Snohomish County
Restorative Trauma Informed CARE
Train the Trainer Training
2020

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Acknowledgments

We would like to give special thanks to the CARE Trainers, CARE Organizations, Champions, and all those who contribute to building Restorative Trauma Informed CARE in Snohomish County.

Agenda

Week 1:

- **Tuesday, August 18th**
  9:00 a.m. - 1:00 p.m. - Introduction to Trauma Informed Care
  Liza Patchen-Short & Laura Mote

- **Wednesday, August 19th**
  9:00 a.m. - 1:00 p.m. - Equity and the Intersection of Trauma Informed Practices
  Tami Farber

- **Thursday, August 20th**
  9:00 a.m. - 1:00 p.m. - Restorative Practices
  Mary Cline-Stively

Week 2:

- **Tuesday, August 25th**
  9:00 a.m. - 1:00 p.m. – Adverse Childhood Experiences
  Joe Neigel & Erin Wood

- **Thursday, August 27th**
  9:00 a.m. - 1:00 p.m. – Adverse Childhood Experiences Deep Dive and Practice
  Joe Neigel & Erin Wood

Week 3:

- **Tuesday, September 1st**
  9:00 a.m. - 1:00 p.m. – Trauma 101 & Resiliency
  Heather Perry

- **Thursday, September 3rd**
  9:00- a.m. - 1:00 p.m. – Trauma 101 & Resiliency Deep Dive and Practice
  Heather Perry & Lindsey Greene

Week 4:

- **Thursday, September 10th**
  9:00 a.m. - 1:00 p.m. – Self-Care & Secondary Traumatic Stress
  Lindsey Greene

- **Friday, September 11th**
  9:00 a.m. - 1:00 p.m. – Self-Care & Secondary Traumatic Stress Deep Dive and Practice & Closing
  Lindsey Greene & Heather Perry

Trauma Informed CARE Champions

Liza Patchen-Short
Children's Mental Health Liaison

Liza Patchen-Short works at Snohomish County in the Human Services Behavioral Health Division as the Children's Mental Health Liaison. Liza has a Bachelor's Degree in Social Work and Master's Degree in Human Services with a focus on resiliency. Liza has over thirty years working in the non-profit sector advocating for youth and families. She is the co-chair of the Snohomish County Children's Wellness Coalition, and is leading the charge by supporting schools, community organizations and the community at large in building a Restorative Trauma Informed Community. Liza is co-facilitating the initial cohorts learning collaboratives to build a strong foundation for a trauma informed community. Liza is married and has two wonderful sons and three great stepsons.

Laura Mote
Mental Health Community Support Specialist

Laura Mote is the Mental Health Community Support Specialist with Snohomish County Behavioral Health for the Denney Juvenile Justice System. Laura holds a Master of Social Work Degree with a focus in adolescent trauma. Laura has worked with high risk youth for over ten years. She is the co-chair of the Snohomish County Children's Wellness Coalition. Laura is a dedicated leader in building a Restorative Trauma Informed Community. Laura is co-facilitating the initial cohorts learning collaboratives to build a strong foundation for a trauma informed community. Laura is devoted to her two dogs.

Mary Cline-Stively
Restorative Practices and Adult Learning Trainer

Mary Cline-Stively started her career working in the mental health field for fifteen years and then transitioned into organization development consulting for another five years. For the past ten years she has worked at ChildStrive and currently serves as the Chief Strategy and Programs Officer. Mary holds a Master's Degree in Organizational Psychology as well as a Graduate Certificate in Restorative Practice. Mary is a licensed trainer for the International Institute of Restorative Practice.

Together, Laura, Liza, and Mary work diligently to bring Restorative Trauma Informed CARE in a way that organizations can systemically bring sustainable changes for the community at large.

Welcome!

Congratulations and Welcome to Snohomish County's CARE Restorative Trauma Informed Train the Trainer Training. You are now a part of CARE Cohort 3. You are joining a movement to help Snohomish County become a restorative trauma informed community. Your commitment and presence states that your organization has committed to become a CARE organization and trusts you are the right person to help. You and your coworker/s have been awarded to be the organizational champions to help implement and shift a culture that aligns with the actions and principles of restorative trauma informed care. The long-term goal is sustainable change, meaning your policies and procedures will reflect these values and principles. This is a process and will take time. That is normal and expected.

Snohomish County Human Services Behavioral Health and The Children's Wellness Coalition have been working in partnership on this work since 2015. More recently, ChildStrive and Snohomish County are working together to blend trauma informed and restorative practices to strengthen the work. ChildStrive and Snohomish County are working in partnership with the Children's Wellness Coalition to deepen the collaboration that occurs when trauma informed practice and restorative practice are brought together to create organizational and community change.

The vision for this partnership is for all Snohomish County residents to thrive in an equitable, sustainable environment that cultivates relationships and a strong feeling of belonging.

Why is it Important for Organizations to Implement these Practices

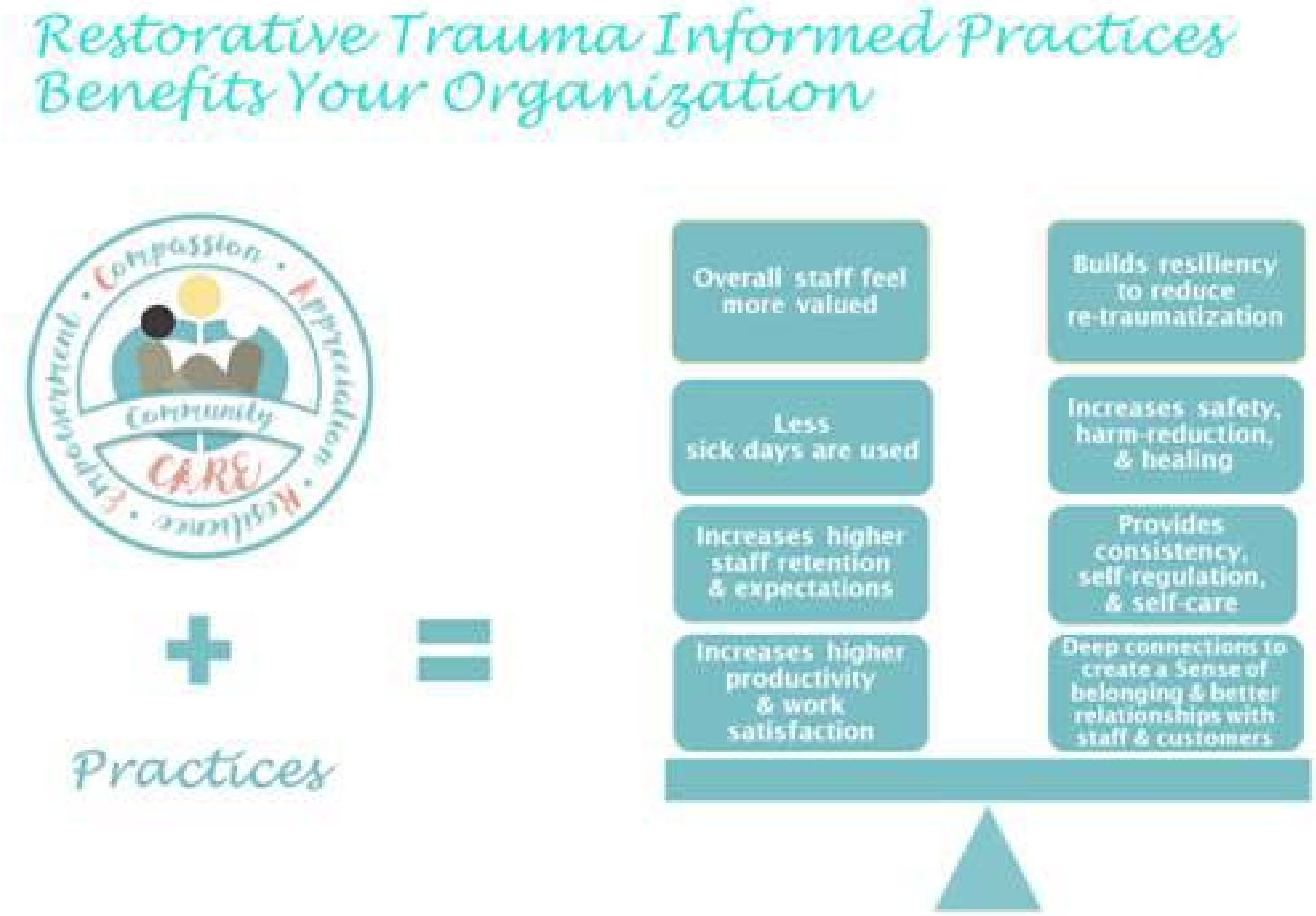
Advancements in brain science over the past two decades have confirmed that our environments have a significant impact on our brains, and brain states affect individual behavior. Stressful environments can trigger behaviors that are challenging and difficult for others to understand. Environments that feel safe result in calmer more cooperative behaviors.

From an organizational perspective, predictable and safe environments make the best working environments and produce many of the outcomes that leaders want (but that often feel elusive), including:

- **Consumers** who engage more actively in services, experience fewer setbacks, and ultimately see better outcomes.
- **Frontline staff** who attend work regularly, stay in their positions longer, and are more productive.
- **Supervisors and managers** who experience significantly less burnout, because their staff routinely come to them with solutions, not problems.
- **Teams** that understand and act in alignment with the organizational mission, interact with greater empathy and shared accountability, experience fewer conflicts, and resolve conflicts quickly and effectively when they arise.

Organizational development research tells us that high-performing organizations achieve results like these by intentionally developing healthy relationships. Trauma informed practice and restorative practice are two best practices for doing so.

The Benefits of Being a CARE Organization



What Does It Mean To Be Trauma Informed

A trauma informed system involves recognizing and responding to the impact of traumatic stress for all those you serve and work with. The goal is to maximize safety, support, relationships, and healing so all have the ability to thrive.

Trauma Informed practice focuses on sustainable change by creating environments of safety, healing, and support. This practice shifts from an attitude of, “What is wrong with this person?” to, “What has happened to this person?”

What Is Restorative Practices

Restorative Practice is a specific approach to building stronger relationships between people and stronger social connections within communities. It is a framework that helps us focus on relationships first, before addressing problems. Restorative Practice gives us practical tools to truly work *with* others, rather than doing things *for* or *to* them.

Restorative Practice arose from the tradition of restorative justice, a method of bringing together those who have *caused* harm and those who have *been* harmed, to repair relationships. Restorative Practice takes that a step further, because practitioners have found that when we spend more of our time proactively building community, we have fewer conflicts to resolve. Specific restorative practices range from informal (impromptu statements and questions) to formal (circles and conferences).

Why Are We Taking A Whole-Community Approach

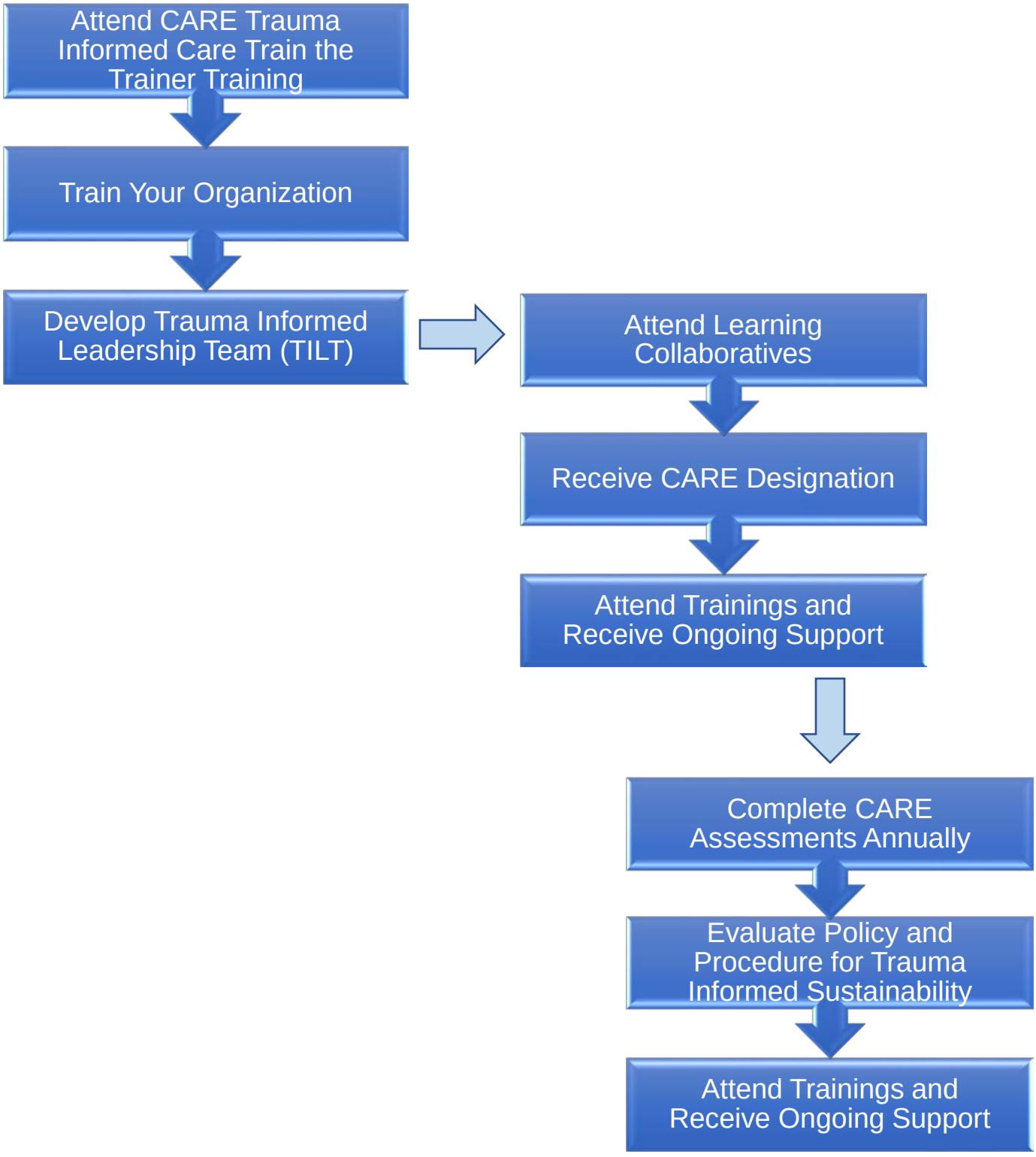
Using these practices within a single organization is beneficial. But imagine what might happen if we could increase feelings of safety and belonging, not just within a few select organizations, but across the entire community!

- Would consumers come in for their appointments feeling calmer and ready to work toward their goals?
- Would consumers, staff, and community partners share a common language that accelerates their ability to build rapport and trust?
- Would consumers come to believe that the network of community-based supports and services truly cares about working in partnership with them to support their well-being?
- Would it be easier to hire staff who already share your team's vocabulary and culture?

Three years ago, the Children’s Wellness Coalition established CARE, a county trauma informed approach. Twenty-five organizations like yours have earned a CARE site designation by completing the CARE training and embedding trauma informed workplace principles and policies.

The Vision of a Trauma Informed Restorative Community

Our Approach to a Sustainable Restorative Trauma Informed Organization



What is CARE?

Compassion, Appreciation, Resilience and Empowerment

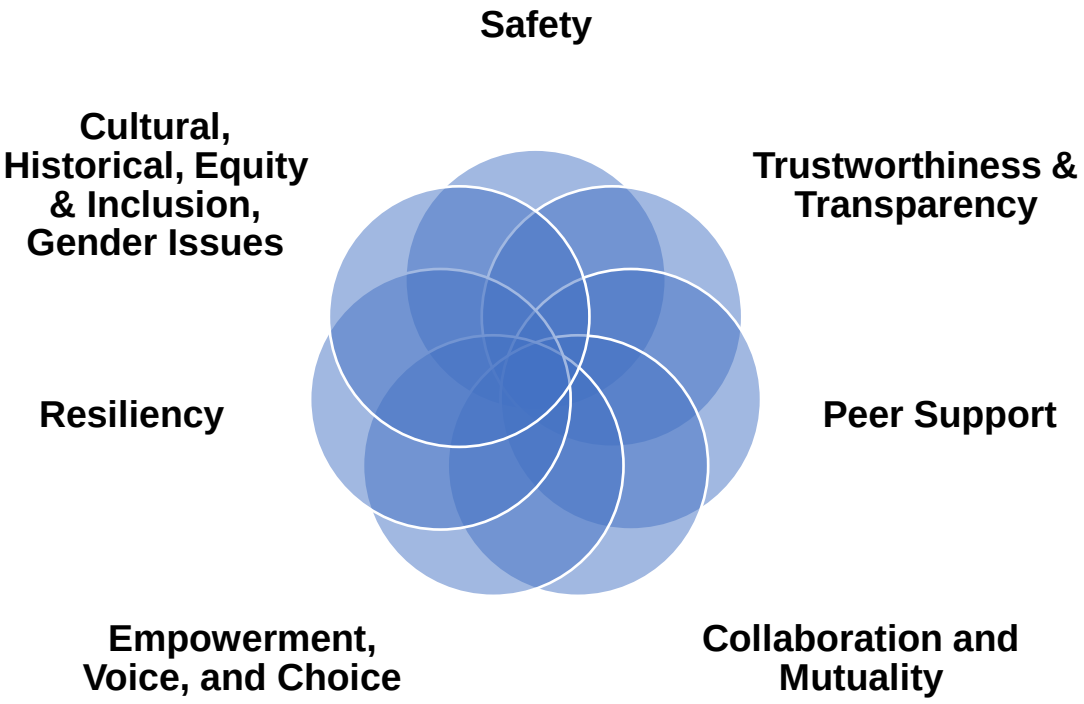
Like you, we believe children are our greatest assets. That is why our goal is to equip all Snohomish County communities with the tools to become trauma informed. Trauma Informed Communities (TIC) are crucial to the growth and well-being of our future.
In this pursuit, the Children's Wellness Coalition has adopted guiding principles for our communities, organizations, and families.

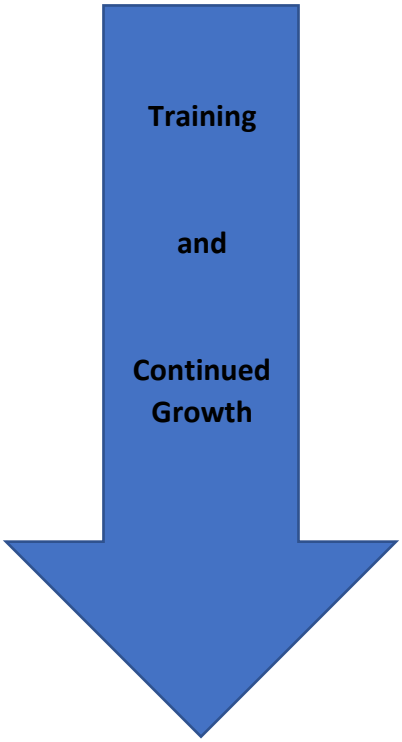
CARE organizations make a commitment to a paradigm shift into a restorative trauma informed organization to include celebrating the organizational strengths as well as guiding and implementing trauma informed principles into each organizations policy, procedures and daily practices. Trainings, support, and technical assistance from CARE Community are ongoing. The CARE certification is the acknowledgement of organizations that embody Trauma Informed Principles.

To become an official CARE Designated Organization:

- The CARE trainers train the core modules to all their entire organization within a one-year time from the Train the Trainer training
- Each organization has a TILT (Trauma Informed Leadership Team) team that meets monthly
- Each organization is willing to work and set goals based on the Standard of Practice Assessment
- Each organization is a part of the CARE learning collaborative community

Trauma Informed Guiding Principles





Safety
Building relationships with others based on mutual respect and inclusion of all individuals. Promoting a safe, physical and emotional environment by understanding the brain science and ACEs of the individuals with whom we come in contact.

Trustworthiness & Transparency
Fostering positive relationships based on trust and honesty among community members. (staff, schools, family members, police, treatment providers)

Peer Support
Identifying common concerns or issues of the community and engaging in collective problem solving. Recognizing and actively working towards solving the needs of every individual.

Collaboration and Mutuality
Recognizing the importance of all roles within the organization and developing involvement and opportunity for decision making. Collaborating with community members, families, and agency's within Snohomish County to promote trauma informed care.

Empowerment, Voice, and Choice
Recognizing that every person's experience is unique and requires an individualized approach. Opportunities to empower all individual's voice and choice is provided.

Resiliency
Building resiliency by modeling compassion with each interaction. Providing the opportunity to promote recovery and ability to bounce back from traumas individuals, agencies and the community has experienced.

Cultural, Historical, Equity & Inclusion, Gender issues
Appreciating the differences and everyone's unique experiences by practicing cultural competency. Implementing equity and inclusion practices.

Training
Attending training and following through with requirements.

Continued Growth

Continuing to be actively engaged in the community, as an entire system, in promoting trauma informed practices reflected in the agency's overall business model and operations.

Children's Wellness Coalition (CWC)

The Children's Wellness Coalition (CWC) meets monthly, the third Friday from 9:00-10:30 a.m. at the Community Resource Center 3900 Broadway Everett, WA 98201. During COVID we will meet on Zoom. The CWC is committed to engaging the community to ensure all children and youth in Snohomish County flourish, equipped with resiliency. The meeting dates are as follows:

August 21, 2020	2021 Dates TBA
September 18, 2020	
October 16, 2020	
November 20, 2020	

Past minutes are stored under the coalition's website:
www.snocochildrenswellnesscoalition.com

This coalition is an open group so please consider coming and inviting your colleagues. This coalition website has many videos, resources and updates regarding the CARE work. Please get acquainted with this website and feel free to use anything that will help support your work. The CARE TOT forum member password is: **protectourfuture**

The county's overall strategy is to build trauma informed schools and organizations. To date, ten districts are involved in this work and over thirty schools. Our goal is to add up to ten more schools every year. It is our intent over time to support all the schools in the county. Our aim is to help decrease suspensions, expulsions, increase a sense of belonging, build stronger relationships, skills and support best practices.

Our community initiative is growing. We have developed an interactive map that shows all the schools and organizations committed to this work. https://arcg.is./01CfW. This tool is intended to help you in your work with finding supportive organizations and for you to think about ways to collaborate with other organizations who share a common language and mission.

The CARE Decal

Once you complete your organizations training on the core competencies of trauma informed practices your organization is eligible for the CARE 8 x 8 decal/s. Please let us know when that is completed, and we will make sure you get the right number of decals needed. Please display your decal at your front entrance and any other prominent places. In addition, your organization will be added to the CARE interactive map. Please take a picture of staff in front of your logo and email it to liza.Patchen-Short@snoco.org and it will be loaded on the CWC photo gallery.

Website Acknowledgement of CARE Certification:
[Agency/Organization] is proud to be designated an official CARE Community site.

