: https://www.healthcare.uiowa.edu/icmh/documents/CCTICSelf-AssessmentandPlanningProtocol0709.pdf

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

Hodas, G. R. (2006). *Responding to childhood trauma: The promise and practice of trauma informed care.* Mental Health Coordinating Council research paper on trauma informed care and practice, Australia. Retrieved from: http://archive.mhcc.org.au/TICP/research-papers/Hodas-2006.pdf

Jennings, A. (2007). *Models for developing trauma-informed behavioral health systems and trauma-specific services: An update of the 2004 report*. Unpublished draft. Retrieved from: http://www.theannainstitute.org/MDT2.pdf

Klinic Community Health Centre. (2013). *Trauma-informed: The trauma toolkit* (2nd ed.). Retrieved from: http://trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed_Toolkit.pdf

Ko, S. (2007, July). *Creating trauma-informed child serving systems.* NCTSN Service Systems Briefs, 1 (1), 1-6. Retrieved from: http://www.nctsnet.org/nctsn_assets/pdfs/Service_Systems_Brief_v1_v1.pdf

Linklater, R. (2014). *Decolonizing trauma work: Indigenous stories and strategies.* Winnipeg: Fernwood Publishing

MacDonald, N. and Fisher, A. (2015, February 26). *Family violence prevention: Building trauma-informed communities* [PowerPoint Slides]. Presented as Fireside Chat #437 (webinar), Chnet-Works, Public Health Agency of Canada. Retrieved from: http://www.chnet-works.ca/index.php?option=com_phocadownload&view=category&id=24%3Afireside-chat-presentations-and-recordings-2015&Itemid=13&lang=en

Menzies, P. (2012). Chapter 14: An intergenerational trauma-informed approach to care for Canada's Aboriginal people. In N. Poole & L. Greaves (Eds.), *Becoming trauma informed* (pp. 175-187). Toronto: Centre for Addiction and Mental Health

Middlebrooks, J. S. and Audage, N. C. (2008). *The effects of childhood stress on health across the lifespan.* Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Retrieved from: http://health-equity.pitt.edu/932/1/Childhood_Stress.pdf

Monture-Angus, P. (1999). Considering colonialism and oppression: Aboriginal women, justice and the "theory" of decolonization. *Native Studies Review, 12(1)*. Retrieved from: http://iportal.usask.ca/docs/Native_studies_review/v12/issue1/pp63-94.pdf

Perez, A. (2011). The building blocks of trauma-informed practice. *Child and Family Professional, 14(3)*, 1-7. Retrieved from: http://thriveinitiative.org/wp-content/uploads/2009/09/The-Building-Blocks-of-Trauma-Informed-Practice.pdf

Poole, N. (2009). 'Trauma-informed': Symposium examines, trauma, addictions, and mental health. *Canadian Women's Health Network Magazine, 11(2).* Retrieved from: http://www.cwhn.ca/en/node/41608

Poole, N. and Greaves, L. (Eds.). (2012). *Becoming trauma informed*. Toronto, ON: Centre for Addiction and Mental Health.

Proulx, J. and Nighswander, M. (2007). *Manitoba Provincial Forum on Trauma Recovery: Final report*. Retrieved from: http://www.klinic.mb.ca/docs/Provincial%20Forum%20Final%20Report%202007.pdf

Ross, R. (2006). *Traumatization in remote First Nations: An expression of concern.* Unpublished paper.

Ross, R. (2008). *Youth violence in the remote First Nations of Northwestern Ontario: Exploring causes and roots to recovery.* Unpublished paper.

Ross, R. (2010). *Discussion paper: Exploring criminal justice and the Aboriginal healing paradigm.* Unpublished paper. Retrieved from: http://www.lsuc.on.ca/media/third_colloquium_rupert_ross.pdf

Ross, R. (2014). *Indigenous healing: Exploring traditional paths*. Toronto, ON: Penguin.

Roy, A. (2014). Intergenerational trauma and Aboriginal women: Implications for mental health during pregnancy. *First Peoples Child and Family Review, 9(1),* 9-21. Retrieved from: http://journals.sfu.ca/fpcfr/index.php/FPCFR/article/view/189/214

Schwartz, C., Waddell, C., Barican, J., Garland, O., Gray-Grant, D., and Nightingale, L. (2011). Helping children overcome trauma. *Children's Mental Health Research Quarterly, 5*(3), 1–16. Vancouver, BC: Children's Health Policy Centre, Faculty of Health Sciences, Simon Fraser University. Retrieved from: http://childhealthpolicy.ca/wp-content/uploads/2012/12/RQ-3-11-Summer.pdf

Söchting, I., Corrado, R., Cohen, I. M., Ley, R. G., Brasfield, C. (2007). Traumatic pasts in Canadian Aboriginal people: Further support for a complex trauma conceptualization? *BC Medical Journal, 49(6),* 320-326. Retrieved from: http://www.bcmj.org/article/traumatic-pasts-canadian-aboriginal-people-further-support-complex-trauma-conceptualization

U.S. Department of Health and Human Services. (2014). *Trauma-informed care in behavioral health services: Part 3: A review of the literature.* Treatment Improvement Protocol (TIP) Series, no. 57, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. Retrieved from: http://store.samhsa.gov/shin/content//SMA14-4816/SMA14-4816_LitReview.pdf

U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. (2012). *Report of the Attorney General's National Task Force on children exposed to violence*. Retrieved from: http://www.justice.gov/defendingchildhood/cev-rpt-full.pdf

Wemigwans, R. (2014, October 3). *Historical impact of trauma on Aboriginal people* [PowerPoint Slides]. Retrieved from: http://eenet.ca/products-tools/camh-addiction-rounds-historical-impacts-of-trauma-on-aboriginal-people/

Wesley-Esquimaux, C. and Smolewski, M. (2004). *Historic trauma and Aboriginal healing.* Retrieved from the Aboriginal Healing Foundation: http://www.ahf.ca/downloads/historic-trauma.pdf

Woll, P. (2013). *Seeding a system's response to trauma: Philadelphia's Integrated Network of Trauma-Informed and Trauma-Focused Behavioral Health Care.* Philadelphia Department of Behavioral Health and Intellectual disAbility Services. Retrieved from: http://iimhl.com/files/docs/2015Vancouver/Evans-IIMHL-2015Vancouver-Seeding_a_Systems_Response_to_Trauma.pdf

Wolpaw, J. W. and Ford, J. D. (2004). *Assessing exposure to psychological trauma and post-traumatic stress in the juvenile justice population. Report of the National Child Traumatic Stress Network Juvenile Justice Working Group.* Retrieved from: http://www.nctsn.org/sites/default/files/assets/pdfs/assessing_trauma_in_jj_population.pdf

2.0 GAIN-SS

Global Appraisal of Individual Need Short Screener version 3.0.1 CAMH (GAIN-SS ver.3.0.1 CAMH)

The GAIN-SS CAMH-modified version is identified as an ideal first stage screening tool for substance use and mental health concerns for justice-involved youth. In particular, it was chosen because it:

- Screens for both substance use, mental health, and cognitive issues;
- Is reliable and valid;
- Is brief (five to seven minutes to complete);
- Can be self-administered, or administered by non-clinician staff with minimal training;
- Has been validated for individuals aged 10 and older (including adults);
- Is low cost;
- Can be used in different service settings (e.g., residential detention, treatment, etc.).

Domains

The GAIN-SS measures overall severity and four main dimensions of emotional/behavioural problems (internalizing, externalizing, substance use, and crime/violence). The CAMH-modified version has added items at the end to screen for eating-related issues, trauma-related distress, disordered thinking, and gambling, gaming, and internet misuse concerns. It quickly identifies those who may be experiencing difficulties in one or more of four dimensions and for rules out people who are not. The GAIN-SS has excellent sensitivity for identifying people with a behavioural health disorder.

Training

A GAIN license must be obtained to use any of the GAIN family of screening instruments. Training is available in a self-paced online course. It takes approximately 60 minutes to complete all three lessons in the course, which covers GAIN-SS administration, scoring, and interpretation.

Where it has been used

The GAIN-SS ver.3.0.1 CAMH is currently used in communities across Ontario. In the United States, the GAIN-SS is one of the most commonly administered screening instruments for mental health courts and co-occurring disorder dockets, and for the drug court program, Treatment Alternatives to Street Crime (TASC)-criminal justice residential program, and probation.