CARE – Compassion, Appreciation, Resilience, Empowerment

In partnership with the Snohomish County Children's Wellness Coalition, Snohomish County Human Services and other organizations throughout Snohomish County, we are committed to implementing trauma informed practices and policies.

We are dedicated to staff professional development, participation in ongoing learning communities and operational change that focuses on the key foundations of Trauma Informed Care, Adverse Childhood Experiences, Brain Science, Resiliency, Restorative Practice, Equity, and Self-Care/Secondary Traumatic Stress.

What Did Your Organization Commit to Being a CARE Organization

Duration
The term of this Agreement shall be for 24 (twenty-four) months beginning August, 2020 through September 30th, 2022.

Duties of the Representative/s

- The representatives from each organization shall attend all the virtual days of the Trauma Informed CARE Train the Trainer 2020.
- Each representative should use Zoom as their virtual platform with access to the speaker and camera. We ask that this is turned on during designated times throughout the entire training. The goal is to help us connect and deepen the learning.
- We are asking that you make a commitment to be fully present for this training. We understand critical needs might arise that you need to attend to. If that happens, please do so discreetly and return back as soon as you can.
- The representative's fee to attend this training shall be waived in lieu of this signed agreement.
- The representative shall participate in a minimum of six (6) additional mandatory learning collaboratives, each year, over two years. These meetings will provide supplemental training, support, and will be a time to provide updates about CARE efforts, successes, challenges and accomplishments. The theme for the learning community sessions is, "Learn more, share more, practice more."
- Each organization is willing to complete a readiness assessment for the entire organization before they come to the training.
- Each organization will identify at least one practice area to change ongoing and work towards others as they see fit.
- Each organization will form a TILT (Trauma Informed Leadership Team) that meets at least monthly. This diverse organizational team of 4-6 individuals will help guide and move forward Trauma Informed Practices at each organization. The Standard of Practices tool will help guide the TILT to strengthen their organization and help make sustainable organizational climate change.
- The representative shall train their workplace to include all the components of Trauma Informed Practices—within the agreement timeframe. The core 6 hour training shall be completed by no later than September 30th, 2021.
- Once completed the organization is eligible for the CARE decal and will be added to the CARE interactive map. https://arcg.is/01CSfW

- The representative shall display the official “CARE Trained” window-cling logo in a high traffic location at their workplace. The window-cling provided will not be larger than 8x8 inches. A photo should be taken of putting up the decal and sent to the CWC website to put on the CARE photo gallery.
- The representative shall become an advocate for incorporating the Coalition’s Community CARE Designation Guiding Principles into their workplace.
- The organization may put information on their website regarding their CARE designation provided by the Children’s Wellness Coalition. The site shall strive towards the trauma informed principles and guidelines.
- Implement the Children’s Wellness Coalition Standards of Practice into the workplace.
- The representative’s agency shall be listed on the Coalition’s “CARE Trained” webpage at www.snohomishcountychildrenswellnesscoalition.com**.**

Duties of the Coalition

- The Coalition shall convene the nine (9) day virtual training. **(**The Trainee’s fee to attend this training shall be waived in lieu of this signed agreement.)
- The Coalition shall coordinate and facilitate a minimum of six (6) follow-up learning community collaboratives per year to provide additional training to participants.
- The Coalition shall provide a “CARE Trained” window-decal to the representative’s organization.
- The Coalition shall provide additional technical assistance for the representative upon request and as availability allows.

Learning Collaboratives

Learning collaboratives are a way to get support, resources, and to further your knowledge of Trauma Informed Care and grow the CARE community.

Cohort 3's learning collaborative will be held on the 2nd week of the month. You will be assigned to either a morning or afternoon collaborative at the end of the week's training. The collaboratives will begin in October and go through September 2021. The learning collaboratives will take place on Zoom until further notice.

The sessions are scheduled for the second Tuesday of the month. In the mornings from 9:00 a.m. – 10:30 a.m. and the afternoons from 1:00 p.m. – 2:30 p.m.

ZOOM Links will be provided following the training.

October 13, 2020	January 12, 2021	April 13, 2021	July 13, 2021
November 10, 2020	February 9, 2021	May 11, 2021	August 10, 2021
December 8, 2020	March 9, 2021	June 8, 2021	September 14, 2021

The Thursday sessions are scheduled for the second Thursday of the month. In the mornings from 9:00 a.m. – 10:30 a.m. and the afternoons from 1:00 p.m. – 2:30 p.m.

October 8, 2020	January 14, 2021	April 8, 2021	July 8, 2021
November 12, 2020	February 11, 2021	May 13, 2021	August 12, 2021
December 10, 2020	March 11, 2021	June 10, 2021	September 9, 2021

Trauma Informed Leadership Team (TILT Team)

The Trauma Informed Leadership Team (TILT) ideally is a diverse representation of team members from each department (such as administration, support staff, human resources, and direct services). The goal of the TILT team is to review, shape, and lead paradigm shifts to embed the trauma informed principles into policies, procedures, and practices within your organization. It is recommended that TILT teams meet monthly, the same time and place, to provide consistency and reliability. The monthly TILT report can assist with guiding your TILT team. For more information on how to form a TILT team, please see the Children's Wellness Coalition CARE forum page and go to TILT module. It is recommended that your first TILT meeting watches the TILT module.

TILT Report
(Trauma Informed Leadership Team)
Please keep this report brief and limit narrative to bullet points ☺

Date:
Agency name and program:

What concrete steps has your agency taken since the last meeting to move toward the CARE designation? (ex. Scheduled internal staff training on date)

-
-
-

What challenges have you encountered?

-
-
-

What additional supports do you need to be successful in achieving the CARE designation for your program?

-
-
-

Anything else you would like to share at our meeting?

Please submit this report to your CARE community facilitator prior to the quarterly in person meeting.

Recertification

Members of the Children's Wellness Coalition met and determined that having a CARE recertification process every two years would be best practice. The goal of the recertification process is to learn and strengthen skills, integrate new research, and continue to build systemic change in your organization. You are probably asking "what does the recertification process look like?"

Attached is the recertification application that needs to completed and emailed to Liza Patchen-Short. Liza.patchen-short@snoco.org

- Your organization must also complete a Continuum of CARE Assessment yearly. The assessment can be found at https://www.surveymonkey.com/r/RVVFXN5
- A minimum of two TILT members attend two CARE trainings over the next two years.
- Participate in a TILT Leadership Facilitated Change Management Cohort

There will be a recertification application that will be uploaded to the Children's Wellness Coalition website for you to complete or get from county staff.

The application can be emailed to Liza Patchen-Short at liza.patchen-short@snoco.org

CARE Recertification Application

Please complete a Continuum of CARE Assessment. The assessment can be found at https://www.surveymonkey.com/r/RVVFXN5

Date:
Organization Name:
Contact Person/s:

- Over the last two years what Trauma Informed work are you most proud of?
- How has this work changed the culture of your organization?
- What opportunities still are ahead?
- Do you feel this culture is embedded in your organization? If so, what are some examples?
- What are some examples of your organization's sustainable practices?
- What goals are your organization committed to work toward now?
- Does your TILT team meet regularly?
- What support/s do you feel you will need to continue to be a CARE designated organization?
- Anything else you want to share?

Adult Learning Summary

Characteristics of Adult Learners (adapted from Malcolm Shepherd Knowles)

1. **Self-Concept:** as we become adults, we become self-directed human beings. Therefore, we want to be able to take some ownership of our learning and be an active participant.
2. **Adult Learner Experience:** As adults we are building experiences that become a great resource for learning. Therefore, we want to be able to incorporate our experiences into our learning.
3. **Readiness to Learn:** Change is hard for everyone. We may access learning situations where the material is different than how we have experienced previously. Adults tend to prefer being part of a "facilitated co-learning experience" verses being taught by the "teacher/expert".
4. **Orientation to learning:** As adults we tend to want our learning to be closely related to our life or work. We want to be able to attach the learning to real life experiences and we want the learning to help us "solve problems" or to make things different.
5. **Motivation to Learn:** Generally, most adult's motivation is internal. Adults want to understand how the material will impact their life.

Things to consider:

Creating a "gracious space" - all feel welcome and their voice is important.

- Start with a check in, introduction type exercises with minimal self-disclosure – building toward creating brave spaces to share throughout the time together.
- Community or group agreements: use as a way to gain engagement early on.
- Clear learning objectives: so, everyone is clear why they are in the room, ask if there are other things folks were hoping for.
- Use a circle process to ensure all voices are heard.
- Ensure everyone has logistical info – restrooms, breaks, how to use technology, etc.
- Be explicit on expectations ("would like to hear from everyone", feel free to pass, "popcorn" style, etc.)
- End with some sort of check out, reflection - how they experienced the time, exercise

Opportunities for engagement – think about ways to practice being "with" the participants

- If material is being read out load, ask for volunteers.
- Use "pair-share" exercises, even if only a few minutes to turn to partner, then group hi-lights.
- Ask "what questions do you have" vs. "any questions?".
- Provide real-life experiences and examples. Ask for examples from the group.
- Use language like "what was your take away", "a-ha moment", "experience" when trying to encourage sharing.
- Use small group interactions whenever possible.
- Use silence – it may mean that folks are absorbing material. It is okay to pause and give a minute for reflection.
- Provide content and then provide some sort of opportunity for engagement around the material like a few minutes of self-reflection, pair-share, small group, etc. The important part is integration, experience and/or practice of material to help make it their own.
- Use self-assessment type of tools or questions as a way to mitigate the gap of experience and the new information.
- Provide a variety of different ways to access the material - Visual; auditory; kinesthetic; etc.

Being Curious - as the trainer, you set the stage

- Use reflective, open ended questions.
- Provide feedback using a strengths based approach: "that might work, another options might be to try XXXX" or "yes and XXXX".
- Ask questions to better understand verses jumping to the conclusion – "can you say more about " or "can you give me an example of when you had that experience".
- Check in with the group: is the pace working, do folks need a break, etc.
- Model being curious, vulnerable, brave and centered (take a deep breath).
- Stay neutral – acknowledge a contribution to the conversation without judgement.

Training PowerPoints & Resources

Liza Patchen-Short
Trauma Informed CARE Trainer

Liza Patchen-Short works at Snohomish County in the Human Services Behavioral Health Division as the Children's Mental Health Liaison. Liza has a Bachelor's Degree in Social Work and Master's Degree in Human Services with a focus on resiliency. Liza has over thirty years working in the non-profit sector advocating for youth and families. She is the co-chair of the Snohomish County Children's Wellness Coalition, and is leading the charge by supporting schools, community organizations and the community at large in building a Restorative Trauma Informed Community. Liza is co-facilitating the initial cohorts learning collaboratives to build a strong foundation for a trauma informed community. Liza is married and has two wonderful sons and three great stepsons.

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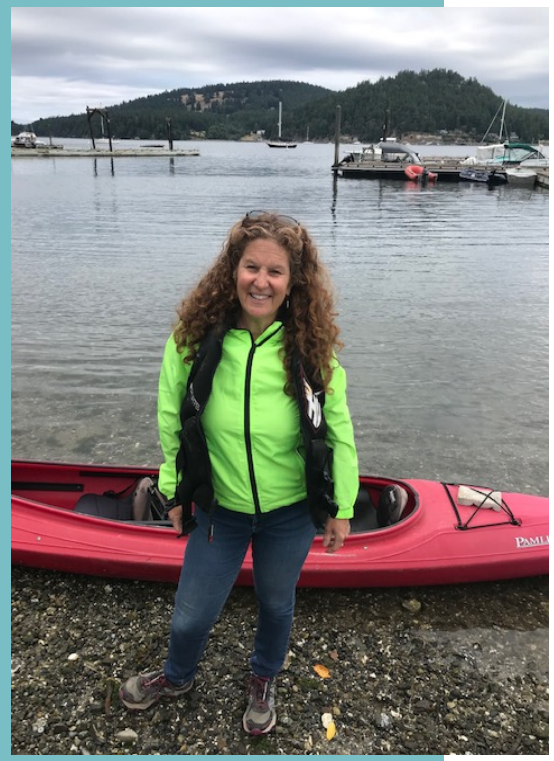
Trauma Informed Care

Presented by
Liza Patchen-Short & Laura Mote

Thank You for your participation and partnership!

Building a Restorative Trauma Informed Community in Snohomish County

Compassion ○ Appreciation ○ Resilience ○ Empowerment



Liza Patchen-Short, MA, LMHCA, MHP, CMHS

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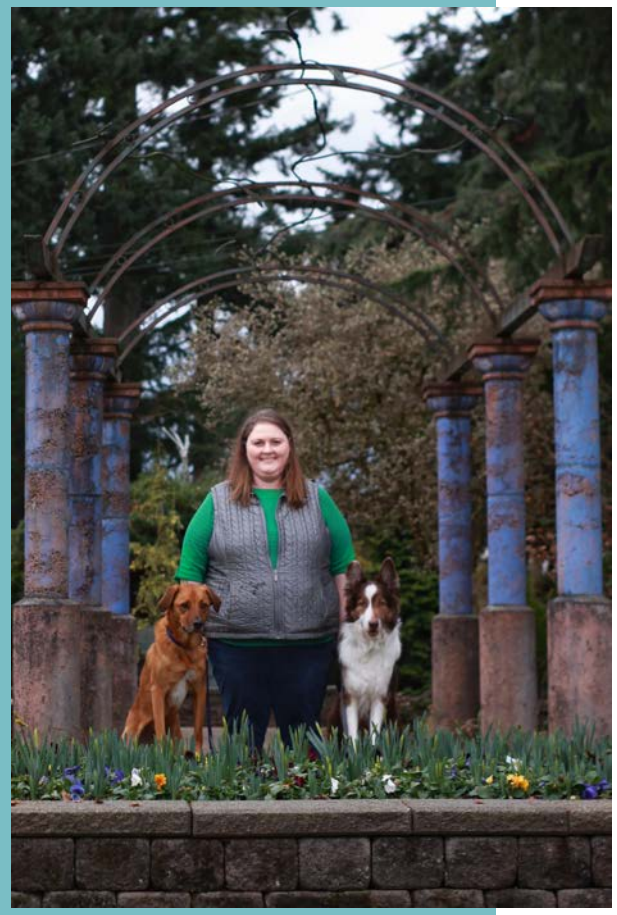


Laura Mote, LSWAIC, MHP

Laura Mote is the Mental Health Community Support Specialist with Snohomish County Behavioral Health for the Denney Juvenile Justice System. Laura holds a Master of Social Work Degree with a focus in adolescent trauma. Laura has worked with high risk youth for over ten years. She is the co-chair of the Snohomish County Children's Wellness Coalition. Laura is a dedicated leader in building a Restorative Trauma Informed Community. Laura is co-facilitating the initial cohorts learning collaboratives to build a strong foundation for a trauma informed community. Laura is devoted to her two dogs.

Together, Laura and Liza work diligently to bring Restorative Trauma Informed CARE in a way that organizations can systemically bring sustainable changes for the community at large.

Compassion ○ Appreciation ○ Resilience ○ Empowerment

Hopes for the Training

- ✓ Understand your role as a **CARE champion and the process of becoming a CARE organization**
- ✓ Understand how to **apply and internalize Restorative & Trauma Informed principles and frameworks** in your practice and begin to use that lens in your daily work
- ✓ Understand the impacts of **Adverse Childhood Experiences (ACEs)**
- ✓ Discuss the role and characteristics of **Resiliency**
- ✓ Learn the basic tenets of **Brain Science and Self-Care, and it's relationship to Trauma Informed Practices**
- ✓ Understand the complex cultural, social, economic, and political forces that impact the lives of our children, families, and communities as a way to identify the root cause of trauma with a **shared equity analysis**.

Compassion ○ Appreciation ○ Resilience ○ Empowerment

August 18 - Introduction to Trauma Informed CARE

9:00 a.m.-9:15 am	Introduction to the Week
9:15 am-9:45 am	Check-In
9:45-am-11:00 am	What is Trauma and What is the Importance and Values of a Trauma Informed Organization
11:00 am-11:50 pm	Trauma Informed CARE
11:50 am-12:00 am	Break
12:00 pm-12:50 pm	Deep Dive and Questions
12:50 pm-1:00 pm	Reflection & Journaling and Closing

Land Acknowledgment

I would like to begin by acknowledging that we gather today on the ancestral homelands of the Coast Salish Peoples, who have lived in the Salish Sea basin, throughout the San Juan Islands and the North Cascades watershed, who since time immemorial have taken care of, hunted, fished and gathered on these lands. We respect their sovereignty, their right to self-determination, and we honor their sacred spiritual connection with the land and water. Please join me in expressing our deepest respect and gratitude for our indigenous neighbors, the Tulalip Tribes, the Snohomish, the Stillaguamish Tribe and the Sauk-Suiattle Tribe, for their enduring care and protection of these lands and waterways.

Grounding exercise

Blue Orb Meditation

Compassion ○ Appreciation ○ Resilience ○ Empowerment

What do you need to give yourself permission to do, feel, or not do to show up for this training session?

Sometimes the first step in getting started is giving ourselves permission.

Maybe you need to give yourself permission to:

1. Stay open minded
2. Give yourself the time you need today
3. Make a list of questions
4. Show up to the group meetings
5. Ask for what you need
6. To pass during group sharing
7. Let go of all the other hats you wear during our time together
8. Be vulnerable

Type your permission slips in the chat window and feel free to have more than one.

Group Agreements

RESPECT WHERE YOU AND OTHERS ARE

WHAT IS LEARNED HERE, LEAVES HERE: WHAT IS SAID HERE, STAYS HERE

OFFER COMPASSION, FOR SELF AND OTHERS

SUPPORT A SPACE FOR LEARNING AND REFLECTION

EVERYONE HOLDS A DIFFERENT PIECE OF THE PUZZLE

OKAY TO NOT HAVE ANSWERS OR SOLUTIONS

ACCOUNTABILITY: LEAN IN, LEAN BACK (E.G. BREAKOUT ROOMS)

OTHER

Compassion ○ Appreciation ○ Resilience ○ Empowerment

If group agreements are broken

We will contact you via email to discuss ways to support you

Introductions

Building a Restorative Trauma Informed Workplace: A Culture of Connection

Compassion ○ Appreciation ○ Resilience ○ Empowerment

So Why Be a Restorative Trauma Informed Organization?

Why Trauma Informed?

- Building relationships, a sense of belonging, trust and connection creates a workplace culture of healing.
- The paradigm shift becomes not what is wrong with you but what has happened to you.
- Trauma informed, restorative principles aim at insuring environments and services to be welcoming, healing and provides a sense of belonging to all.

Under the Surface

Breakout Group Discussion

What did you notice or find important ?

Acute vs. Complex Trauma

Acute trauma is caused by a **single traumatic event** that causes extreme emotional or physical stress.

Common examples :

- An accident
- An act of violence
- A natural disaster
- A loved one's passing
- Physical or sexual assault
- COVID-19

Complex Trauma is caused by exposure to **multiple traumatic events.** The long-term impact of this exposure is **severe and pervasive**.

- Many children with complex trauma histories suffer a variety of traumatic events, such as physical and sexual abuse, witnessing domestic and community violence, separation from family members, and revictimization by others
- Often begins early in life
- Can disrupt child's development and formation of self

Behavior is an Iceberg

How Does Trauma Affect Us and the People We Serve and Work With?

Initial reactions to trauma can include: exhaustion, confusion, sadness, anxiety, agitation, numbness, dissociation, confusion, physical arousal, and blunted affect or emotions .

Behaviors can include: intense and ongoing emotional upset, depressive symptoms or anxiety, behavioral changes, difficulties with self-regulation, problems relating to others or forming attachments, regression or loss of previously acquired skills, attention seeking or inability to concentrate that looks like ADHD.

What is Trauma Informed Care?

Trauma Informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma…that emphasizes relationships, being curious, non-judgmental, and creates space for physical, psychological, and emotional safety for all. This paradigm shift builds and allows for opportunities to rebuild and keep a sense of empowerment and resiliency.

What is a Trauma Informed System?

"A human services or health care system whose primary mission is altered by virtue knowledge about trauma and the impact it has on the lives of consumers receiving services"

Maxine Harris (2004)
Executive Director of The National Capital Center for Trauma Recovery and Empowerment

What does a Trauma Informed Organization look like

Workplace Principles

Safety –

Building relationships with others based on mutual respect and inclusion of all individuals. The goal is to promote a secure, safe, physically and emotionally, environment by building positive relationships that build resiliency for all in each interaction.

Trustworthiness & Transparency-

Fostering positive relationships based on trust and honesty. Share as much information as possible, relational.

Peer Support-

Identifying common concerns within the community and engaging in collective problem solving. This means recognizing and actively working towards solving the needs of every individual.

Collaboration and Mutuality-

Recognizing the importance of all roles within the organization and developing equal opportunities for decision making. Best practice is to collaborate with community members, families, and organizations within Snohomish County to promote trauma informed principles and systems of care. Allow time for social interaction for staff to stay in touch with family and team members during COVID times.

Compassion ○ Appreciation ○ Resilience ○ Empowerment

Workplace Trauma Informed Principles

Empowerment, Voice, and Choice-

Recognizing that every person's experience is unique and requires an individualized approach. Create opportunities and systems that empower *all* individual's voice and choice. Seek staff and consumers input.

Resiliency-

Building resiliency by modeling compassion and regulation with each interaction and by providing skills and protective factors. Providing the opportunity to promote recovery and the ability to bounce back from adverse conditions.

Cultural, Historical, Gender issues-

Appreciating and celebrating the differences and each individual's unique experiences by practicing cultural competency. Implementing a competency lens of cultural , historical and gender issues in your daily work.

Compassion ○ Appreciation ○ Resilience ○ Empowerment

Reflection Time…..

Any Questions?

Internal Processing Prompt- 10 min

What engages you about being a trauma informed care champion for your organization?

Breakout Rooms -15 min

- What workplace principle do you feel is a daily/weekly practice for you? What do you notice, see and feel that you do?
- What workplace principle is more challenging for you? What do you think makes it difficult?

Break – 10 minutes

What Can We Do?
Build Systems and Frameworks That Are:

- **Clear, consistent, predictable** and follow through to ensure emotional safety
- **Validate**
- **Teach self-regulation, and curiosity**
- **Assume positive intent**, build on success, rather than establishing limits
- **Teach and expect de-escalation**
- **Check assumptions** - observe and ask questions
- Always have an **equity** and **inclusion** lens on in daily work

- Deeply listen, notice **strengths and successes**
- **Maintain high expectations**
- Provide guided opportunities for **voice and choice** participation
- **No** re-traumatizing , strive for healing
- Focus on developing feelings of **safety, trust, and reliability** within the relationship
- **Embed Self-Care into your organization**– it is an ethical obligation.

Those who have been in the midst of trauma or toxic stress have difficulty understanding their own emotions and communicating them appropriately – they tend to use behaviors to communicate their emotions.

Compassion ○ Appreciation ○ Resilience ○ Empowerment

The benefits and importance of this work with the people we serve and those we serve with

- Staff become more regulated, flexible and resilient. A better sense of wellbeing for all.
- A trauma Informed workplace is calmer and staff have deeper relationships
- Staff and customers feel like they belong and are heard
- We prioritize human over tasks
- We find out the real story and do not make judgements or assumptions
- Mental health days are supported instead of absenteeism
- Increased productivity and retention

NO TRAUMA INFORMED CARE LENS	TRAUMA INFORMED CARE LENS
POWER OVER	POWER WITH
YOU CAN'T CHANGE	NEUROPLASTICITY CAN CHANGE
PEOPLE NEED FIXING FIRST	PEOPLE NEED SAFETY FIRST
OPERATE FROM THE DOMINANT CULTURE	CULTURE HUMILITY
PEOPLE ARE OUT TO GET YOU	PEOPLE CAN LIVE UP TO THE TRUST YOU GIVE THEM
THERE'S ONLY RIGHT OR WRONG	THERE'S MULTIPLE VIEWPOINTS
HELPING	LEARNING
"YOU'RE CRAZY!"	"IT MAKES SENSE"
COMPLIANCE/OBEDIENCE	EMPOWERMENT/COLLARBORATION
INFO IS SHARED ON A NEED TO KNOW BASIS	TRANSPARENCY AND PREDICTABILITY
PRESENTING ISSUE	WHOLE PERSON AND HISTORY
"US AND THEM"	"WE'RE ALL IN THIS TOGETHER"
LABELS, PATHOLOGY	BEHAVIOR AS COMMUNICATION
FEAR BASED	EMPATHY BASED
I'M HERE TO FIX YOU	SUPPORT THE HEALING
INSTRUCTIVE	PARTICIPATORY
PEOPLE MAKE BAD CHOICES	PEOPLE WHO FEEL UNSAFE DO UNSAFE THINGS
BEHAVIOR VIEWED AS PROBLEM	BEHAVIOR VIEWED AS A PERSONAL SOLUTION
WHAT'S WRONG WITH YOU?	WHAT HAPPENED TO YOU?
BLAME/SHAME	RESPECT
GOAL IS TO GO THINGS THE "RIGHT" WAY	GOAL IS TO CONNECT
PRESCRIPTIVE	CHOICE

What Does the Cultural Shift of Trauma Informed Care Look Like

How to build a thriving community through relationship and connection

Understanding Trauma

Understanding Brain Science

Having community common language & understanding

Compassion and human over tasks

Building Resiliency

Diversity and Inclusiveness

Repairing Harm

"What has happened?"

NOT

"What is wrong?"

Science and evidence-based practices

+

Building Healing Relationships

Community Building and Collaborating

Providing Care & Compassion

Compassion ○ Appreciation ○ Resilience ○ Empowerment

Organizational Resilience

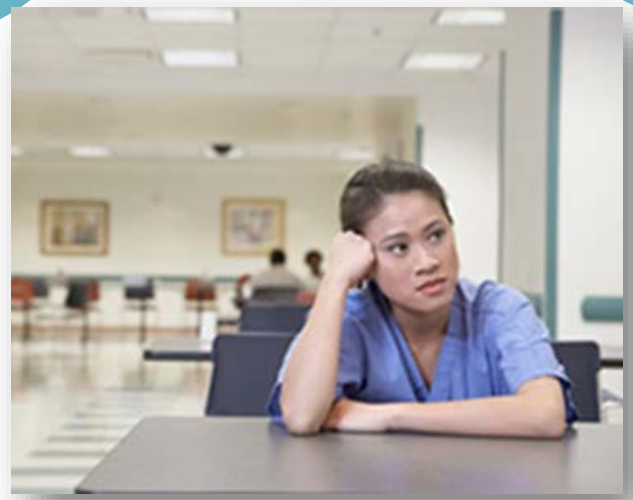
(Bloom & Farragher, 2013)

Challenges to Implementing Trauma Informed CARE

- Getting buy in from the whole organization can be hard
- Inconsistent understanding of what it means to be trauma informed
- Most view this work as more work or just a training rather than a culture shift
- Understanding this is complex system change work. It will take the whole organizations commitment, and dedication.
- Evaluating measures of trauma informed change is difficult
- Workplaces not prioritizing the work
- Building sustainable methods and systems

Organizational Stress

- Staff turnover
- Changes in leadership
- Budget cuts
- Paperwork and technology demands
- Feeling unsafe with clients
- Not enough time for collaboration
- Mandates without resources



(Bloom & Farragher, 2013)

Reflection Time…..

Any Questions?

Internal Processing Prompt- 10 min

- What value do you see in your organization being a trauma informed system?

Breakout Rooms -15 min

- Where are your organizations strengths and opportunities to grow as a trauma informed system?
- What do you think the challenges are going to be to bring trauma informed principles to your organization?
- What is one way you can work through the challenges?

Deep Dive

Compassion ○ Appreciation ○ Resilience ○ Empowerment

Reflection

Personal Prompt

- Based on the starred slides, in your own words how would you define trauma informed care and it's defining values & culture shift

Break Out Room Exercise

Figure out who is going to be the time keeper

Everyone is going to present

Each presenter has 5 minutes to present the 5 core slides based on your reflection and understanding of the slides.

Each person in the group will provide feedback to the presenter.

The feedback will include:

presentation strengths & opportunities

Closing Reflection

What is your biggest take away from today's training ?

Thanks for being a Trauma Informed Care Champion!

Compassion ○ Appreciation ○ Resilience ○ Empowerment

Trauma Informed Care Resources

Books:

Trauma Stewardship by Laura van Dernoot Lipskyhttps://www.amazon.com/Trauma-Stewardship-Everyday-Caring-Others/dp/157675944X

A Boy Who was Raised as a Dog by Bruce Perry https://www.amazon.com/Boy-Who-Was-Raised-as-Dog-audiobook/dp/B07HJBHFTB/ref=sr_1_1?crid=ZHXLETFLGXRZ&dchild=1&keywords=bruce+perry+the+boy+who+was+raised+a

The Deepest Well by Nadine Burke Harris (This on audiobook and she reads it.)
https://www.amazon.com/Deepest-Well-Long-Term-Childhood-Adversity/dp/132850266X/ref=tmm_pap_swatch_0?_encoding=UTF8&qid=&sr=

The Body Keeps the Score by Bessell van der Kolk, M.D.
https://www.amazon.com/Body-Keeps-Score-Healing-Trauma/dp/0143127748

Resilience Factor by Karen Reivich https://www.amazon.com/Karen-Reivich-Resilience-Overcoming-Paperback/dp/B01FOD5Q1U/ref=pd_lpo_14_t_1/139-0400576-4760459?_encoding=UTF8&pd_rd_i=B01FOD5Q1U&pd_rd_r=29cca8c8-8c57-469a-87ee-1ad6c4348653&pd_rd_w=4q9Bc&pd_rd_wg=ErlGD&pf_rd_p=7b36d496-f366-4631-94d3-61b87b52511b&pf_rd_r=QDZ25HTAMHV3XBE1GAZ2&psc=1&refRID=QDZ25HTAMHV3XBE1GAZ2

Change your World The Science of Resilience and the True Path to Success by Michael Ungar

Amazon.com/Change-Your-World-Science- https://www.amazon.com/Change-Your-World-Science-Resilience/dp/199943952X/ref=sr_1_1?dchild=1&keywords=michael+ungar+change+your+world&qid=1596641931&sr=8-1

Videos:

- Nadine Burke Harris Childhood Trauma and ACEs
  https://www.youtube.com/watch?v=95ovIJ3dsNk
- Oprah Winfrey Childhood Trauma
  https://www.youtube.com/watch?v=dF20FaQzYUI
- Beyond the Cliff Laura van Dernoot Lipsky
  https://www.youtube.com/watch?v=uOzDGrcvmus

Websites:

https://traumainformedoregon.org/

https://www.ncbi.nlm.nih.gov/books/NBK207194/

https://www.health.harvard.edu/blog/trauma-informed-care-what-it-is-and-why-its-important-2018101613562

http://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/what-is-trauma-informed-care.html

https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/

https://connectingparadigms.org/wp-content/uploads/2019/05/21360-Organizational_Stress_as_a_Barrier_to_Trauma-Informed-Bloom.pdf

https://kathleennaltyconsulting.com/wp-content/uploads/2016/05/Strategies-for-Confronting-Unconscious-Bias-The-Colorado-Lawyer-May-2016.pdf

https://www.ce-credit.com/articles/100716/PrevVicariousTrauma.pdf

Tami Farber
Equity Trainer

Tami L Farber, MSW is a Leader, Organizer, Educator, Facilitator, Coach, Change Agent and Truth Seeker, bringing over twenty-five years of experience in the fields of Youth Development and Education, Organizational and Leadership Development, and Systems Change work. Tami is a Consultant and Life Coach in Arlington, WA. Previously she was the Senior Director of Equity Training and Development for Leadership Snohomish County and the Vice President of Equity, Advancement and Global Engagement for the YMCA of Snohomish County in addition to her consulting and coaching work.

Tami has an extensive portfolio and spent over a decade centering her work on international development living and working in numerous countries throughout East & Southern Africa, South Asia, Europe and Central and South America. Tami now resides in Arlington WA. She earned her bachelor's degree from Long Island University-Global College and a Master's Degree in Social Work from Columbia University. She received her anti-racist training through the People's Institute for Survival and Beyond and her Coaching Certification through Seattle Life Coach Training.

Equity and the Intersection of Trauma Informed Practices

Presented by

Tami Farber

Thank You for your participation and partnership!

RACING TO EQUITY

Land Acknowledgment

First, we want to begin by acknowledging that we are on Indigenous land, the traditional territories of the Coast Salish people, who since time immemorial have taken care of, hunted, fished and gathered on these lands. We respect their sovereignty, their right to self-determination, and we honor their sacred spiritual connection with the land and water.

RACING TO EQUITY

Why We Acknowledge The Land

- Offer recognition and respect
- Acknowledge sovereignty of local tribes
- Remind us historical contexts still affect current realities and future outcomes
- Native Americans have lived in North America since time immemorial

Overview

As we approach our work to be Trauma Informed practitioners and organizations it is important to understand the complex cultural, social, economic and political forces that impact the lives of our children, families and communities as a way to identify the root cause of Trauma.

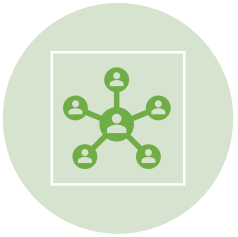
Belief/Rationale

A significant contributing factor to ACEs stems from the inequities and forms of oppression and marginalization we see in this country due to ones social identity, lack of access to resources, threats of harm and injury, humiliating and shaming events, and the ongoing experiencing of and witnessing of discrimination.

Learning Outcomes

BUILD AND STRENGTHEN RELATIONSHIPS OF CARE TEAM TO CREATE A SUSTAINABLE NETWORK WITH A SHARED EQUITY ANALYSIS

BUILD A COMMON VOCABULARY FOR EQUITY



EXPLORE THE RELATIONSHIP BETWEEN SOCIAL IDENTITY AND HISTORICAL AND MULTI-GENERATIONAL TRAUMA

DEFINE AND DISCUSS THE UTILIZATION OF AN EQUITY ANALYSIS TO INFORM POLICIES, PRACTICES, PROCEDURES

CROSS-POLLINATE IDEAS ON THE INTERSECTION BETWEEN WORKING TOWARDS EQUITABLE OUTCOMES AND BEING TRAUMA INFORMED

Community Agreements

- We start where we are.
- We question ourselves.
- We acknowledge our own identities and power and how it interacts with others
- We are all responsible for the group.
- This is an ongoing experience our focus is on education and growing.
- Our values, cultural identities, and past experiences matter.
- Disagreement is part of the process and can be transformational. Understand your part in disagreement.
- Use your heart and humanity to see each other and hear each other

Compassion ○ Appreciation ○ Resilience ○ Empowerment

RACING TO EQUITY

Mix and Mingle

1. If you walk into a room what would be your theme song?
2. How have dimensions of your identity shaped/informed your lived experiences?
3. Name at least one way you feel you have experienced a form of trauma due to a dimension of your identity?

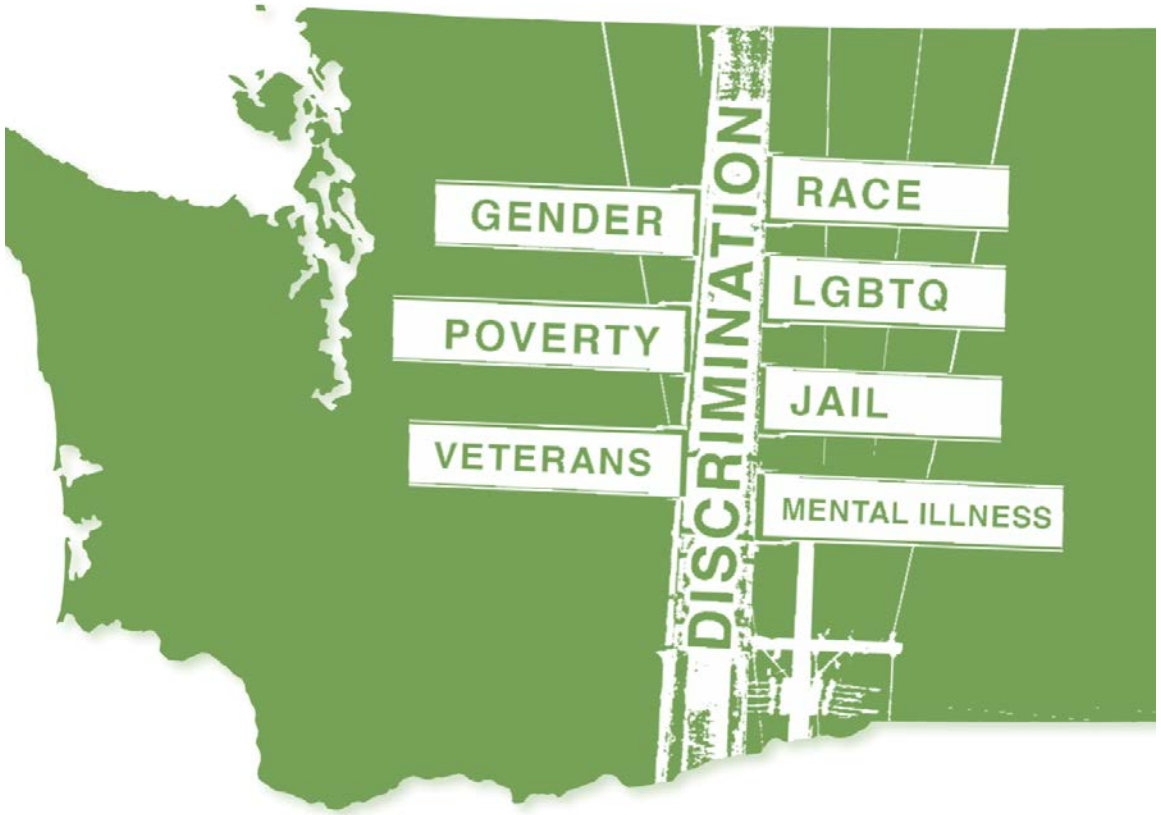
Equity Framework

Trauma is historical, structural, political, intergenerational, interpersonal, and embodied. So, then, must be our healing.

Compassion ○ Appreciation ○ Resilience ○ Empowerment

Our "Lasik" PROP

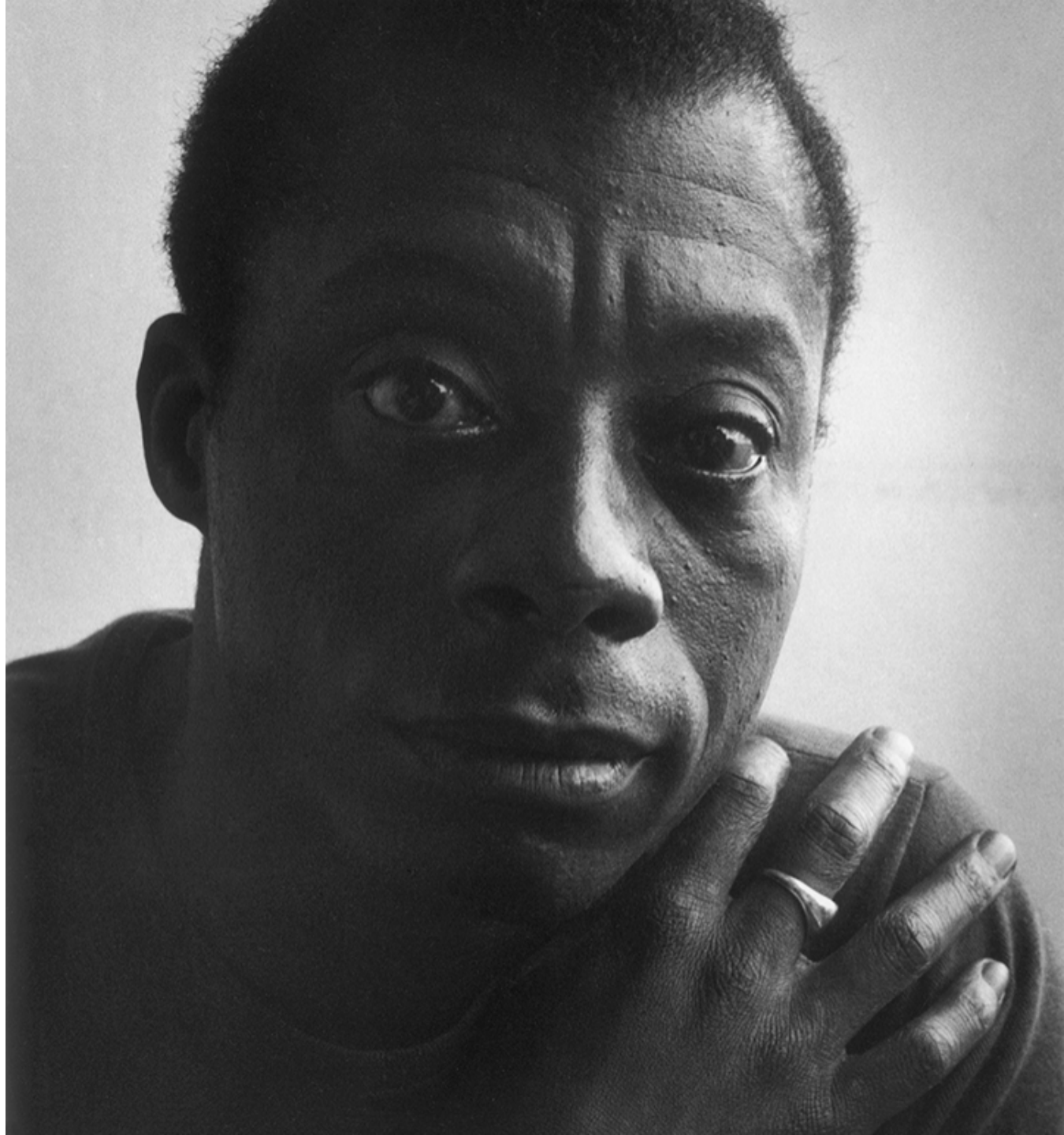
- **P**ower
- **R**ace
- **O**ppression
- **P**rivilege



Discussion

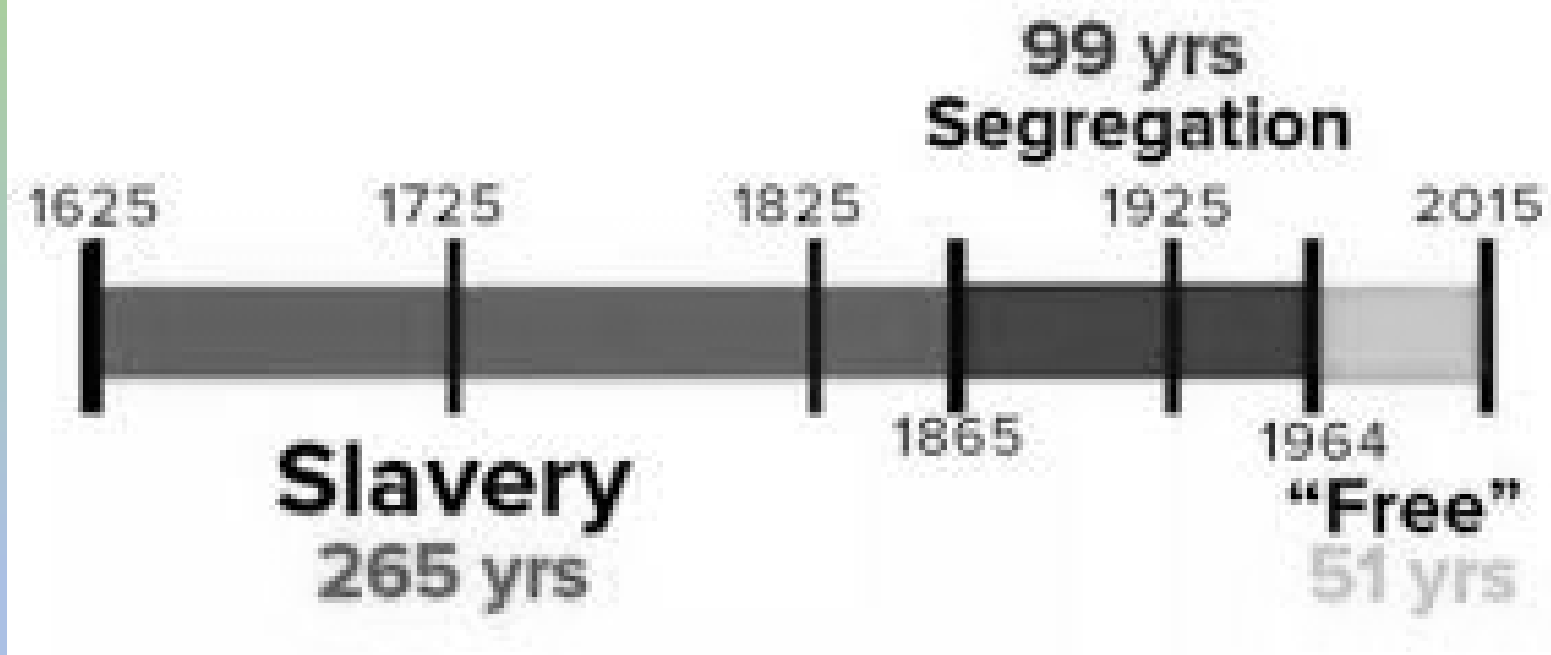
How has Power Race Oppression and Privilege contributed to the individual and collective trauma we see in our communities?