For more information on the GAIN-SS:

GAIN Coordinating Centre (including GAIN-SS Administrative and Scoring Manual):
http://www.gaincc.org/GAINSS

CAMH Knowledge Exchange Network:
http://knowledgex.camh.net/amhspecialists/Screening_Assessment/screening/screen_CD_youth/Pages/GSS.aspx

To be filled out by the interviewer

Client Name: a._____ b. __ c._____
(First name) (M.I.) (Last name)

Date: |__|__| / |__|__| / 20 |__|__| (MM/DD/YYYY)

GAIN Short Screener (GAIN-SS)

Version [GVER]: GAIN-SS ver. 3.0.1 CAMH

The following questions are about common psychological, behavioural, and personal problems. These problems are considered **significant** when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following questions, please tell us the last time, **if ever**, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0
IDScr 1. **When was the last time** that you had **significant** problems with…					
a. feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	4	3	2	1	0
b. sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?	4	3	2	1	0
c. feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?	4	3	2	1	0
d. becoming very distressed and upset when something reminded you of the past?	4	3	2	1	0
e. thinking about ending your life or committing suicide?	4	3	2	1	0
f. seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?	4	3	2	1	0
EDScr 2. **When was the last time** that you did the following things **two or more times**?					
a. Lied or conned to get things you wanted or to avoid having to do something	4	3	2	1	0
b. Had a hard time paying attention at school, work, or home.	4	3	2	1	0
c. Had a hard time listening to instructions at school, work, or home.	4	3	2	1	0
d. Had a hard time waiting for your turn.	4	3	2	1	0
e. Were a bully or threatened other people.	4	3	2	1	0
f. Started physical fights with other people	4	3	2	1	0
g. Tried to win back your gambling losses by going back another day.	4	3	2	1	0
SDScr 3. **When was the last time** that…					
a. you used alcohol or other drugs weekly or more often?	4	3	2	1	0
b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (e.g., feeling sick)?	4	3	2	1	0
c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	4	3	2	1	0
d. your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events?	4	3	2	1	0
e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?	4	3	2	1	0

(Continued) After each of the following questions, please tell us the last time, **if ever**, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

CVScr 4. **When was the last time** that you…

a.	had a disagreement in which you pushed, grabbed, or shoved someone?	4	3	2	1	0
b.	took something from a store without paying for it?	4	3	2	1	0
c.	sold, distributed, or helped to make illegal drugs?	4	3	2	1	0
d.	drove a vehicle while under the influence of alcohol or illegal drugs?	4	3	2	1	0
e.	purposely damaged or destroyed property that did not belong to you?	4	3	2	1	0

The original GAIN-SS (sections 1 through 4) is copyrighted by Chestnut Health Systems 2005-2013. For more information on the measure or licensure, please see www.gaincc.org or email gainsupport@chestnut.org.

Additional questions (CAMH modified)

After each of the following questions, please tell us the last time, **if ever**, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

AQ5. **When was the last time** you had **significant** problems with… **(not related to alcohol/drug use)**

a.	missing meals or throwing up much of what you did eat to control your weight?	4	3	2	1	0
b.	eating binges or times when you ate a very large amount of food within a short period of time and then felt guilty?	4	3	2	1	0
c.	being disturbed by memories or dreams of distressing things from the past that you did, saw, or had happen to you?	4	3	2	1	0
d.	thinking or feeling that people are watching you, following you, or out to get you?	4	3	2	1	0
e.	videogame playing or internet use that caused you to give up, reduce, or have problems with important activities or people of work, school, home or social events?	4	3	2	1	0
f.	gambling that caused you to give up, reduce, or have problems with important activities or people at work, school, home, or social events?	4	3	2	1	0