“History is not the past, it is the present. We carry our history with us. We are our history”
- James Baldwin



RACING TO EQUITY

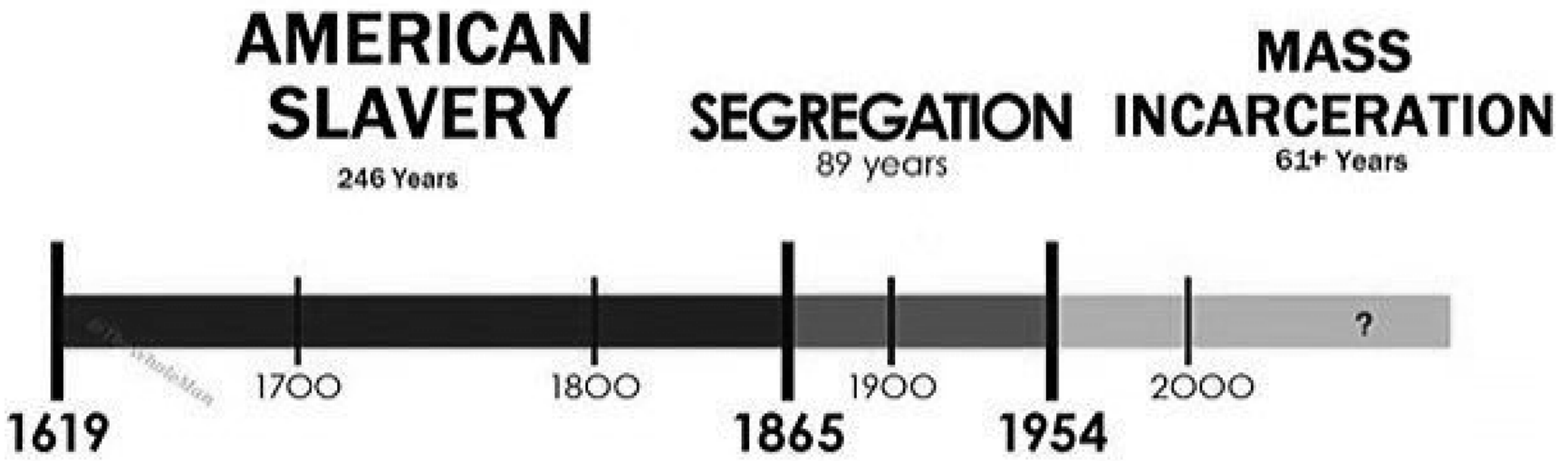
History
Legacy
Structure



Compassion ○ Appreciation ○ Resilience ○ Empowerment

RACING TO EQUITY

Somatic History Eras



Compassion ○ Appreciation ○ Resilience ○ Empowerment

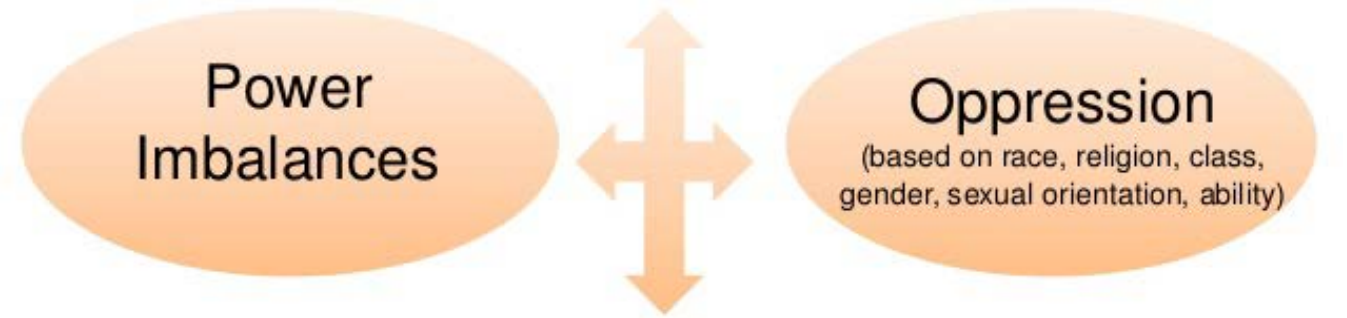
RACING TO EQUITY

Break

5 minutes

RACING TO EQUITY

Root Causes of Inequities



- Laws and Policies that created all types of systems of unbalanced power and privilege
- Caused by historical practice of exclusion & discrimination across life course
- Led to geographic concentration of poverty and hyper-segregation

Compassion ○ Appreciation ○ Resilience ○ Empowerment

RACING TO EQUITY

3 Types of ACEs

ACEs Connection supports communities to accelerate the global ACEs science movement and to solve our most intractable problems. We recognize that three major types of adverse childhood experiences — family, community, and climate — cause most of the trauma that leads to toxic stress. Left unaddressed, toxic stress in people, organizations, systems and communities can harm our health and reduce the ability to respond with resilience to stressful events. The three different types of ACEs appear and intertwine throughout our lifetimes, and the lives of our organizations, systems, and communities.

POWER

OPPRESSION

PRIVILEGE

Who Is Missing From The Original ACE Study?

The people in the original ACE's study are disproportionately white, employed, insured, college educated and middle income

Everyone Has Many Identities

Compassion ○ *Appreciation* ○ *Resilience* ○ *Empowerment*

RACING TO EQUITY

Compassion ○ Appreciation ○ Resilience ○ Empowerment

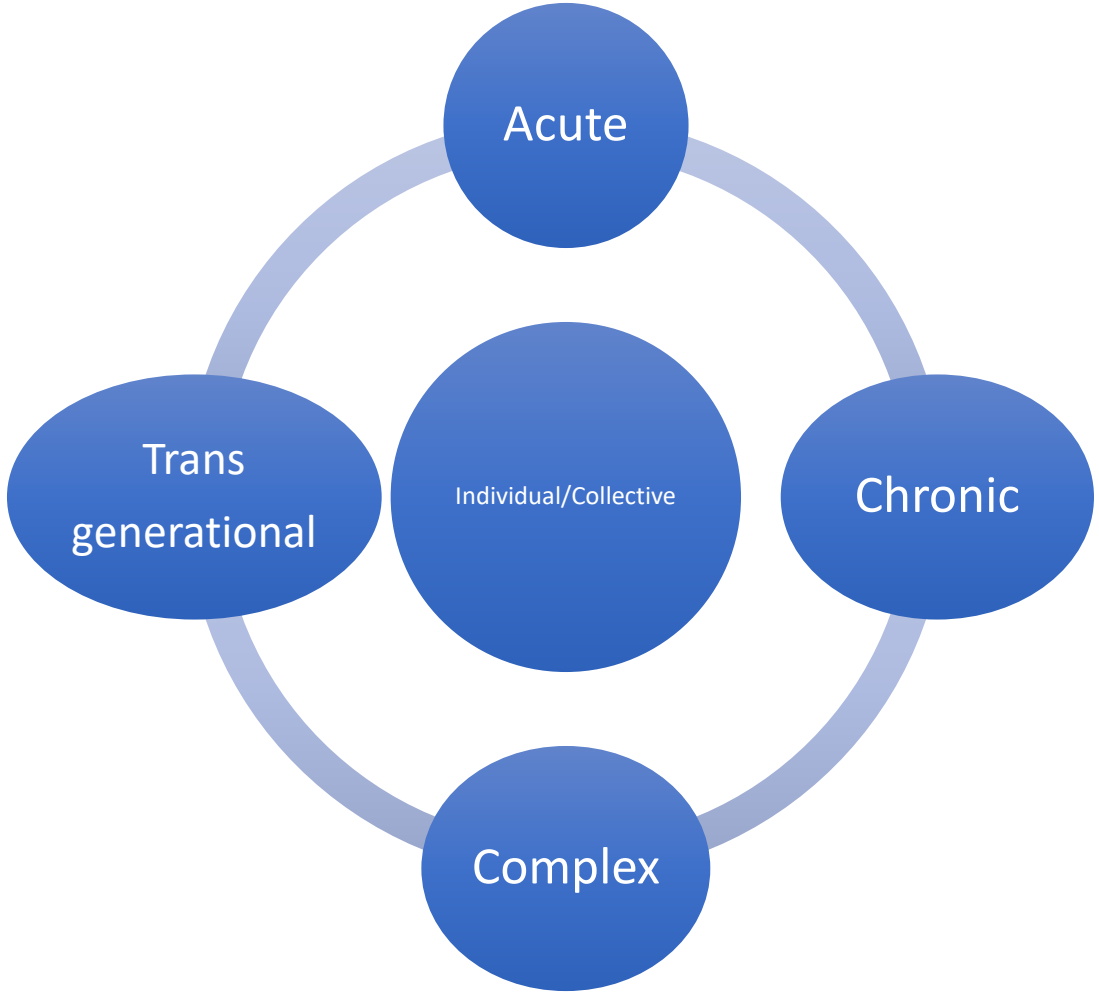
RACING TO EQUITY

Dominant Group	Marginalized Group	Oppression
White	People of Color	Racism
Colonizer	Native/Indigenous	Colonialism
Cisgender Men	Women, Transgender, non-binary genderfluid, gender neutral	Sexism
Able-bodied, Able-minded	People with a disability	Ableism
Christian	Other religions or spiritual practices	Christian Hegemony
Heterosexual	Lesbian, Gay, Bi, Queer	Heterosexism
Adult	Youth/Elder	Ageism
Wealthy & Middle class	Poor and working class	Classism
Citizen	Non-citizen	Nationalism
Formally educated	Non-formally educated	Elitism
English speaking	Non-English Speaking, English with an accent or dialect	Linguicism

Discussion

As Trauma Informed Care Leaders how can you use this power analysis to inform how you engage in the work that you do to advance equity and social justice?

Types of Trauma



Intergenerational Trauma

Discussion

What did you See?

What did you Hear?

What did you Feel?

How is historical /multigenerational trauma connected to equity?

Establishing a Common Vocabulary For Equity and Trauma

1. Move into Breakout Groups of 5-6
2. Work as a team using the worksheet to match each word to its definition
3. Complete the Worksheet
4. Come back to larger group to review and Discuss

Levels of Oppression

INTERPERSONAL (Between individuals) INDIVIDUAL	**INSTITUTIONAL** (Within an institution or sector)
INTERNALIZED (Within an individual: Inferiority or Superiority)	**STRUCTURAL** (Between institutions)

RACING TO EQUITY

Group Discussion

In what ways do you think these levels of oppression contribute to the generational trauma we experience and see?

INTERPERSONAL (Between individuals) INDIVIDUAL	**INSTITUTIONAL** (Within an institution or sector)
INTERNALIZED (Within an individual: Inferiority or Superiority)	**STRUCTURAL** (Between institutions)

RACING TO EQUITY

Break

5 minutes

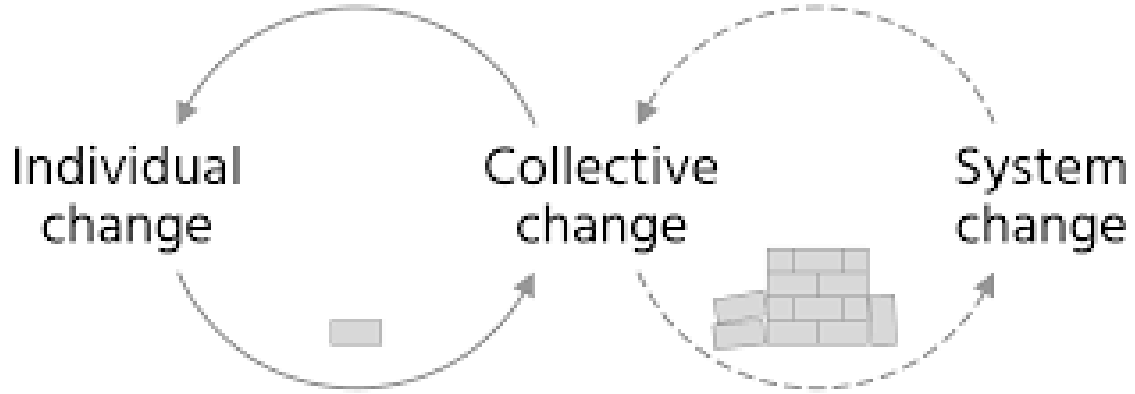
RACING TO EQUITY

No Equity Informed Lens	Equity Informed Lens
NO TRAUMA INFORMED CARE LENS	TRAUMA INFORMED CARE LENS
POWER OVER	POWER WITH
YOU CAN'T CHANGE	NEUROPLASTICITY CAN CHANGE
PEOPLE NEED FIXING FIRST	PEOPLE NEED SAFETY FIRST
OPERATE FROM THE DOMINANT CULTURE	CULTURE HUMILITY
PEOPLE ARE OUT TO GET YOU	PEOPLE CAN LIVE UP TO THE TRUST YOU GIVE THEM
THERE'S ONLY RIGHT OR WRONG	THERE'S MULTIPLE VIEWPOINTS
HELPING	LEARNING
"YOU'RE CRAZY!"	"IT MAKES SENSE"
COMPLIANCE/OBEDIENCE	EMPOWERMENT/COLLARBORATION
INFO IS SHARED ON A NEED TO KNOW BASIS	TRANSPARENCY AND PREDICTABILITY
PRESENTING ISSUE	WHOLE PERSON AND HISTORY
"US AND THEM"	"WE'RE ALL IN THIS TOGETHER"
LABELS, PATHOLOGY	BEHAVIOR AS COMMUNICATION
FEAR BASED	EMPATHY BASED
I'M HERE TO FIX YOU	SUPPORT THE HEALING
INSTRUCTIVE	PARTICIPATORY
PEOPLE MAKE BAD CHOICES	PEOPLE WHO FEEL UNSAFE DO UNSAFE THINGS
BEHAVIOR VIEWED AS PROBLEM	BEHAVIOR VIEWED AS A PERSONAL SOLUTION
WHAT'S WRONG WITH YOU?	WHAT HAPPENED TO YOU?
BLAME/SHAME	RESPECT
GOAL IS TO GO THINGS THE "RIGHT"	

Discussion

1. What do you notice about these 2 lists?
2. In what ways as a leader are you engaging in using your “equity Lasik”?
3. From your perspective where would you place your organization and why?
    1. No equity/trauma informed lens or
    2. Yes equity/trauma informed lens or
    3. Somewhere in-between

Intersection TIC and Equity



The effects of Adverse Childhood Experiences (ACEs) and toxic stress can be counteracted through the Trauma Informed Care framework by:

Realizing the prevalence of trauma

REALIZE

RECOGNIZE

Recognizing the signs and symptoms of trauma

Responding by putting knowledge into practice

RESPOND

RESIST

Resisting re-traumatization of clients and staff

Trauma Informed Care is Enhanced with an Equity Framework by:

Realize Trauma is deeply rooted in a multi-generational, dehumanizing process of systems of inequities

REALIZE

RECOGNIZE

the ways in which Power Race Oppression and Privilege influence/impact individuals and communities lived experiences and recognize your own biases

Respond to Trauma in a culturally responsive way and hold healing as the restoration of identity and ensure your responses are happening at all levels: individual, community and institutional

RESPOND

RESIST

Resist perpetuating/maintaining dominant cultural norms through your policies and practices when engaging in TIC

Compassion ○ Appreciation ○ Resilience ○ Empowerment

RACING TO EQUITY

The 4 R's of a Resilient System

Recognition:
Historical and Structural Components

Repair:
Devastating Impacts through Reflection, Validation and Practice

Reconcile:
Integrating knowledge about trauma into policies, procedures, and practices

Renew and Restore:
Resist Re-traumatization

Compassion ○ Appreciation ○ Resilience ○ Empowerment

Racial Equity Tool For Policies Practices and Procedures

A simple set of questions:

1. **Proposal:** What is the policy, program, practice or budget decision under consideration? What are the desired results and outcomes?
2. **Data:** What's the data? What does the data tell us?
3. **Community engagement:** How have communities been engaged? Are there opportunities to expand engagement?
4. **Analysis and strategies:** Who will benefit from or be burdened by your proposal? What are your strategies for advancing racial equity or mitigating unintended consequences?
5. **Implementation:** What is your plan for implementation?
6. **Accountability and communication:** How will you ensure accountability, communicate, and evaluate results?

Government Alliance for Racial Equity

Compassion ○ Appreciation ○ Resilience ○ Empowerment

RACING TO EQUITY

Personal Reflection

1. What are the connections I made today as a TIC practitioner?
2. What are some of the implications of what I learned today for my work moving forward?
3. What are some of the applications of what I learned today?

Equity and the Intersection of Trauma Informed Practices

Presented by Tami Farber

Thank You

唔該

Gracias

Cảm ơn ông Asante

Спасибо!

Дякую

謝謝

Thank You for your participation and partnership!

Equity and Diversity Resources

Anti-Racism Resources

Videos to watch:

- How Studying Privilege Systems Can Strengthen Compassion | Peggy McIntosh at TEDxTimberlaneSchools (18:26)
- George Floyd and the Dominos of Racial Injustice | The Daily Show with Trevor Noah (18:12)
- Black Feminism & the Movement for Black Lives: Barbara Smith, Reina Gossett, Charlene Carruthers | National LGBTQ Task Force (50:48)

Articles to read:

- "America's Racial Contract Is Killing Us" by Adam Serwer | Atlantic (May 8, 2020)
- "Applying a Race Equity Lens: A Call to Action for Human Services" by The American Public Human Services Association (APHSA)
- "Blaine Police Chief: It's long past time the two Americas come together" by Donnell Tanskley | The Northern Light (June 3, 2020)
- "Ella Baker and the Black Freedom Movement: A Radical Democratic Vision"By Barbara Ransby | University of North Carolina Press, 2003
- "Groundwater Approach Impacts of Structural Racism" By Bayard Love and Deena Hayes-Greene | Racial Equity Institute, 2019
- "My Life as an Undocumented Immigrant" by Jose Antonio Vargas | NYT Mag (June 22, 2011)
- Resources for refugees and immigrants on racism and anti-racism compiled by the Office of Immigrant and Refugee Affairs
- "The 1619 Project" (all the articles) | The New York Times Magazine
- "The COVID-19 and Racial Wealth Gap" by Darrick Hamilton and Danyelle Solomon | Kirwan Institute, 2020
- "The Combahee River Collective Statement"
- "The Historical Origins and Development of Racism" by George M. Fredrickson | PBS, 2003
- "The Intersectionality Wars" by Jane Coaston | Vox (May 28, 2019)
- "Tips for Creating Effective White Caucus Groups" developed by Craig Elliott PhD
- "Where do I donate? Why is the uprising violent? Should I go protest?" by Courtney Martin (June 1, 2020)
- "White Privilege: Unpacking the Invisible Knapsack" by Peggy McIntosh
- "Who Gets to Be Afraid in America?" by Dr. Ibram X. Kendi | Atlantic (May 12, 2020)
- https://aphsa.org/About/call_to_action.aspx

Podcasts to subscribe to:

- 1619 (New York Times)
- About Race
- Code Switch (NPR)
- Intersectionality Matters! hosted by Kimberlé Crenshaw
- Momentum: A Race Forward Podcast
- Pod For The Cause (from The Leadership Conference on Civil & Human Rights)
- Pod Save the People (Crooked Media)
- Seeing White
- Talking Race With Young Children

Books to read:

- Black Feminist Thought by Patricia Hill Collins
- Eloquent Rage: A Black Feminist Discovers Her Superpower by Dr. Brittney Cooper
- Heavy: An American Memoir by Kiese Laymon
- How To Be An Antiracist by Dr. Ibram X. Kendi
- I Know Why the Caged Bird Sings by Maya Angelou
- Just Mercy by Bryan Stevenson
- Me and White Supremacy by Layla F. Saad
- Raising Our Hands by Jenna Arnold
- Redefining Realness by Janet Mock
- Sister Outsider by Audre Lorde
- So You Want to Talk About Race by Ijeoma Oluo
- The Bluest Eye by Toni Morrison
- The Fire Next Time by James Baldwin
- The New Jim Crow: Mass Incarceration in the Age of Colorblindness by Michelle Alexander
- The Next American Revolution: Sustainable Activism for the Twenty-First Century by Grace Lee Boggs
- The Warmth of Other Suns by Isabel Wilkerson
- Their Eyes Were Watching God by Zora Neale Hurston
- This Bridge Called My Back: Writings by Radical Women of Color by Cherríe Moraga
- When Affirmative Action Was White: An Untold History of Racial Inequality in Twentieth-Century America by Ira Katznelson
- White Fragility: Why It's So Hard for White People to Talk About Racism by Robin DiAngelo, PhD

- Your Black Colleagues May Look Like They're Okay — Chances Are They're Not by Danielle Cadet | Refinery29

Films and TV series to watch:

- 13th (Ava DuVernay) — Netflix
- American Son (Kenny Leon) — Netflix
- Black Power Mixtape: 1967-1975 — Available to rent
- Blindspotting (Carlos López Estrada) — Hulu with Cinemax or available to rent
- Clemency (Chinonye Chukwu) — Available to rent
- Dear White People (Justin Simien) — Netflix
- Fruitvale Station (Ryan Coogler) — Available to rent
- I Am Not Your Negro (James Baldwin doc) — Available to rent or on Kanopy
- If Beale Street Could Talk (Barry Jenkins) — Hulu
- Just Mercy (Destin Daniel Cretton) — Available to rent for free in June in the U.S.
- King In The Wilderness — HBO
- See You Yesterday (Stefon Bristol) — Netflix
- Selma (Ava DuVernay) — Available to rent
- The Black Panthers: Vanguard of the Revolution — Available to rent
- The Hate U Give (George Tillman Jr.) — Hulu with Cinemax
- When They See Us (Ava DuVernay) — Netflix

More anti-racism resources to check out:

- 75 Things White People Can Do for Racial Justice
- Anti-Racism Project
- Jenna Arnold's resources (books and people to follow)
- Rachel Ricketts' anti-racism resources
- Resources for White People to Learn and Talk About Race and Racism
- Save the Tears: White Woman's Guide by Tatiana Mac
- Showing Up For Racial Justice's educational toolkits
- The [White] Shift on Instagram
- "Why is this happening?" — an introduction to police brutality from 100 Year Hoodie
- Zinn Education Project's teaching materials

Resources for parents on taking about racism and anti-racism:

- **Articles:**
  - Educating our Children: Talking to Kids About Racism & Police Brutality
  - National Geographic: Talking to kids about xenophobia
  - PBS's Teaching Your Child About Black History Month
  - Racism and Violence: Using Your Power as a Parent to Support Children Aged Two to Five
  - Raising Race Conscious Children
  - Talking to Children About Racial Bias

    - Talking to Children After Racial Incidents
    - Talking to Kids About Racial Violence
    - They're Not Too Young to Talk about Race
    - https://thriveglobal.com/stories/inclusivity-workplace-end-systemic-racism-support-black-colleagues-action/?utm_source=Newsletter_General&utm_medium=Thrive
    - https://www.acesconnection.com/blog/we-stand-in-solidarity-with-the-worldwide-protests-for-racial-justice
    - Your Kids Aren't Too Young to Talk About Race: Resource Roundup
    - Your Kids Aren't Too Young to Talk About Race: Resource Roundup from Pretty Good

- **Books:**
    - 31 Children's books to support conversations on race, racism and resistance
    - A Kids Book About Racism
    - Coretta Scott King Book Award Winners: books for children and young adults
    - Let's Talk About Race
    - Not My Idea – A Book About Whiteness
    - Something Happened in Our Town
    - Teaching Tolerance: A Parent's Guide to Preventing and Responding to Prejudice

- **Podcasts:**
    - How White Parents Can Talk To Their Kids About Race - NPR Life Kit
    - Parenting Forward podcast episode 'Five Pandemic Parenting Lessons with Cindy Wang Brandt'
    - Fare of the Free Child podcast
    - Integrated Schools podcast episode "Raising White Kids with Jennifer Harvey"

- **Videos:**
    - How to Talk to Kids About Race
    - Sesame Street Town Hall on Racism - Part 1
    - Sesame Street Town Hall on Racism - Part 2
    - Sesame Street Town Hall on Racism - Part 3
    - Why we need to Talk to Children about Race & Difference
- Resources for talking about race, racism and racialized violence with children
- The Conscious Kid: follow them on Instagram and consider signing up for their Patreon

- **Suggested Reading:**
  - Opportunities for White People in the Fight for Racial Justice
    https://www.whiteaccomplices.org/

  - Raising Race Conscious Children
    http://www.raceconscious.org/

  - Black People Need Stronger White Allies – Here's How You Can Be One
    https://www.refinery29.com/en-us/2020/05/9841649/allyship-ahmaud-arbery-george-floyd

  - This Bias is not Implicit
    https://medium.com/@timjwise/this-bias-is-not-implicit-4719a0d061a0

  - 10 Simple Ways White People Can Step Up to Fight Everyday Racism
    https://www.mic.com/articles/97900/10-simple-rules-for-being-a-non-racist-white-person

- **Book Club:**
  - This might be a good time to have work book clubs.
    https://www.intheknow.com/2020/06/01/anti-racism-books/

Mary Cline-Stively
Restorative Practices and Adult Learning Trainer

Mary Cline-Stively started her career working in the mental health field for fifteen years and then transitioned into organization development consulting for another five years. For the past ten years she has worked at ChildStrive and currently serves as the Chief Strategy and Programs Officer. Mary holds a Master's Degree in Organizational Psychology as well as a Graduate Certificate in Restorative Practice. Mary is a licensed trainer for the International Institute of Restorative Practice.