5. Do you have other **significant** psychological, behavioural, or personal problems that you want treatment for or help with? (If yes, please describe below) ..... Yes 1 No 0

v1. _____

_____

6. What is your gender? (If other, please describe below) 1 - Male 2 - Female 99 - Other

v1. _____

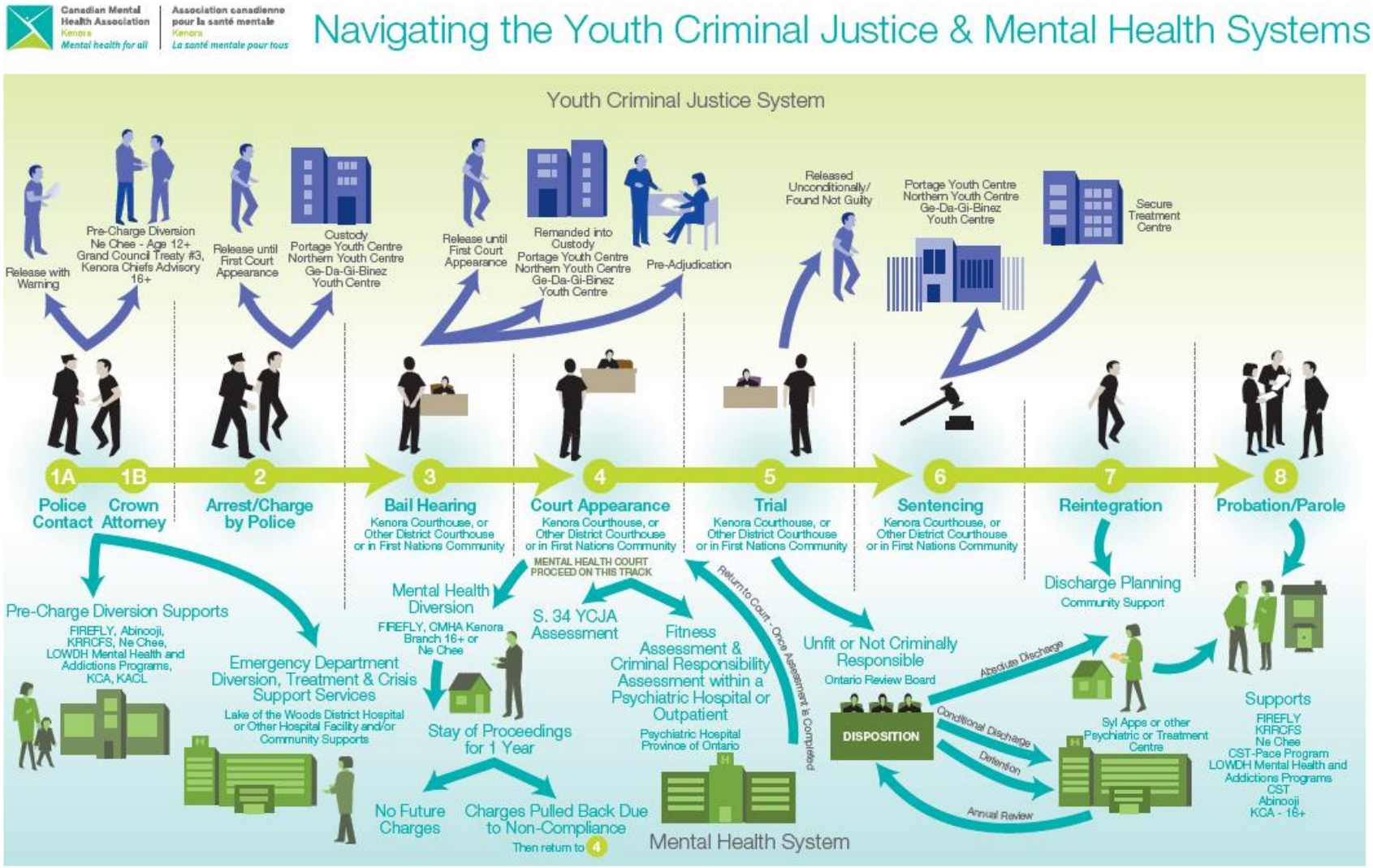
7. How old are you today? |__|__| Age

7a. How many minutes did it take you to complete this survey? |__|__|__| Minutes

Staff Use Only					
8. Site ID: _____ Site name v. _____					
9. Staff ID: _____ Staff initials v. _____					
10. Client ID: _____ Comment v. _____					
11. Mode: 1 - Administered by staff 2 - Administered by other 3 - Self-administered					
13. Referral: MH ____ SA ____ ANG ____ Other ____ 14. Referral codes: _____					
15. Referral comments: v1. _____					
Scoring					
Screener	**Items**	**Past month (4)**	**Past 90 days (4, 3)**	**Past year (4, 3, 2)**	**Ever (4, 3, 2, 1)**
IDScr	1a – 1f				
EDScr	2a – 2g				
SDScr	3a – 3e				
CVScr	4a – 4e				
TDScr	1a – 4e				
Supplemental questions	AQ5a-f				

GAIN-SS copyright © Chestnut Health Systems. For more information on this instrument, please visit http://www.gaincc.org or contact the GAIN Project Coordination Team at (309) 451-7900 or GAINInfo@chestnut.org

3.0 Youth Justice Mental Health System Navigation Map



Canadian Mental Health Association Kenora *Mental health for all* | Association canadienne pour la santé mentale Kenora *La santé mentale pour tous*

Navigating the Youth Criminal Justice & Mental Health Systems

Agency Information

Anishinaabe Abinoojii Family Services (AAFS)

Agency Contact Information:
807-548-1099
807-468-6224

Shawendaasowin Child and Family Services,
807-226-2844

Wabaseemoong Child Welfare Authority,
807-927-2222

Kitapinoonjiminaanik Family Services,
807-468-8238
www.aafs.ca

Canadian Mental Health Association (CMHA) Kenora Branch

Agency Contact Information:
227 Second Street South, 2nd Floor
Kenora, ON P9N 1G1
807-468-1838
office@cmhak.on.ca
www.cmhak.on.ca

Choices - Mental Health and Addiction programs Lake of the Woods District Hospital

Agency Contact Information:
St. Joseph Health Centre
21 Wolsley Street Kenora , Ontario , P9N 3W7
Intake Worker: 807-467-3555
Fax: 807-468-9083

Community Support Team (CST) – William W. Creighton Youth Services

Agency Contact Information:
243 Rabbit Lake Road
Kenora, ON P9N 4L9
807-548-2835
Toll-free: 1-877-548-2837
Fax: 807-548-2838
www.creightonyouth.com

FIREFLY

Agency Contact Information:
820 Lakeview Drive, Kenora, ON P9N 3P7
807-467-5437
Fax: 807-467-5444 or 807-467-5553
www.fireflynw.ca
(refer to website for other FIREFLY location specifics)

Ge-Da-Gi-Binez Youth Centre (GYC)

Agency Contact Information:
620 Eighth St E, Fort Frances ON P9A 1X5;
Mail: PO Box 522, Fort Frances ON P9A 3M8
807-274-3784
Fax: 807-274-1940

Kenora Association for Community Living (KACL)

Agency Contact Information:
501 8th Ave. S. Kenora ON P9N 3Z9
807-467-5225

Kenora Chiefs Advisory (KCA)

Agency Contact Information:
240 Veterans Drive, 3rd Floor
Mailing Address:
P.O. Box 349 Kenora, ON P9N 3X4
Phone: 807-467-8144
Toll Free: 855-367-2600
Fax: 807-467-2656
www.kenorachiefs.ca

Kenora Rainy River Districts Child and Family Services (KRRCFS)

Agency Contact Information (Fort Frances):
240 First St. East, Suite 200
Fort Frances, ON P9A 1K5
807-274-7787

Agency Contact Information (Kenora):
820 Lakeview Drive
Kenora, ON P9N 3P7
807-467-5437
Fax: 807-467-5539
www.kenorarainyriverscfs.ca

Legal Aid Ontario / Northwest Community Legal Clinic (LAO)

Agency Contact Information:
Kenora Legal Aid Office & Northwest Community Legal Clinic
308 Second Street South, Suite 6
Kenora, ON P9N1G4

Legal Aid Office: 807-468-6722
Toll-free: 1-800-267-0660
(The fastest way to get legal aid help is to call Legal Aid Ontario toll-free. You should always call us before visiting an office. Legal Aid Ontario accepts collect calls.)
Fax: 807-468-4096
www.legalaid.on.ca/en/

Northwest Community Legal Clinic
Agency Contact Information:
Phone: (807) 468-8888
Fax: (807)468-4928
Toll-free: 1-800-403-4757
www.northwestcommunitylegalclinic.ca/

Mental Health and Addiction Programs Lake Of the Woods District Hospital (Youth Addictions)

Agency Contact Information:
For Intake: Contact our intake worker at 467-3555
Fax: 468-9083
21 Wolsley Street St. Joseph Health Centre,
Kenora, ON P9N 3W7