Restorative Practices

Presented by
Mary Cline-Stively

Thank You for your participation and partnership!

As We Gather…..

- Please make sure your screen name includes your first name and pronouns
  - Go to the 3 dots in the upper right hand corner of your image/frame and choose “rename”
- Share in the chat 1-2 words that describe how you are coming into the space today.

Introduction

How we will spend our time together

- Using different tools to engage
- I LOVE questions and comments – feel free to raise your hand or jump off mute
- Use reactions

Break out – 5 minutes

- Groups of 2-3
- Name, what you do and questions or thoughts you have about Restorative Practice.

Community Agreements

- Assume positive intent
- Embrace the power of humble, respectful listening
- Create trusting and safe spaces – where a little bit of discomfort is okay. Learning leaves – Stories stay
- Avoid blame, speculation, and inflammatory language
- Speak from your own experience instead of generalizing
- Participate to the fullest of your ability -- community growth depends on the inclusion of every individual voice

The Intent of our time together….

- Describe the key concept of Restorative Practice
- Reflect on how Restorative Practice can help us be more Trauma Informed in our approach
- Apply some Restorative Practice tools into your work

Restorative Practice

A way of thinking and being focused on creating safe spaces for real conversations that deepen relationships and build stronger more connected communities. ~Mark Vander Vennen

https://www.youtube.com/watch?time_continue=9&v=_obyZY4XzaI&feature=emb_logo

Restorative Practices

An emerging social science that studies how to ***strengthen relationships*** between individuals as well as social connections within communities.

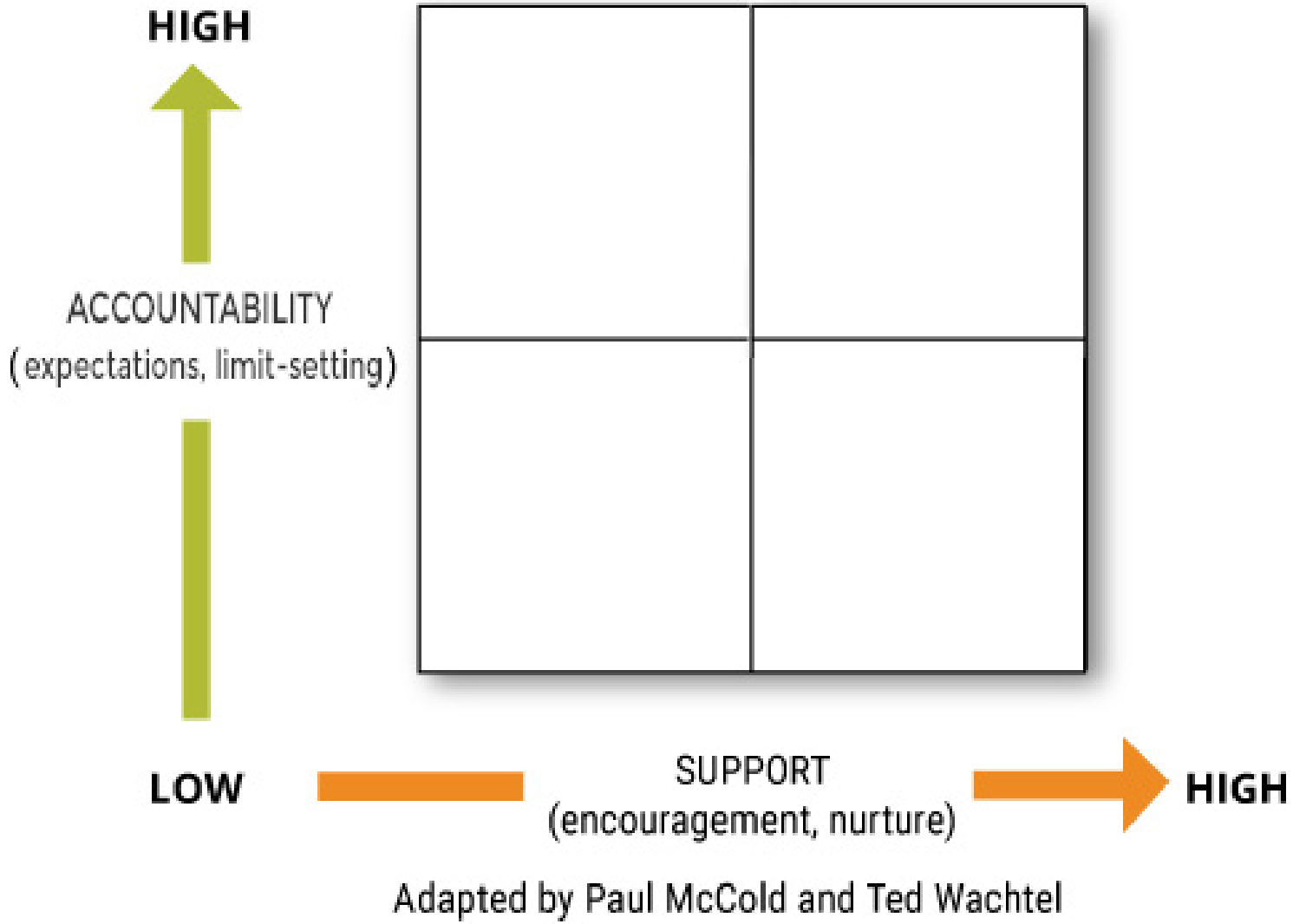
Healthy Relationships

What do healthy, positive, appropriate relationships look like? Feel like? Sound like?

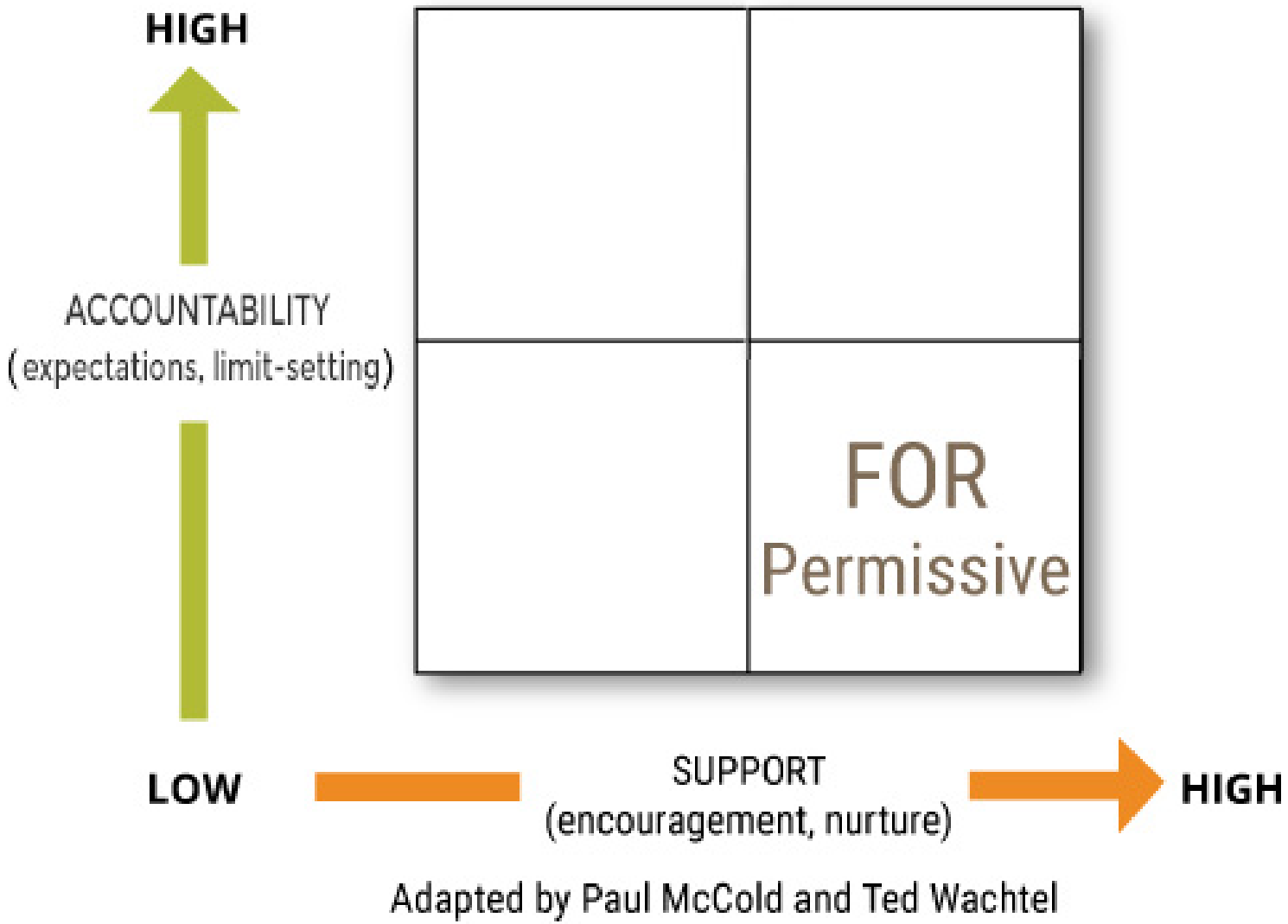
Fundamental Hypothesis
International Institute of Restorative Practice

The fundamental hypothesis of restorative practice is that human beings are happier, more cooperative and productive, and more likely to make positive changes in their behavior when those in positions of authority do things ***with*** them, rather than ***to*** or ***for*** them.

Social Discipline Window

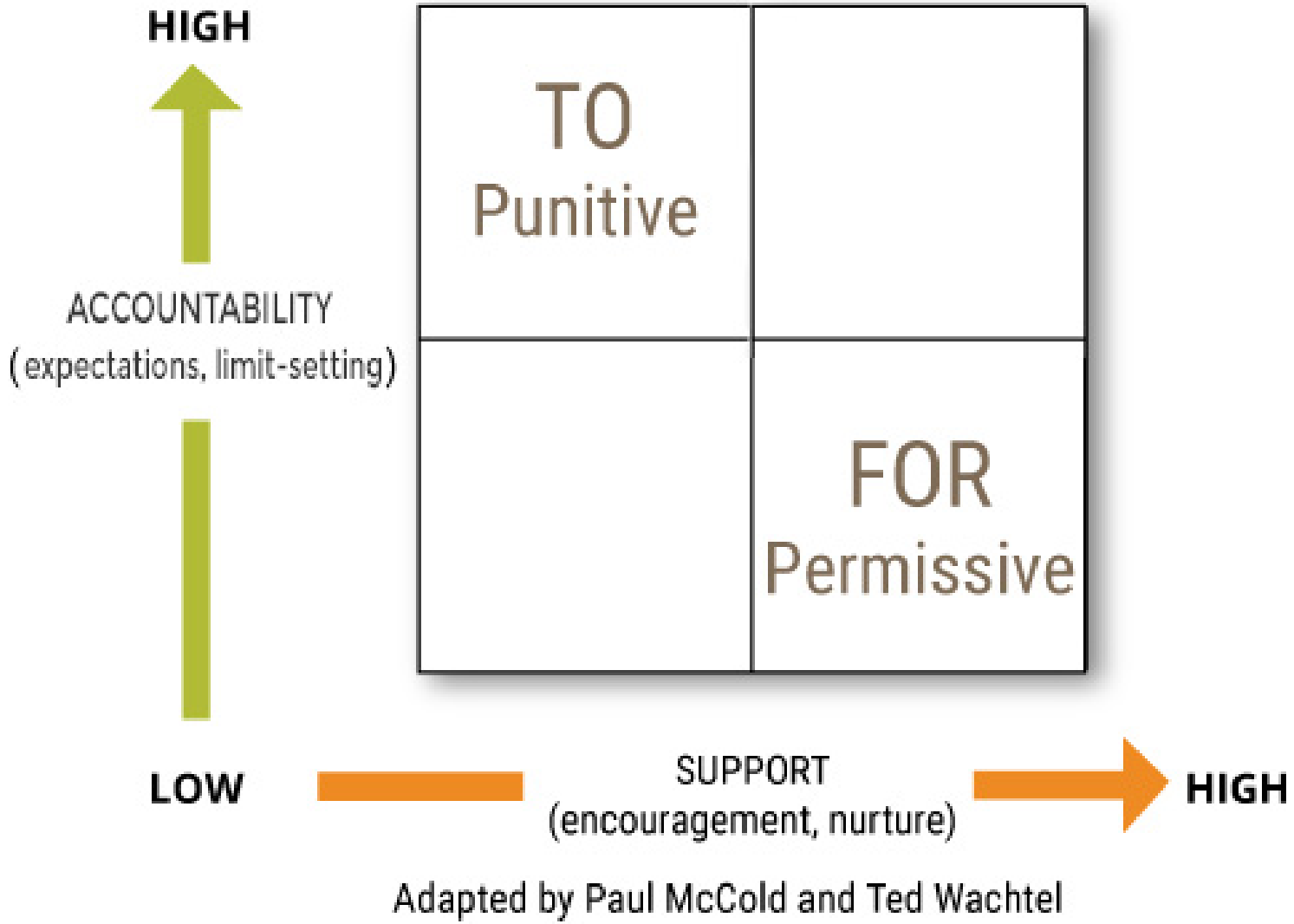


Social Discipline Window



Adapted by Paul McCold and Ted Wachtel

Social Discipline Window



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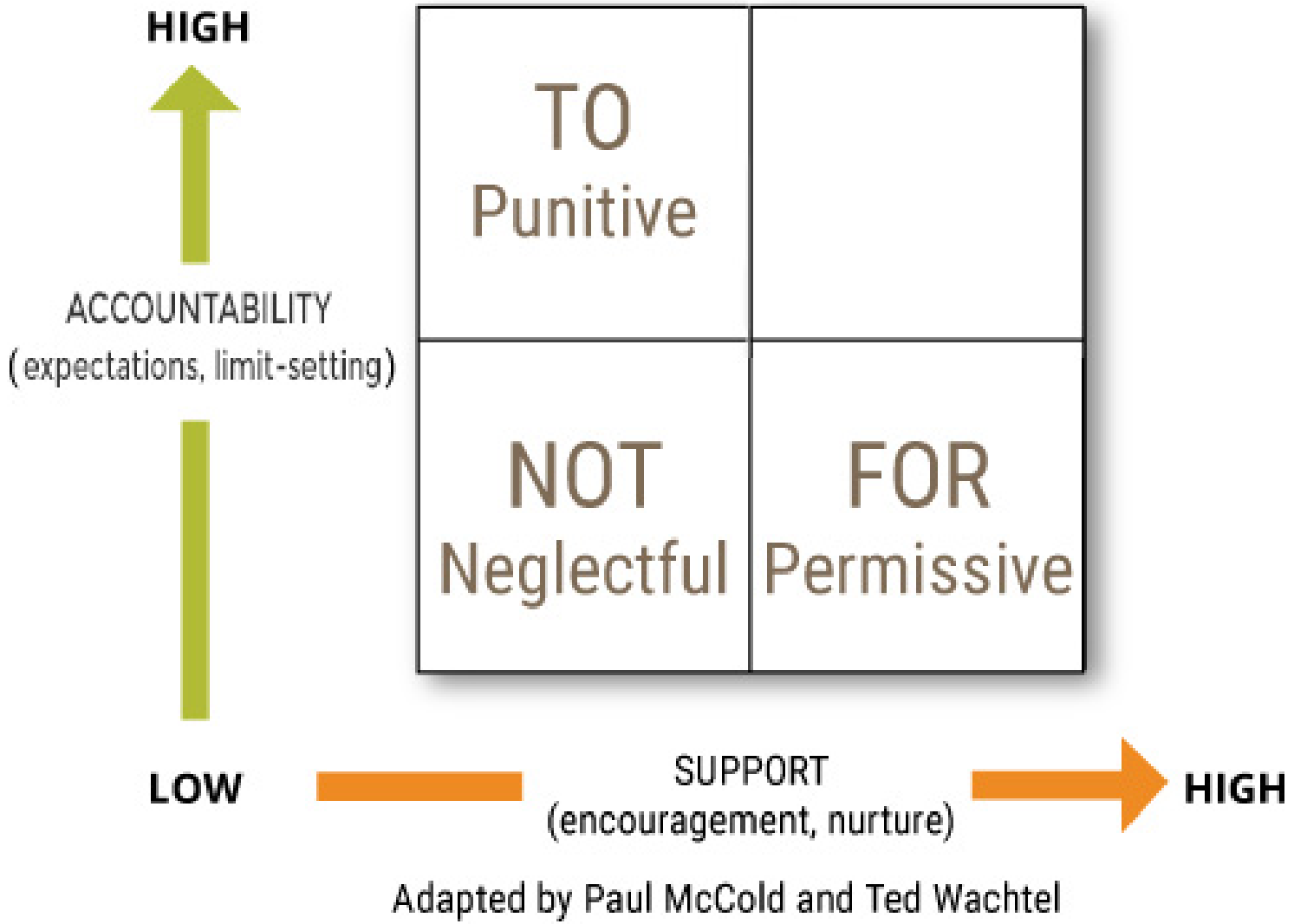

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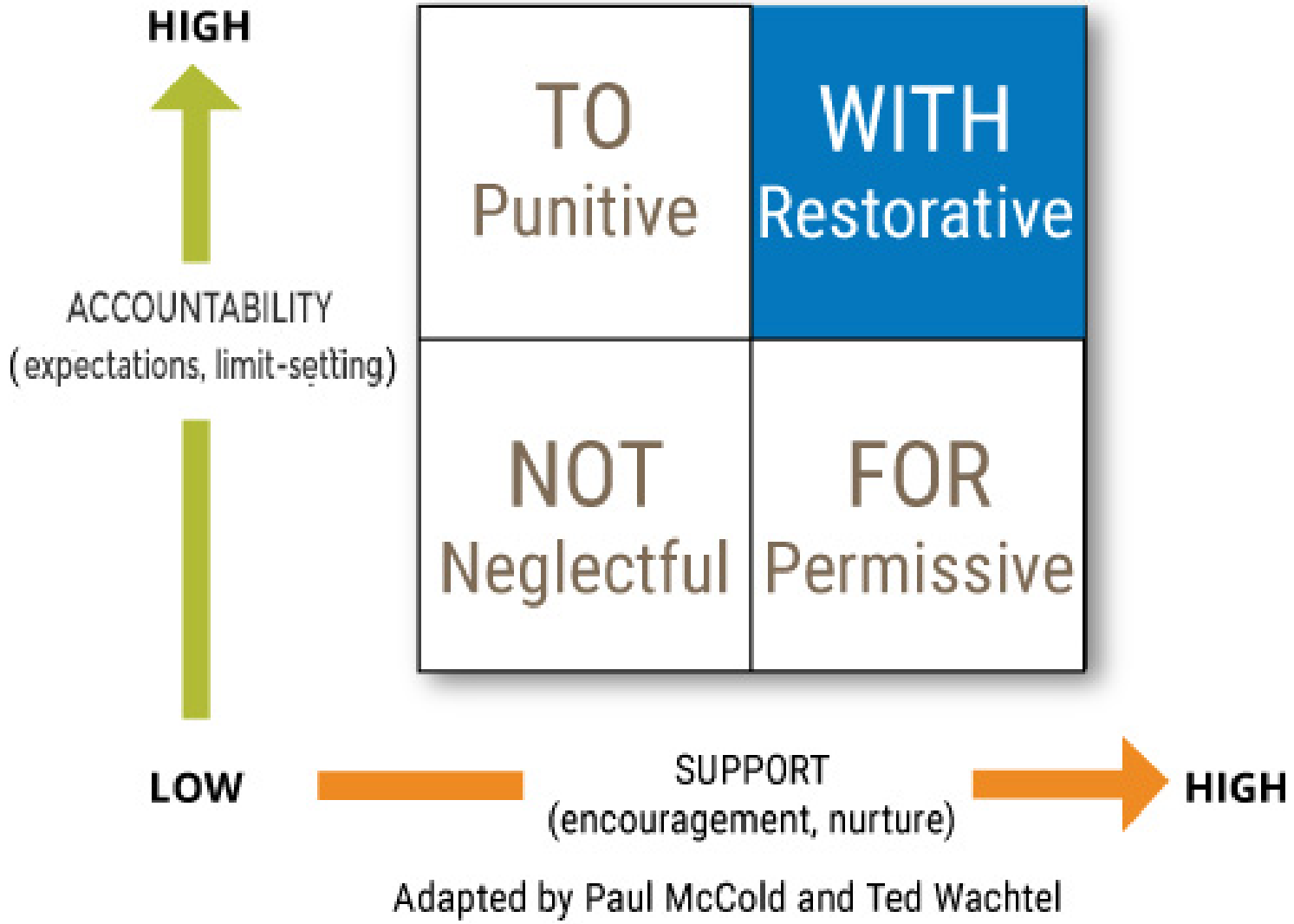

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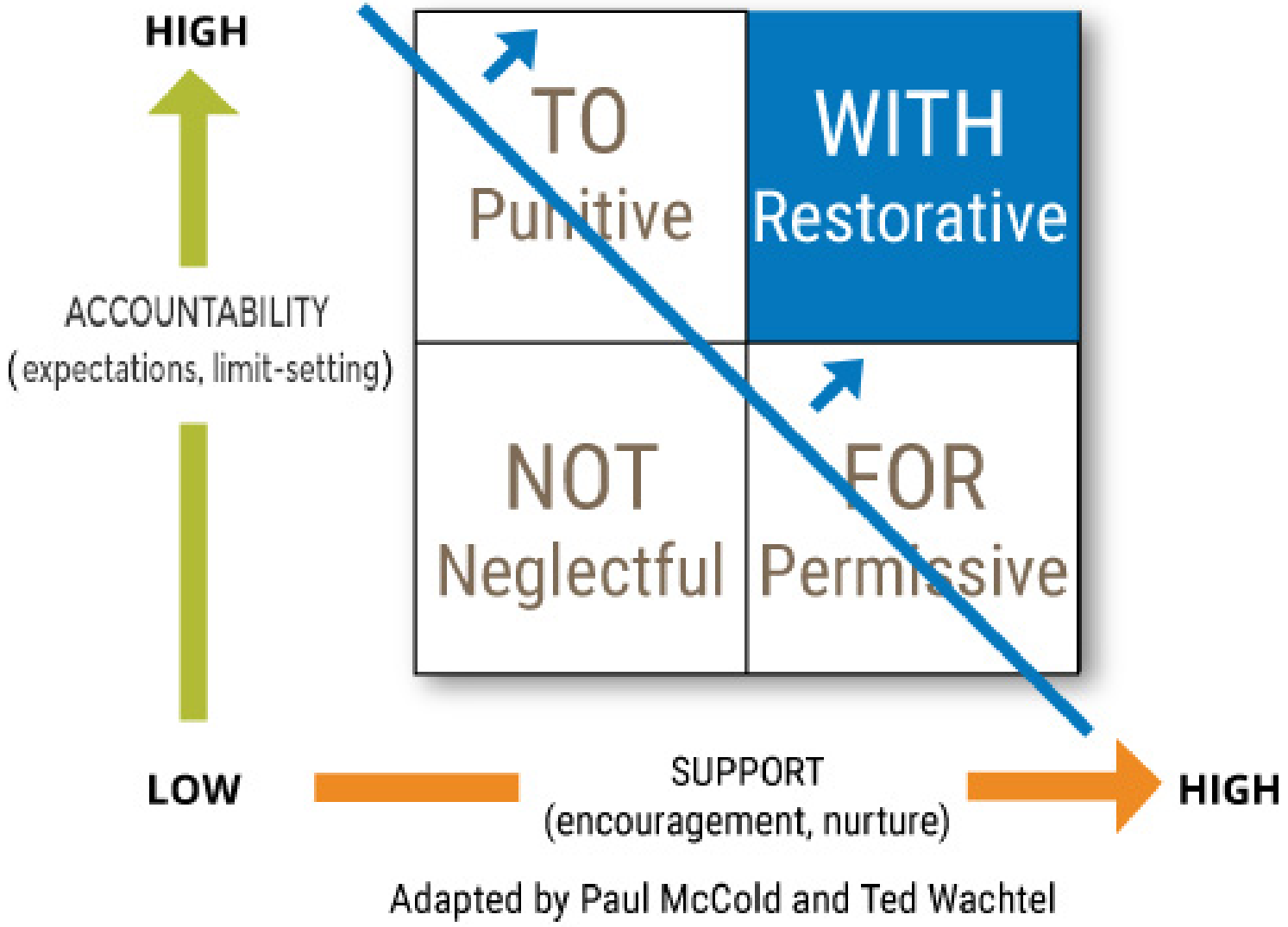

Break out Exercise

- We are going to break into 8 groups. Each group will be assigned one of the quadrants: To, For, Not and With
  - Groups #1 and #5 NOT
  - Groups #2 and #6 TO
  - Groups #3 and #7 WITH
  - Groups #4 and #8 FOR

- Where, within your organization, do you see this style? What do those behaviors look like? What is the outcome?

- When we come back please have one person who can report out on your work

Let's do a survey!

Compassion ○ Appreciation ○ Resilience ○ Empowerment

ChildStrive
Child • Family • Community

Break

5 minutes

To take care of yourself….

- Stretch
- Hydrate/Snacks
- Get Fresh Air
- Close your eyes

Restorative Questions

- Open-ended questions to help elicit emotion
- Allow individuals space to explore issues in a non-threatening way.
- Address past, present and future.
- Proactively used to explore positive changes in behavior.
- Responsively used to explore harm and how that harm impacts others.

Restorative Questions

What happened?

What were you thinking at the time? or What impact did it have?

Who has been affected and in what way?

What has been the hardest part for you?

What do you think you need to make it right?

Compassion ○ Appreciation ○ Resilience ○ Empowerment

ChildStrive
Child • Family • Community

Exercise

- In pairs
  - Think about a time when you were harmed or created harm for another person. Take turns asking the other person the questions in regard to their situation.
  - The goal is to ask the questions and listen generously. This is NOT a time to engage in conversation.
  - I will be asking for a few people to share their highlights or experience with the questions.

Break

5 minutes

To take care of yourself….

- Stretch
- Hydrate/Snacks
- Get Fresh Air
- Close your eyes

Circles and community

"There can be no vulnerability without risk; there can be no community without vulnerability; there can be no peace, and ultimately no life, without community."

(M. Scott Peck, Psychiatrist and Best-Selling Author)

"Circles create soothing space, where even reticent people can realize that their voice is welcome."

(Margaret J. Wheatley)

"If people stand in a circle long enough, they'll eventually begin to dance."

(George Carlin, Comedian)

Circle and Community

"You have noticed that everything an Indian does is in a circle, and that is because the Power of the World always works in circles, and everything tries to be round...The sky is round, and I have heard that the earth is round like a ball, and so are all the stars. The wind, in its greatest power, whirls. Birds make their nest in circles, for theirs is the same religion as ours…

Even the seasons form a great circle in their changing, and always come back again to where they were. The life of a man is a circle from childhood to childhood, and so it is in everything where power moves."

(Black Elk)

Why Circles?

Compassion ○ Appreciation ○ Resilience ○ Empowerment

ChildStrive
Child • Family • Community

Types of Circles

- Proactive
- Responsive
- Sequential
- Non-sequential

Secrets to Success

- Remember to facilitate
- Clear topic and goal
- Set a positive tone
- Keep the focus
- Get some allies
- Use silence
- Active listening
- Pay attention to body language
- Come into the circle well regulated

Circle Planning

- In groups of 3-4: brainstorm places you can start using circles
  - What is the goal?
  - What type of circle?
  - What questions would you use?
  - I will ask for several group to report out on what they really liked, what questions they had or other highlights.

“Sadly, the skepticism of approaches that challenge the status quo is often a significant barrier that prevents promising innovations from moving to the mainstream. In her article, Supporting Pioneering Leaders as Communities of Practice, Meg Wheatley identifies this challenge as a common one faced by “paradigm pioneers”: those whose focus is NOT on process improvement (helping existing systems work more efficiently and effectively) but rather on process revolution (the development of radically new processes and methods and new systems, based on new assumptions.) She notes, paradigm pioneers do “double-duty”: they simultaneously invent new approaches while at the same time they are working to solve the challenges created by the previous paradigm. What makes this work particularly challenging, Wheatley notes is that, “Past habits of practice exert strong pressures. When crises mount and people feel fearful and overwhelmed, we default back to practices that are familiar, even if they are ineffective.” (Wheatley, 2002, p. 4)

Next Steps and Wrap Up

Reflection:

- How does what you learned about Restorative Practice impact how you plan to approach bringing Trauma Informed Care to your organization?

Circle go around:

- I learned, I realized or I was surprised by…..

Thank You

Mary Cline-Stively, MA

Chief Strategy and Programs Officer

Mary.cline-Stively@childstrive.org

206-619-2475

ChildStrive

Child • Family • Community

Break Out Exercise Worksheet

Introduction:

- Groups of 2-3
  - Name, what you do and questions or thoughts you have about Restorative Practice.

Social Discipline Window:

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Restorative Practices Resources

- https://www.iirp.edu/restorative-practices/what-is-restorative-practices
- https://www.iirp.edu/resources/community-health-restorative-practices

Restorative Listening Circles Ideas: by Mary Cline Stively - ChildStrive

For me I think it is really about creating space for folks to share their story – my favorite general question is “What impact has this had on you?” “What is the hardest part?”.

This is such a challenging time and I really think about how can we be in the struggle with? How can we listen, be curious and not add burden, especially to our collogues and neighbors who are black and people of color? How can we reflect on our own learning edges and seek to understand and not just try to make the struggle go away?

Joe Neigel
Adverse Childhood Experiences Trainer

Joe Neigel is Monroe School District's Prevention Services Manager, where he supervises the Behavioral Health Team and the implementation of multi-tiered, evidence-based strategies to address student substance use, mental health and suicide. Joe is also an elected Council Member in the City of Sultan, sits on Community Transit's Board of Directors, and coordinates the Monroe Community Coalition. He is recognized across Washington State as an expert speaker on the topics of substance abuse prevention, Adverse Childhood Experiences and evidence-based prevention kernels. His community guide, "Prevention Tools: What Works, What Doesn't" and its companion training video is distributed statewide and nationally by the Washington State Health Care Authority. Most importantly, Joe is a daddy to five wonderful children aged 7-20.

Erin Wood
Adverse Childhood Experiences Trainer

Erin Wood is a licensed mental health counselor and the Behavioral Health Specialist for Monroe School District. She specializes in the prevention and intervention of youth suicide and supports students and staff in raising awareness and understanding of mental health across the lifespan. Erin organizes the district's Crisis Recovery Team and student-focused prevention efforts including Sources of Strength and the Signs of Suicide Prevention Program. Erin loves working with students K-12, and is especially passionate about supporting the mental, emotional, and behavioral needs of every young person in our community.

Adverse Childhood Experiences

Presented by
Joe Neigel & Erin Wood

Thank You for your participation and partnership!

Joe Neigel, BA, CPP

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Erin Wood, MA, LMHC

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Compassion ○ Appreciation ○ Resilience ○ Empowerment

ACES 101: The Hidden Risk Factor

Understanding Adverse Childhood Experiences, Complex Trauma and What We Can Do About It!

MONROE SCHOOL DISTRICT

Monroe Community Coalition

Our Learning Goals

Start with the End in Mind

A different kind of data set

Enhance our Understanding

The Adverse Childhood Experiences Study (ACES)

Look Across Disciplines

Evidence-based Kernels

CLIENT OF CONCERN - 10 Minute Breakout Session

Think about a client for whom you have concern. Discuss the following:

1. What worries do you have for this client?
2. What challenging behaviors does this client exhibit?

Adverse Childhood Experiences Study (ACES)

ACES began as a weight-loss study in the 1990's by Kaiser-Permanente in San Diego, California. It became the largest study ever.

Over 17,000 people participated in a health examination, which ultimately assessed the social effects of traumatic childhood experiences over one's lifespan.

Most critically, we have learned there is a direct connection with traumatic experiences and health. The Centers for Disease Control and Prevention (CDC) recognizes ACES as a *public health crisis.*

ACES Participants were mostly:

- Middle class, average age of 57
- 80% White, 10% Black, 10% Asian
- 74% Some college
- 44% Graduated college
- 49.5% Men

But since the original ACE study, research indicates

that ACEs are more prevalent for those living in poverty…

THREE TYPES OF ACEs MEASURED

The original ACE study measured three types of ACEs through a 10 question assessment:

But, there's actually more than just these…

ABUSE

Physical

Emotional

Sexual

NEGLECT

Physical

Emotional

HOUSEHOLD DYSFUNCTION

Mental Illness

Incarcerated Relative

Mother treated violently

Substance Abuse

Divorce

Since the original ACE study, exposure to additional early life stressors are being studied.

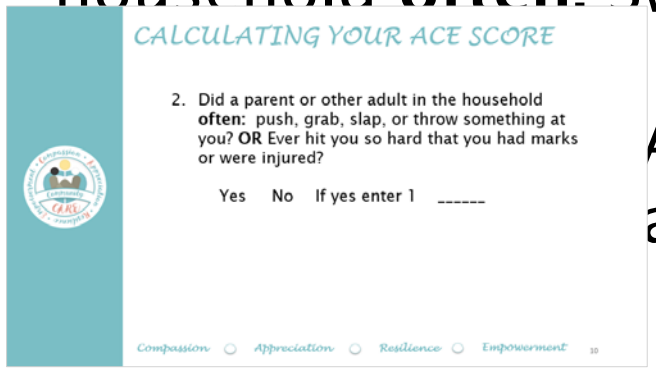
Acute Trauma: is caused by a *single* traumatic event that triggers extreme emotional or physical stress.

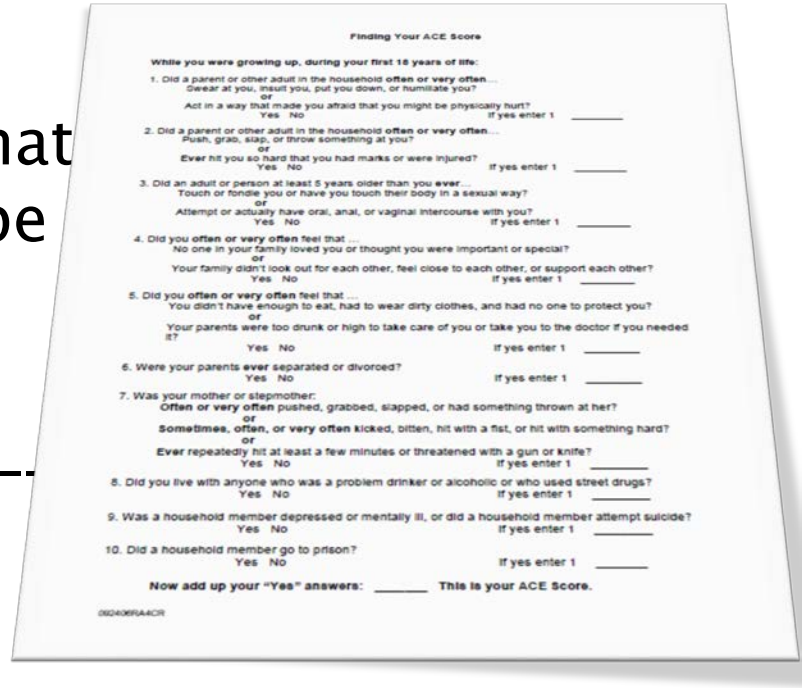
Complex Trauma: is caused by exposure to *multiple* traumatic events. The long-term impact of this exposure is severe and pervasive.

Historical Trauma: is a complex and collective trauma experienced over time and across generations by a group of people who share an identity, affiliation, or circumstance.

ACE SCORE CALCULATOR

1. Did a parent or other adult in the household **often:** Swear at you, down, or Act in a way that at you might be





Yes No If yes enter 1 _____

CALCULATING YOUR ACE SCORE

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 _____

CALCULATING YOUR ACE SCORE

3. Did an adult or person at least 5 years older than you **ever t**ouch 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 _____

CALCULATING YOUR ACE SCORE

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 _____

CALCULATING YOUR ACE SCORE

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 _____

CALCULATING YOUR ACE SCORE

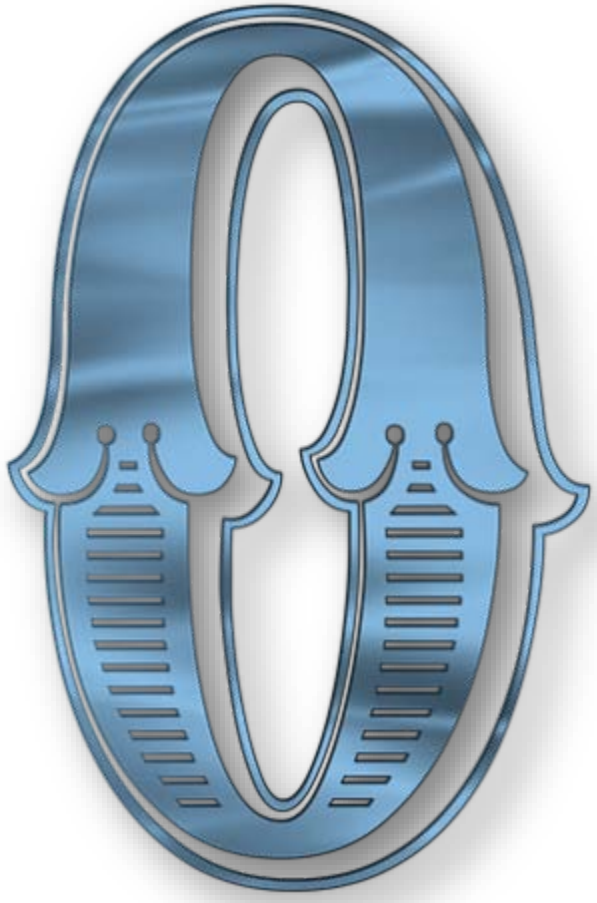
9. Was a household member depressed or mentally ill or did a household member attempt suicide?

   Yes No If yes enter 1 _____

10. Was a household member ever incarcerated?

    Yes No If yes enter 1 _____

Did Anyone Score Zero

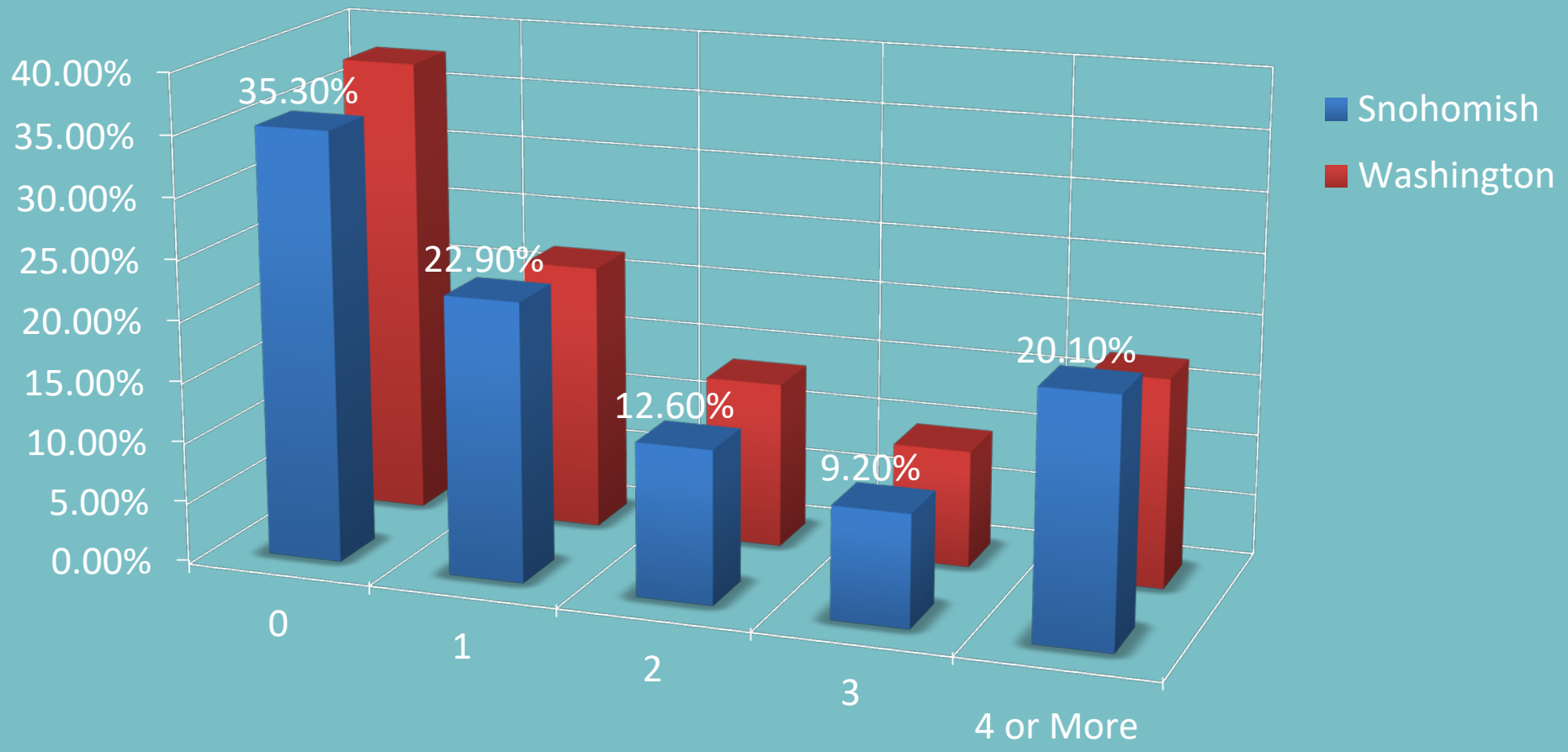


Compassion ○ Appreciation ○ Resilience ○ Empowerment

POLL: What is Your ACE SCORE?