Ministry of the Attorney General

Agency Contact Information:
Courthouse
216 Water Street
Kenora, Ontario P9N 1S4
807-468-2835

Ne-Chee Friendship Center

Agency Contact Information:
1301 Railway St, Kenora, ON P9N 3X3
807-468-5440
youthjustice@nechee.org

Northern Youth Centre (NYC)

Agency Contact Information:
Northern Youth Centre - WJS Canada
401 Muriel Lake Road
Keewatin ON P0X1C0
807-543-2815
Toll Free 1-866-369-5401 Fax 807-543-2770

Kenora Attendance Centre - WJS Canada
Unit #9 - 621 Lakeview Drive
Kenora ON P9N3P6
807-468-5414

ACE Program - WJS Canada
Unit #8 - 621 Lakeview Drive
Kenora ON P9N3P6
807-468-5387

Portage Youth Centre (PYC) – William W. Creighton Youth Services

Agency Contact Information:
463 Rabbit Lake Road
Kenora, ON P9N 4M3
807-543-8859
Toll-free: 1-800-767-8241 Fax: 807-548-3062
www.creightonyouth.com

Probation (Ministry of Children & Youth Services- Youth Justice Services)

Agency Contact Information:
610 Lakeview Drive
Kenora, ON P9N 3P7
807-468-2975 ext. 223
General Inquiry: 807-468-2975
Toll Free:1-866-578-4763 Fax: 807-468-2981

Victim/Witness Assistance Program, Victims and Vulnerable Persons Division, Ministry of the Attorney General

Agency Contact Information:
216 Water Street- 2nd Floor
Kenora, ON P9N 1S4
807 468 2839
1-866-931-3484

4.0 Inter-agency Referral Form

MENTAL HEALTH AND ADDICTION SERVICES INTERAGENCY REFERRAL FORM

❒ ADULT REFERRAL ❒ YOUTH REFERRAL ❒ CHILD REFERRAL

- ☐ ALZHEIMER SOCIETY (phone:468-1516; fax:468-9013)
  First Link, Monthly Caregiver Support Group, Learning Series
- ☐ CANADIAN MENTAL HEALTH ASSOCIATION – KENORA BRANCH (phone: 468-1838; fax: 468-6396)
  Mental Health Counselling, Case Management, Court Diversion and Court Support Program, Supportive Housing Assertive Community Treatment Team (phone: 468-4215; fax: 468-6446)
- ☐ CMHA –FORT FRANCES BRANCH – PEER SUPPORT, DROP-IN CENTRE, (phone: 468-7617; fax: 468-2220)
- ☐ CHANGES RECOVERY HOME (phone: 547-2125; fax: 547-2128)
- ☐ COMMUNITY MENTAL HEALTH SUPPORT SERVICES (KACL)(phone: 467-5236;
- ☐ fax: 467-5264)
  Intensive Case Management, Dual Diagnosis Services, Service Enhancement/Housing Subsidies, Wellness Project
- ☐ DEPRESSIVE AND MANIC DEPRESSIVE GROUP OF KENORA (contact: Barbara 547-2972 or Val 468-7555)
- ☐ DISTRICT MENTAL HEALTH SERVICES FOR OLDER ADULTS (CMHA-FF) (phone: 468-4699; fax: 468-7628)
- ☐ FAMILY SUPPORT SERVICES (contact: Joyce 468-9380)
- ☐ FIREFLY (phone: 467-5437; fax: 467-5553)
- ☐ KENORA CHIEFS ADVISORY (phone:467-2600;fax:467-2656)
- ☐ KENORA SEXUAL ASSAULT CENTRE (phone: 468-7958; fax: 468-4808)
- ☐ LWDH MENTAL HEALTH & ADDICTION PROGRAMS(COMMUNITY PROGRAMS) (phone: 467-3555; fax: 468-9083)
  Mental Health Counselling, Adult Addiction Counselling, Youth Addiction Counselling, Problem Gambling, Psychosocial Day Treatment Program (Challenge Club), Post Custody Enhancement, MECCA, Morningstar, Early Years, MODEL program

Client Information

Consent to Disclosure: ❒ written ❒ verbal ❒ Parent/Guardian consent (child under 12) ❒ (release of information attached)

Name: _____

- *If you are referring a child or youth please include their guardian's name & contact information*