Compassion ○ Appreciation ○ Resilience ○ Empowerment

ACES IN SNOHOMISH COUNTY

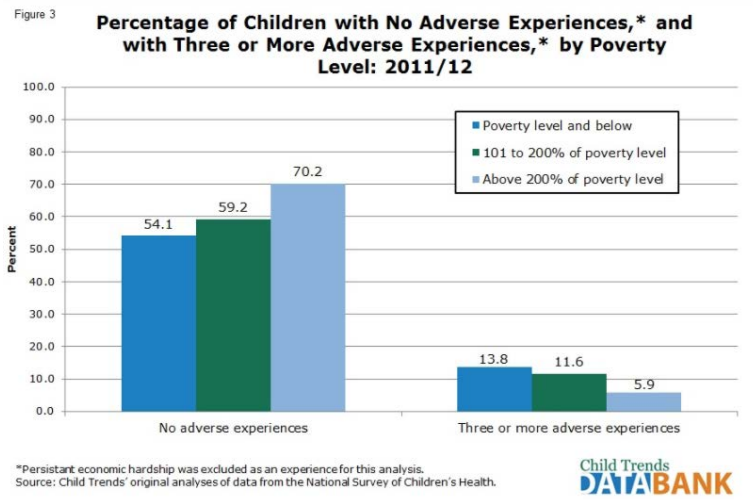


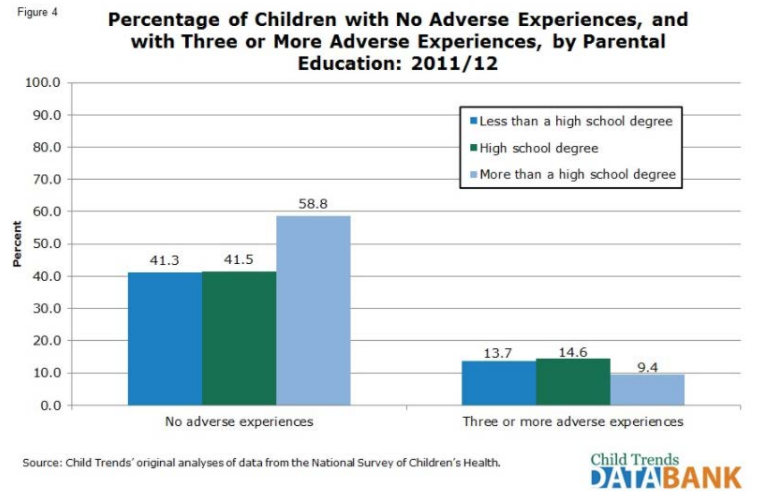
Five Minute Break

ACES & Poverty are Linked

If you serve youth, know that poor and near poor children are **more likely to be exposed to ACES** if their parents lack a high school education.

They are also **more than twice as likely** to have three or more categories of trauma exposure compared to children not impacted by poverty.





Do You Really Know Maja?

https://www.youtube.com/watch?v=E_zaoQFWeLs

Annotate: What is Maja's ACE SCORE?

0	1-3	4+

Compassion ○ Appreciation ○ Resilience ○ Empowerment

Annotate: Client of Concern

Do you suspect your client of concern has been exposed to ACEs?

No | Yes

ACE STUDY FINDINGS

COMMON

ACEs are strong indicators of what happens in school and later in life.

Category exposure determines outcomes

WELL CONCEALED

How Common are ACEs?

Unfortunately, ACEs are so common the CDC has deemed them the #1 chronic health epidemic

45%

The 2016 National Survey of Children's Health (NSCH) revealed that 45% of U.S. children have experienced at least one ACE

The most common ACEs nationally reported in this 2016 study were:

Economic Hardship

Divorce or Separation of a Parent or Guardian

64%

Almost **two-thirds** of participants of the original ACE study reported being exposed to at least one ACE

Women were more likely to report:

Emotional Abuse

Sexual Abuse

Mental Illness

The Brain Science

A person's environment and experience shapes their behavior and health.

Our brain is designed to prioritize survival.

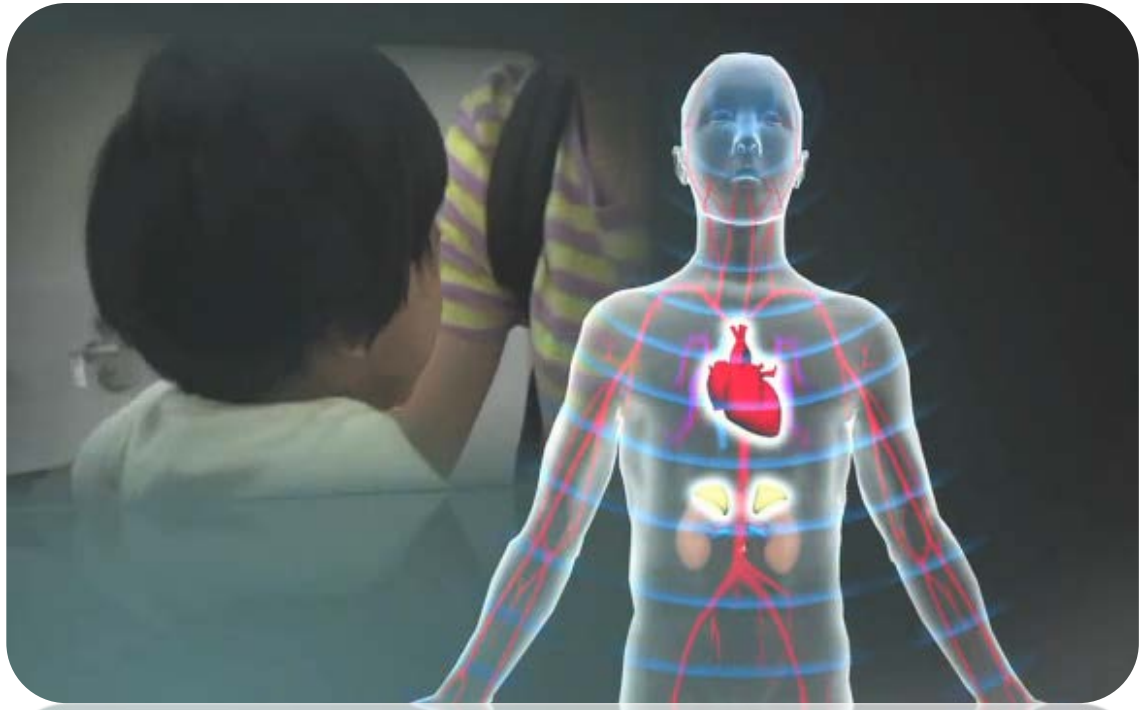
Hormones like Cortisol are released when our "Fight, Flight, or Freeze" response is triggered.

Toxic Stress

Prolonged exposure to Cortisol and other stress hormones is toxic, and makes permanent changes to the brain.

This means you may encounter clients who are **perfectly adapted to survive** in their home environment, but who **cannot turn-off** their behavioral and stress response adaptations in your organization, community or other “normal” situations.

Our Stress Response System



https://www.youtube.com/watch?v=rVwFkcOZHJw&t=2s

Not All Stress is Bad

Positive Stress

Common stressful events
that produce a mild stress response within the context of supportive families, schools and communities.

Tolerable Stress

Living in a high stress environment, but buffered by a supportive family and community system.

Toxic Stress

Continuous activation of the stress response system without a protective buffer, causing lasting damage and impairing parts of the brain responsible for learning, concentration and self-control.

Do You Recognize Signs of Traumatic Brain Development?

Hypervigilance – On edge, always scanning for threats.

Display of ADHD-like symptoms, including an inability to stay on task or follow directions, but meds don't work.

Difficulty identifying feelings or communicating needs.

Early onset of sexualized behaviors and activity.

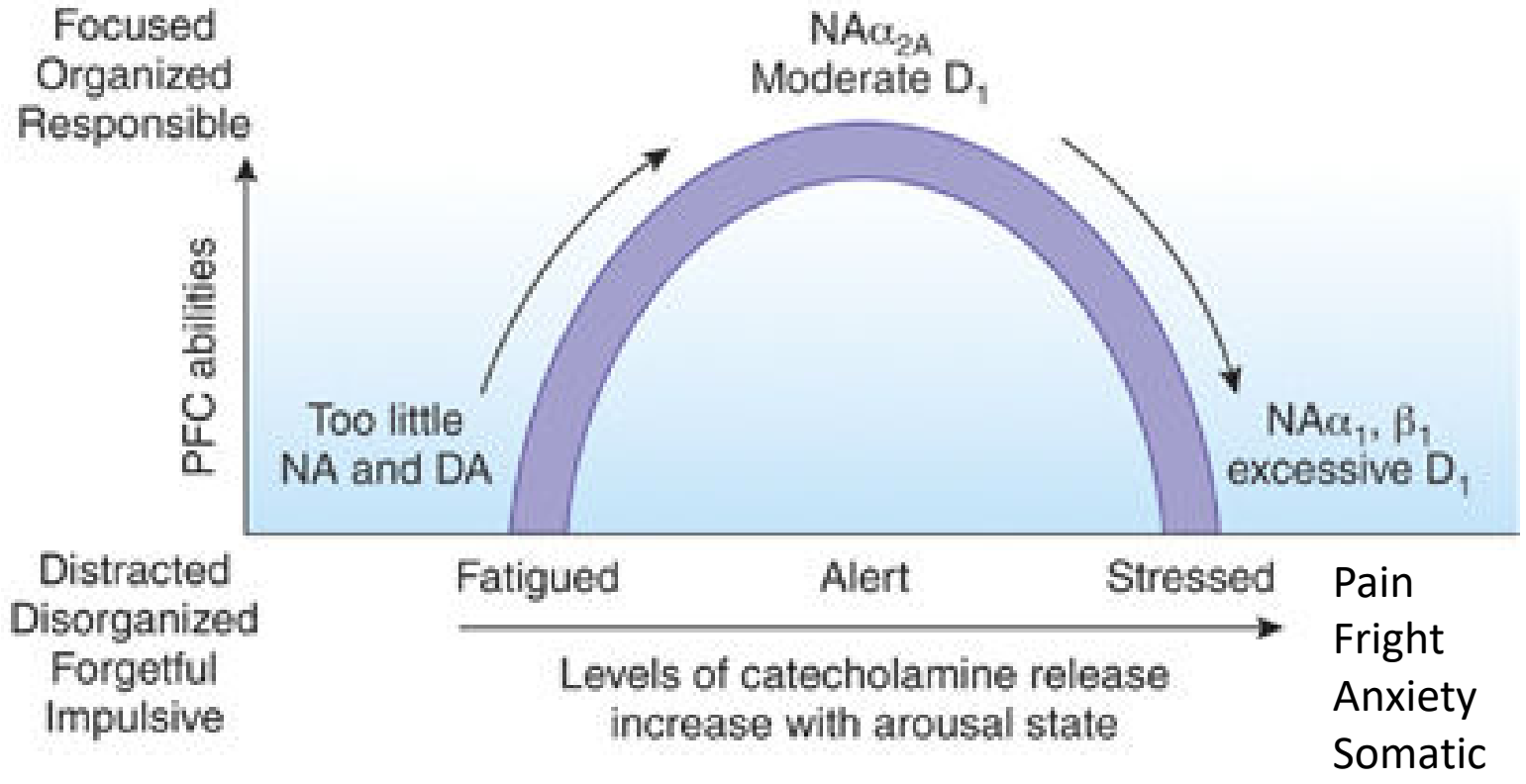
More impulsive, aggressive and disruptive behaviors, including those leading to suspension, expulsion and arrest.

Difficulty with transitions.

CATECHOLAMINE PRODUCTION IMPACTS ADHD SYMPTOMS

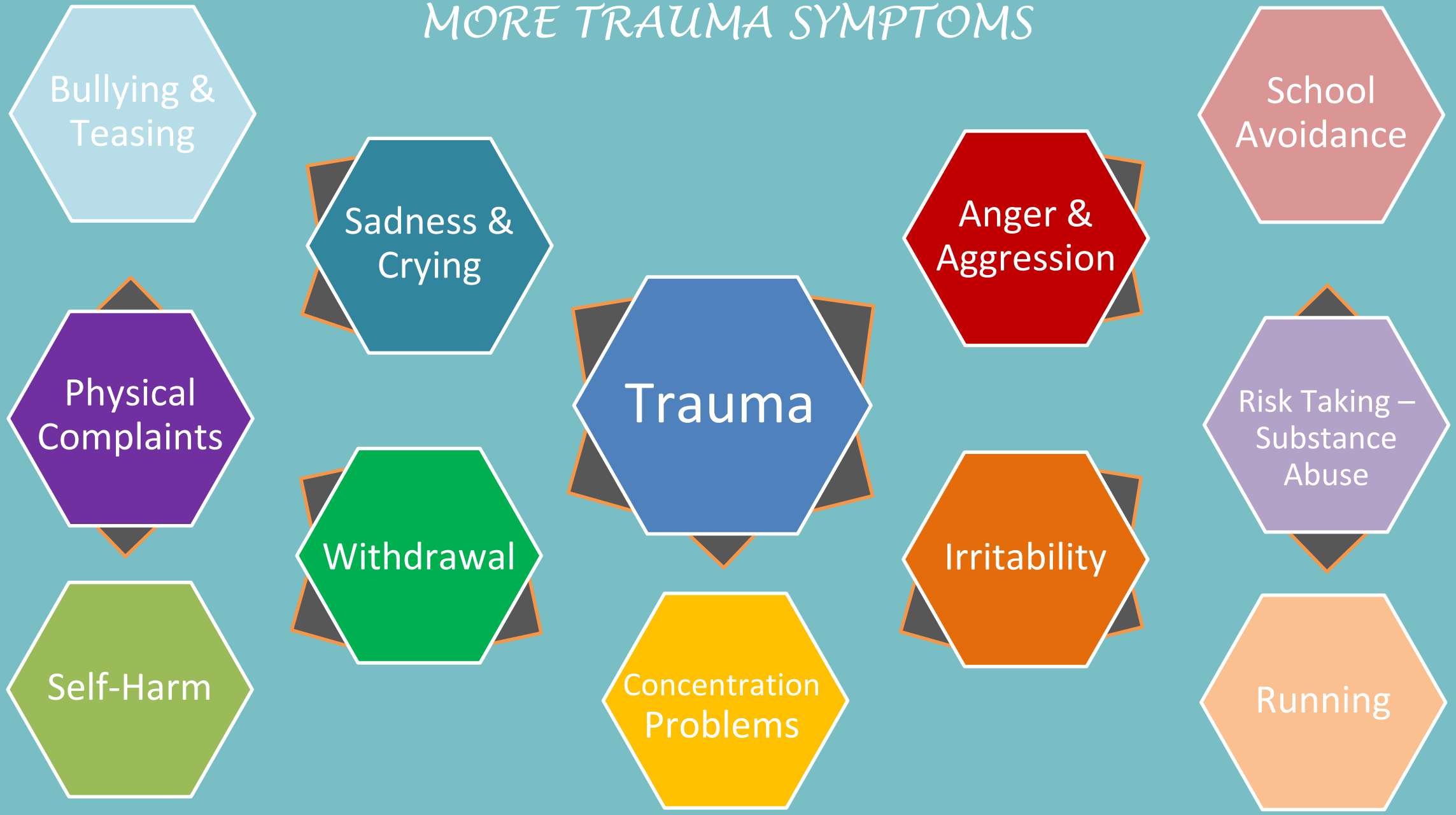
Low catecholamine production results in distracted and impulsive behaviors.

High catecholamine production impact somatic symptoms



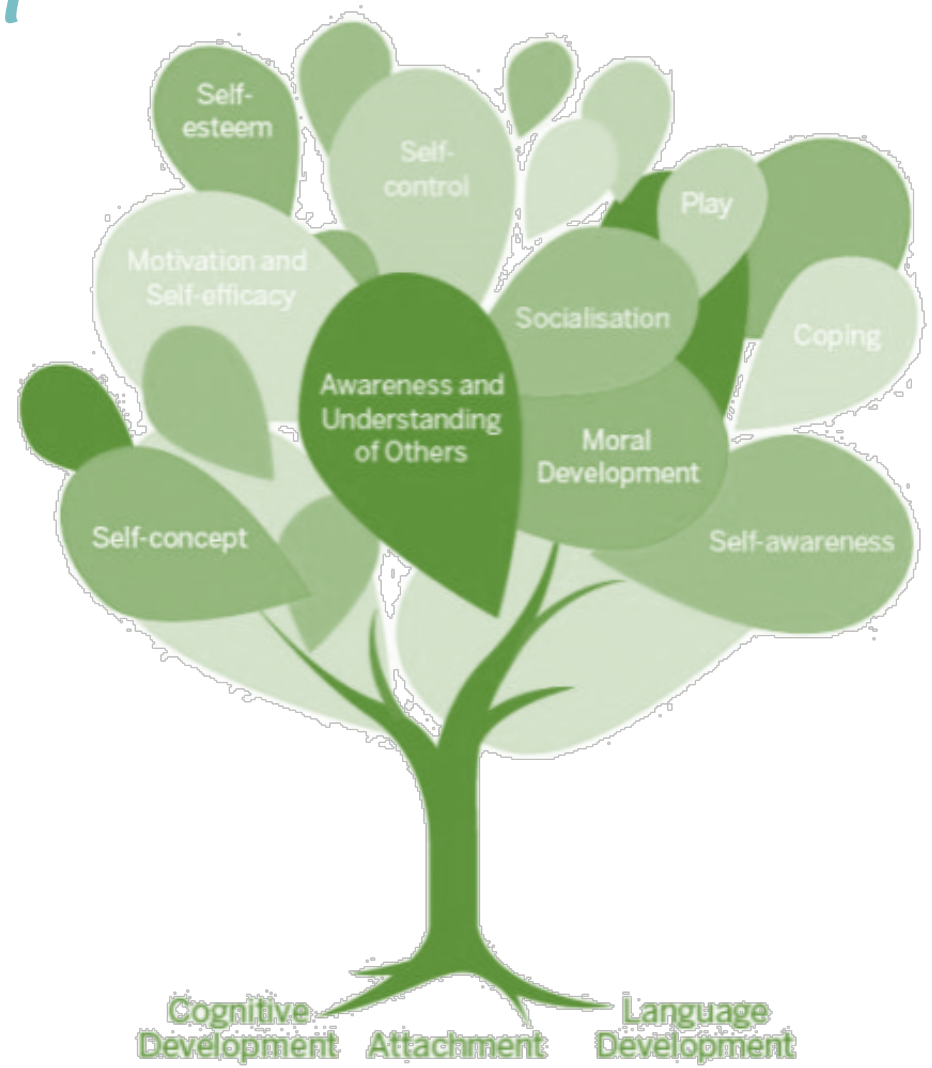
Neuropsychopharmacology (2010) **36,** 207-226; doi:10.1038/npp.2010.160

MORE TRAUMA SYMPTOMS



Trauma Impacts Self-Concept

- Hopelessness
- Body image
- Shame, guilt, self-blame
- Do not feel safe in this world
- Difficulty developing healthy relationships
- Dissociation
- Hard time with boundaries
- Hesitant to trust people for support or attention



Physiological Impacts

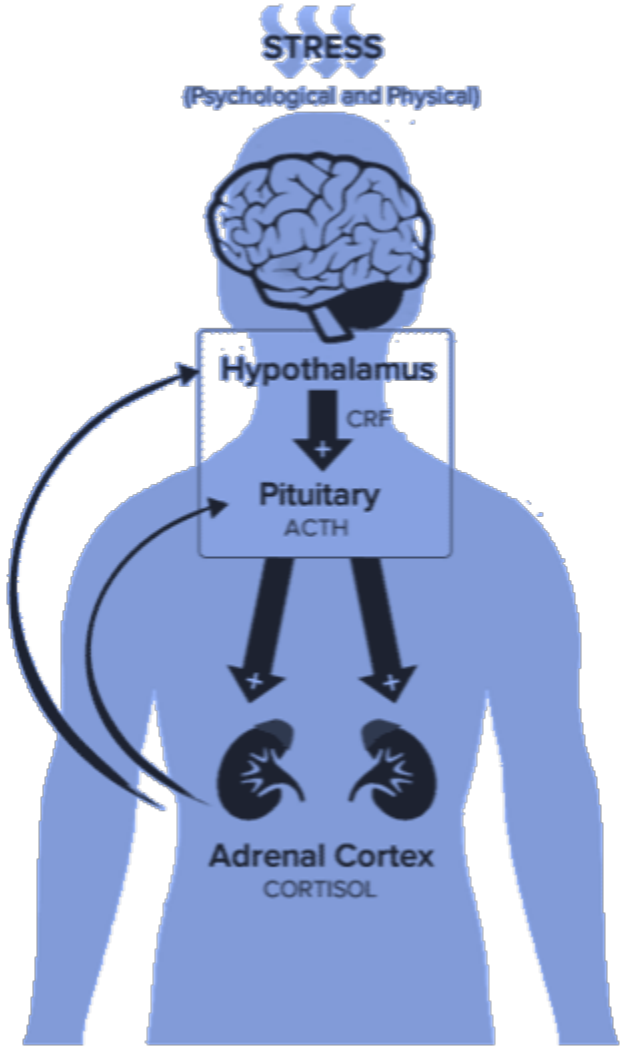
Trauma Induced Physiological Outcomes	
Difficulty concentrating and negative thoughts	Headaches, muscle tension, stomach aches and other somatic symptoms
Impaired memory	Weakened immune system
Higher blood pressure	Decreased bone density and muscle tissue
Hyperglycemia (fatigue, excessive thirst/urination)	Slower healing
Coordination problems	Development of health risk behaviors

CORTISOL AWAKENING RESPONSE

People exposed to high levels of conflict, abuse or other dysfunction may develop dysregulated HPA Axis reactivity, leading to increases in health and social, emotional and behavioral problems.

Cortisol Awakening Response (CAR) – A burst of the stress hormone Cortisol at each morning wakeup that orients us to our place in space and time in order to prepare us for our day.

Our CAR brings us to full alertness, activates our immune system, helps us to recall memories that help us to anticipate our day (like a project being due or an upcoming test), and increases energy availability for coping with demands.



Source: Zhang, Jihui et al. "Family Conflict and Lower Morning Cortisol in Adolescents and Adults: Modulation of Puberty." *Scientific Reports* 6 (2016): 22531. *PMC*. Web. 27 Mar. 2018.

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BLUNTED STRESS RESPONSE

Blunted Stress Response – Occurs when constant activation of the stress response system creates a homeostatic reaction in the HPA Axis – a forced dampening of stress hormone production.