Address: _____

Telephone: (h) _____ Message okay ❒ (w) _____ Message okay ❒

Guardian's Name: _____ Telephone # _____

No need to fill out any further information for referral to:

Depressive & Manic Depressive Group, Sunset Country Psychiatric Survivors or Family Support Services

PLEASE CONTINUE FOR REFERRAL TO ANY OTHER AGENCY

Revised Mar 2015

INTERAGENCY REFERRAL FORM

Date of Birth: ____/ ____/____ Age: _____ Sex (m/f): _____

Yr mth day

Family Physician: _____ OHIP# _____

CURRENT OR PAST INVOLVEMENT WITH ADULT MENTAL HEALTH SERVICES:

_____

_____

_____

SERVICES REQUESTED/REASON FOR REFERRAL:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____ _____

REFERENT'S NAME NAME OF AGENCY DATE

5.0 Protocol Implementation Rating Scale

Category	Rating 1 – 5	
1 (never) **2** (rarely) **3** (sometimes) **4** (frequently) **5** (always)		
A. A More Trauma-Informed Youth Justice System	Circle your response	Total
1. Trauma informed practice is discussed at staff meetings and/or during staff supervision meetings	1 2 3 4 5	/25
2. Further trauma-informed training for staff is supported by leadership	1 2 3 4 5	
3. Education and support are provided to staff experiencing trauma exposure response (vicarious trauma)	1 2 3 4 5	
4. Agency works at developing common language and approaches between other agencies and sectors working with justice-involved youth	1 2 3 4 5	
5. Agency contributes to improve system capacity to support justice-involved youth exhibiting trauma exposure response and their caregivers	1 2 3 4 5	
B. Improved Cultural Awareness		
6. Staff attend cross-sectoral training groups (FNIM, mainstream, frontline, management)	1 2 3 4 5	/20
7. Agency works to improve relationships and collaboration between FNIM and non-FNIM agencies	1 2 3 4 5	
8. Agency works towards improved capacity to support traditional ways of knowing and forms of healing	1 2 3 4 5	
9. Agency has knowledge of and access to traditional supports	1 2 3 4 5	
C. Universal Screening using the GAIN-SS – CAMH-modified version		
10. Agency uses the GAIN-SS screener with clients	1 2 3 4 5	/20
11. Appropriate staff complete the training for GAIN-SS use with clients	1 2 3 4 5	
12. Screening results are shared with other agencies as appropriate	1 2 3 4 5	
13. Use of the GAIN-SS increases appropriate client referrals	1 2 3 4 5	
D. Improved System Navigation & Referrals		
14. Agency has knowledge of FNIM organizations, traditional healing methods, and/or cultural resources	1 2 3 4 5	/20
15. Agency uses the navigation map to assist with referrals	1 2 3 4 5	
16. Agency uses the map to assist justice-involved youth and their caregivers navigate the system	1 2 3 4 5	
17. Agency uses the inter-agency referral form	1 2 3 4 5	
E. Monitoring & Evaluation		
18. Agency completes protocol-related surveys, and evaluation and data requests	1 2 3 4 5	/15
19. Agency implementation progress is monitored using the Protocol Implementation Rating Scale	1 2 3 4 5	
20. Agency reports implementation progress at annual Service Collaborative evaluation meeting	1 2 3 4 5	
Total Score	/100	

6.0 Implementation and Action Plan

Item	Timeline
Discussion & consensus • Developed and reviewed protocol with input from Service Collaborative	August 2015 - March 2016
◆ Completed final draft	April 2016
Launch ◆ Identified agencies signing onto protocol	April 2016
Awareness campaign – • Determined if public campaign will focus on increasing Service Collaborative awareness, trauma awareness, or both • Determined cost of awareness campaign	April – July 2016
• Considered a logo to represent Service Collaborative • Decided on which media to use (radio, newspaper/internet, billboards/poster) and length of campaign	March – August 2016
• Developed campaign	April – July 2016
• Launched protocol and awareness campaign	July – September 2016
• Deputation to Kenora City Council and invited council members to attend Policy Level trauma-informed workshop • Hosted Executive/Policy level trauma-informed workshop	June 2016
Execution	
• Began agency self-evaluations for trauma-informed practice	April 2016
• Reviewed progress of agency self-evaluations and fidelity checklist	September – December 2016
• PDSA (Plan, Do, Study, Act) Year 1 of protocol work and plan for Year 2	April – March 2017
**This implementation strategy is a guideline only – implementation may take less time than indicated, or more due to delays or other unforeseen circumstances.	

7.0 Participating Agencies

7.1 Protocol Working Group Co-Chairs and Members (at the time of creation 2015/16)

- **Co-Chair** Sheri Norlen, Manager William W. Creighton Youth Services, PYC
- **Co-Chair** Michelle Guitard, FIREFLY, Youth Mental Health Court Worker
- **Member** Gina Clark, Centre for Addiction and Mental Health, PSSP
- **Member** Jack Martin, Service Collaborative Implementation Team Member
- **Member** Rooke Pitura, William W. Creighton Youth Services, Community Support Team
- **Member** Sean Spencer, Anishinaabe Abinoojii Family Services

7.2 List of Participating Agencies*

- Anishinaabe Abinooji Family Services
- Canadian Mental Health Association, Fort Frances Branch

- Canadian Mental Health Association, Kenora Branch
- Changes Recovery Home
- FIREFLY
- Ge-Da-Gi-Binez Youth Centre
- Gizhewaadiziwin Health Access Centre
- Keewatin Patricia District School Board
- Kenora Association for Community Living
- Kenora Chiefs Advisory
- Kenora Catholic District School Board
- Kenora Rainy River Child and Family Services
- Lake of the Woods District Hospital, Mental Health and Addictions Programs
- Métis Nation of Ontario
- Ne-Chee Friendship Centre
- Ontario Provincial Police, Ministry of Community Safety and Correctional Services
- Thunder Bay Regional Health Sciences centre, Youth Forensics Program
- Victim Witness Services, Ministry of the Attorney General
- William W. Creighton Youth Services
- WJS Canada
- Youth Justice (Probation), Ministry of Child and Youth Services

*Participating agencies will be updated annually.

7.3 Roles, Responsibilities, and Governance

Co-Chairs

- Prepare agendas, convene, and facilitate the Service Collaborative meetings
- Attend a minimum of 80% of all Service Collaborative and Implementation Team meetings
- Assign work tasks to members
- Incorporate feedback and content provided by members, as appropriate
- Ensure progress on overall project implementation and action plan
- Ensure progress on fidelity checklist
- Ensure the perspectives of all members are heard and respected
- Communicate information outside the Service Collaborative as determined and agreed upon by the Service Collaborative

Member Agencies

- Review materials in advance of meetings as applicable
- Have the ability to make decisions within the agency/institution represented
- Attend meetings/designate an alternate to attend scheduled meetings as needed
- Respond to requests within specified timeframe
- Communicate back to agency/organization regarding progress on project as relevant/appropriate
- Participate in development and execution of implementation and action plan
- Participate in evaluation and data collection throughout the project
- Complete fidelity checklist for agency/organization and report progress to Service Collaborative
- Provide direction and feedback to Service Collaborative Implementation Team
- Participate as a member of the Service Collaborative Implementation Team, if applicable

- Oversee effective execution of the implementation and action plan at the agency and system level
- Monitor process and intervention outcomes against objectives
- Advocate for resources, policy, and system changes

Governance

- The Service Collaborative will be co-chaired by local leaders who have the ability to lead the engagement of respective collaborative members to implement the action plan
- The Co-chairs will be selected by the membership
- The Co-chairs will make an effort to achieve consensus on issues requiring a decision. In the event that consensus cannot be reached, the voting members may resort to a vote. No decisions will be executed unless there is quorum present (simple majority of 50% +1) and of quorum present 66% or 2/3's are in favour of the decision.

Frequency of Meeting

- The Service Collaborative members will establish meeting frequency based on the demands and timeline of the implementation and action plan. Members will be expected to participate in the majority of the meetings held throughout each year to maintain their membership. Members are asked to assign an alternate representative who will attend meetings when they are unable to.
- Frequency of meetings will be determined by the Service Collaborative membership. Meetings may occur for both the Service Collaborative membership as a whole, as well as identified Service Collaborative Implementation Team members.
- Service Collaborative meetings will be accessible via OTN and teleconference whenever possible to ensure participation by those unable to attend in-person.