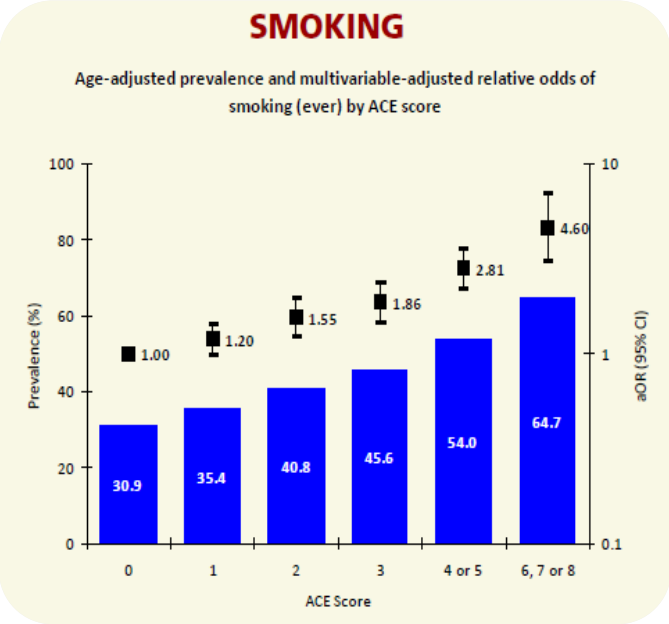
A dysregulated CAR system diminishes executive function and is related to these issues in your classroom:

Memory Distortion	Persistent Aggression	Diminished Coping	Callousness
Depression	Hyporeactivity	Sleep/Fatigue Problems	Less adaptive to change
Anxiety/Pervasive Worry	Less motivation/ engagement	Blunted response to reward	Over-response to social environment

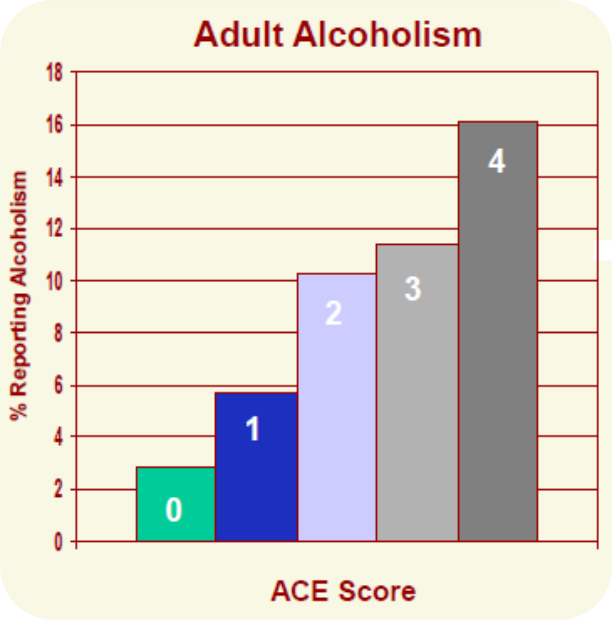
Researchers have linked advanced stress management skills to improvements CAR functioning.

McGinnis, Ellen W et al. "Cortisol Awakening Response and Internalizing Symptoms Across Childhood: Exploring the Role of Age and Externalizing Symptoms." International journal of behavioral development 40.4 (2016): 289–295. PMC. Web. 29 Mar. 2018.

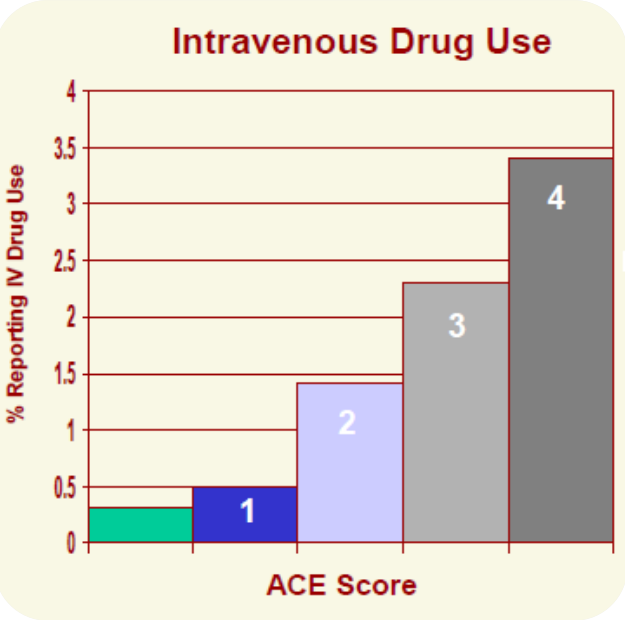
ACES IMPACT BEHAVIORAL HEALTH



46% increase from baseline.

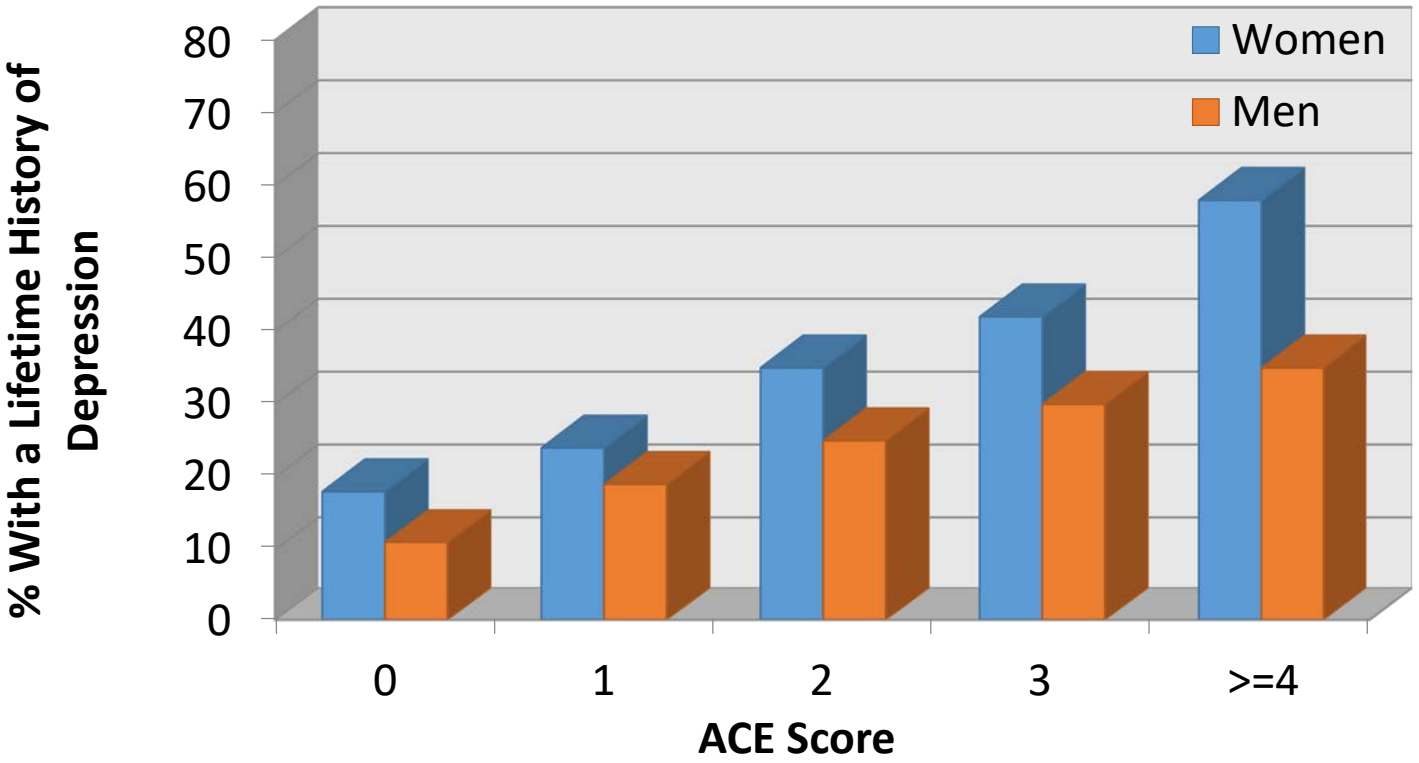


440% increase from baseline.



820% increase from baseline.

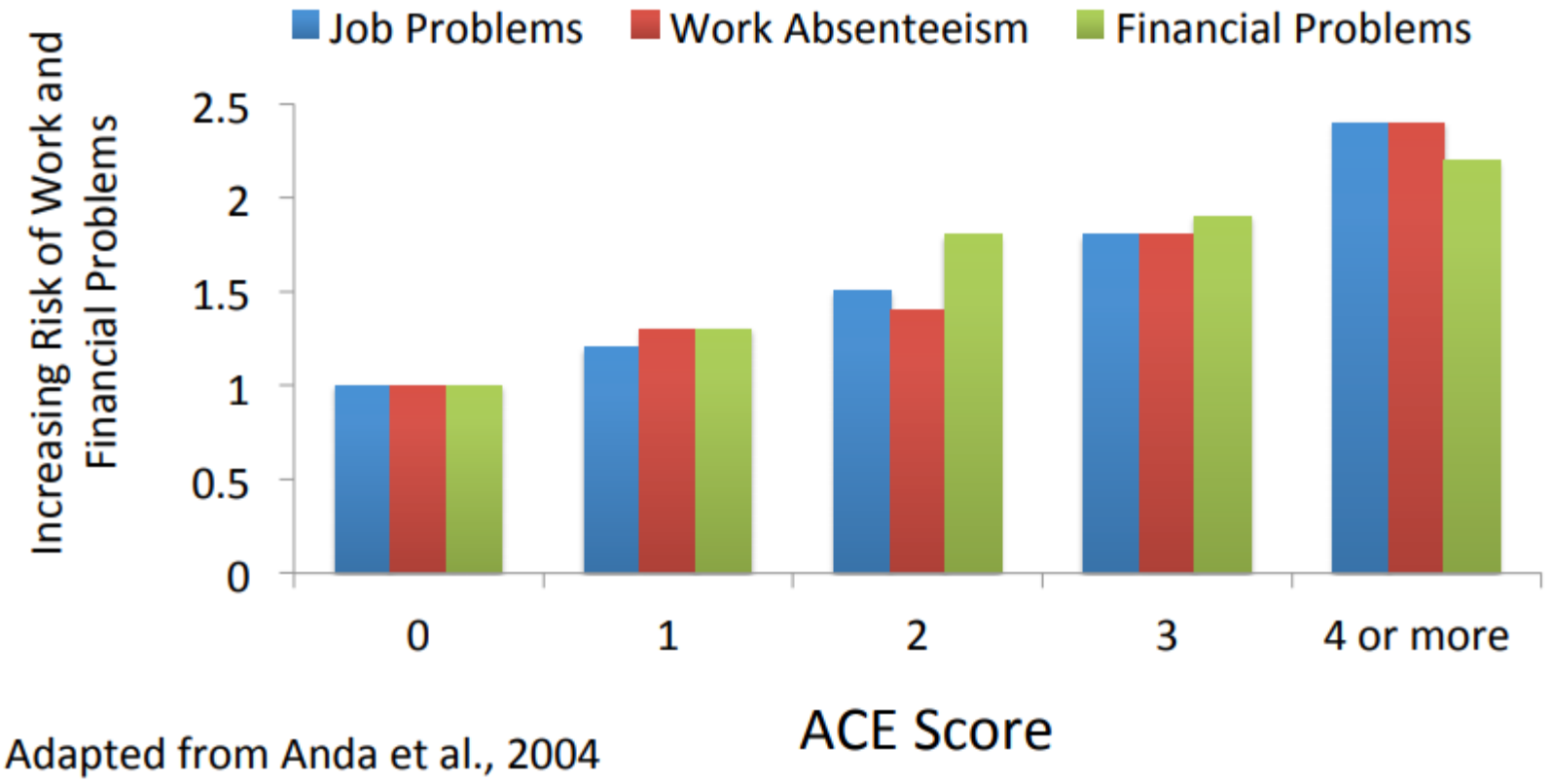
ACES IMPACT MENTAL HEALTH



220% increase from baseline.

2,275% increase from baseline.

ACES IMPACT EMPLOYMENT



Adapted from Anda et al., 2004

ACES LEAD TO THE 10 MOST COMMON CAUSES OF EARLY DEATH

REFRAMING OUR POINT OF VIEW

With an ACE score of 0, the majority of adults have few, if any, risk factors for the most common diseases leading to early death.

With an ACE score of 4 or more, the majority of adults have multiple risk factors for these diseases or the diseases themselves.

Much of what we see as problem behaviors should actually be viewed as a ***personal solution*** *to an unrecognized prior adversity.*

ACES IMPACT SNOHOMISH COUNTY SCHOOLS

Special education needs

Grade repetition

Problems at school

Educator burnout

Meet Malory

Mallory is in 8th grade at Centennial Middle School.

Her counselor knows Mallory's mother physically abused her in the past. As a result, **Mallory's *known* ACE Score is "1."**

Keep in mind - ACEs travel in clusters: Among people exposed to physical abuse, **84% report exposure to at least 2 additional ACEs.**

MALLORY'S AGGRESSION

Mallory is frequently sent to the office for aggressive and defiant behavior. Three months ago, she was suspended again for fighting in the cafeteria.

- Students like Mallory are **nearly twice as likely (1.9x)** to report getting into a **physical fight** within the past 12 months.
- They are **4.2x more likely** to be in **six or more physical fights**.

Washington State Healthy Youth Survey 2018 Results retrieved from www.askhys.net

BULLYING & SAFETY AT SCHOOL

Mallory has trouble making lasting friendships and is frequently the target of bullying behavior.

8th graders like Mallory are:

- **Twice as likely** (2.0x) to report being the *victims* of bullying.
- **3.0x as likely** to report missing days of school because they feel unsafe.

Washington State Healthy Youth Survey 2018 Results retrieved from www.askhys.net

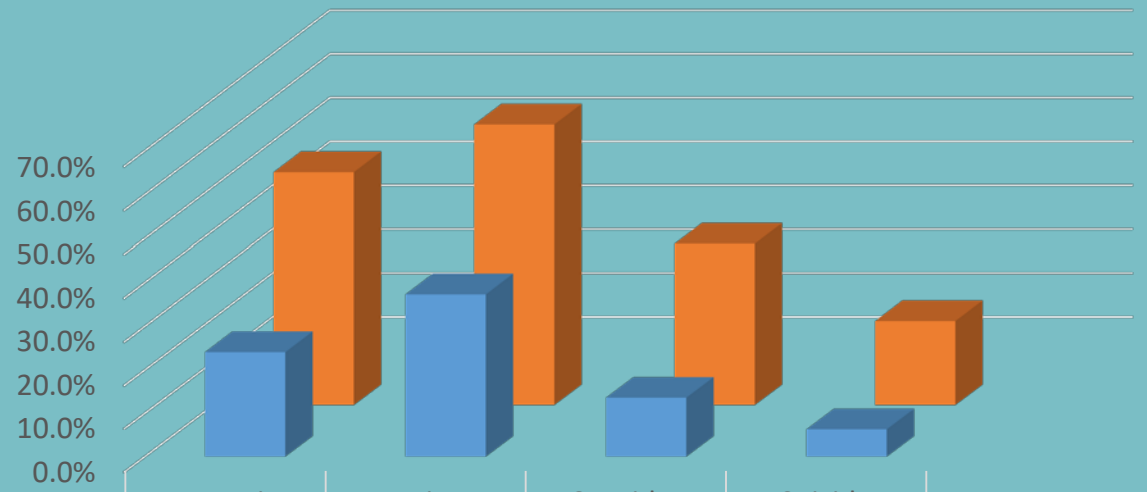
BEYOND ACES - BULLYING

Emerging evidence suggests the negative impacts of childhood bullying on long-term adult health and wellness outcomes are **more severe than the impacts of child abuse and neglect.**

The Lancet Psychiatry, Vol. 2, No. 6, p524–531, April 28, 2015

Bullying Impacts 8th Grade Mental Health

Source: Washington State Health Youth Survey 2018



	Depression	Anxiety	Consider Suicide	Suicide Attempt
Not Bullied	24.1%	37.3%	13.6%	6.3%
Bullied	53.2%	64.1%	36.9%	19.3%
Risk				
	2.2x	1.7x	2.7x	3.1x

MALLORY'S MENTAL HEALTH

Mallory seems pretty disengaged in class and always looks tired. She can't remember facts or directions from 10 minutes ago.

- Students who report being physically abused by an adult are **more than twice as likely** (2.2x) to report being **depressed** on the most recent HYS.
- They are also **nearly three times as likely** (2.8x) to report **contemplating suicide**.
- They are **more than three times as likely** **(3.3x)** to have made an actual **attempt to die by suicide** within the last year.

Washington State Healthy Youth Survey 2018 Results retrieved from www.askhys.net

MALLORY'S PERSONAL SOULTIONS

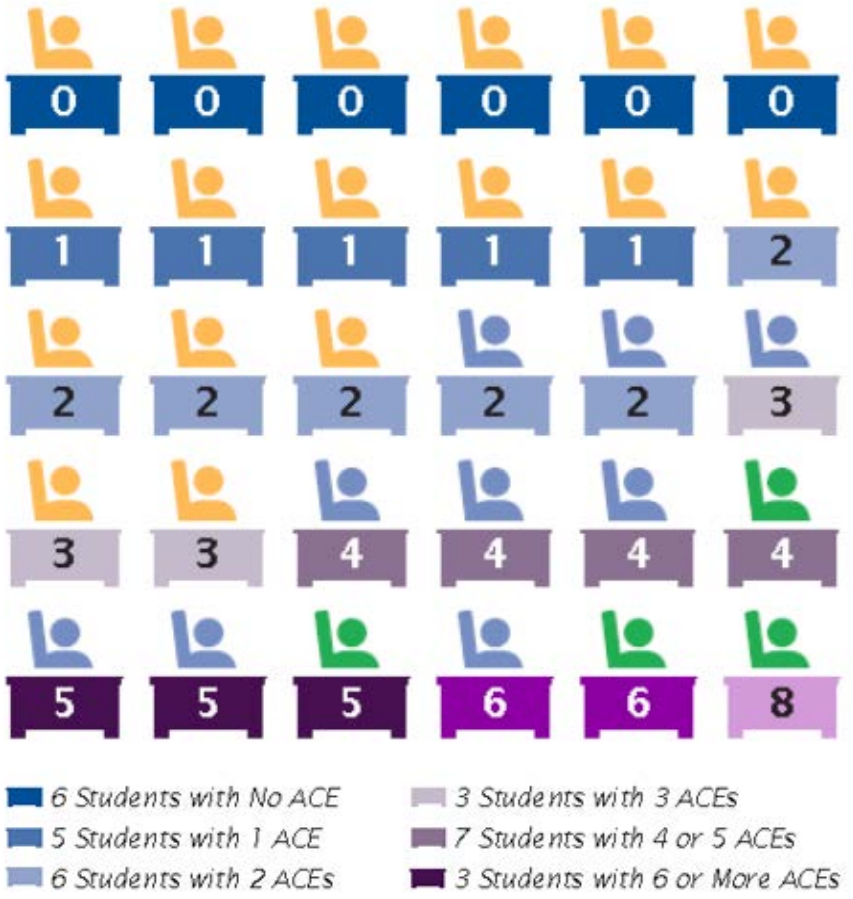
Mallory was caught bringing a flask of alcohol to school in 7th grade. She was suspended and hasn't really engaged with any helping adults since then.

- 8th Graders like Mallory are **3.4x more likely** to report **current alcohol or marijuana use**.
- They are **8.6x more likely** to indicate **current prescription pain killer use**.

Washington State Healthy Youth Survey 2018 Results retrieved from www.askhys.net

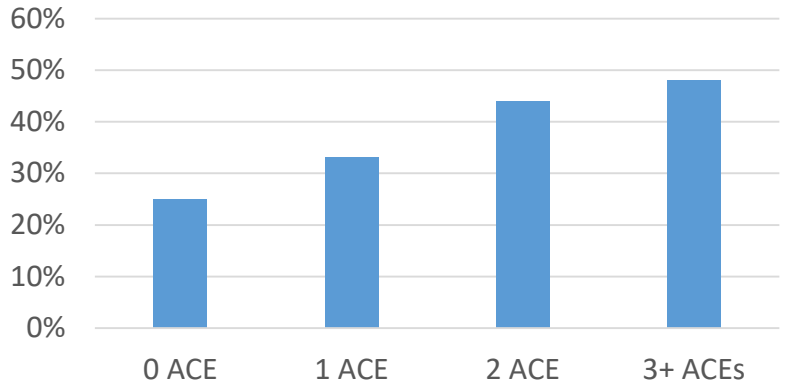
ACES in Every Classroom

More than 1 in 5 8th graders in Snohomish County Schools indicate they have been intentionally hurt by an adult on the most recent Healthy Youth Survey.

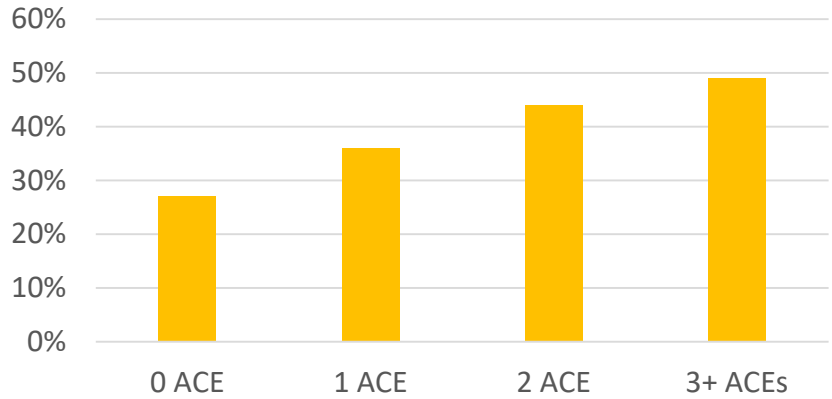


ACE IMPACTS RISK FACTORS FOR DROP OUT

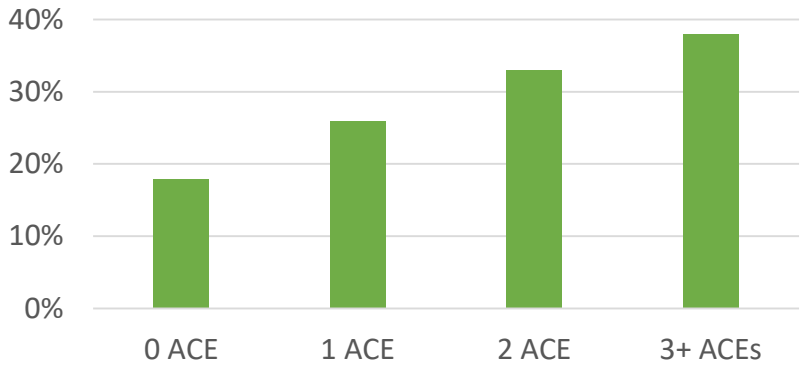
Low School Engagement



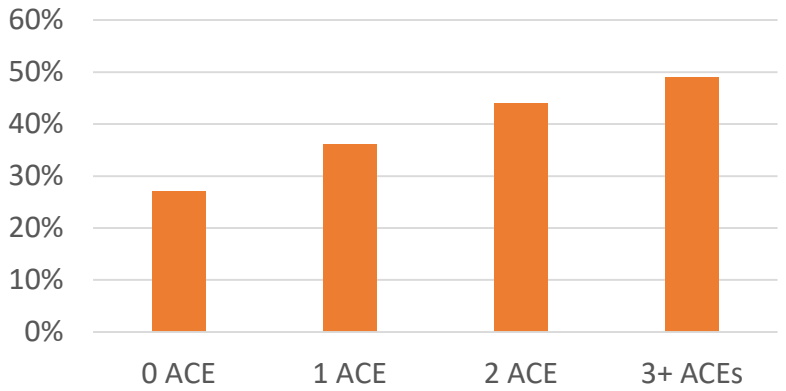
Contacted Home Due to Problems



Highly Externalizing Behavior

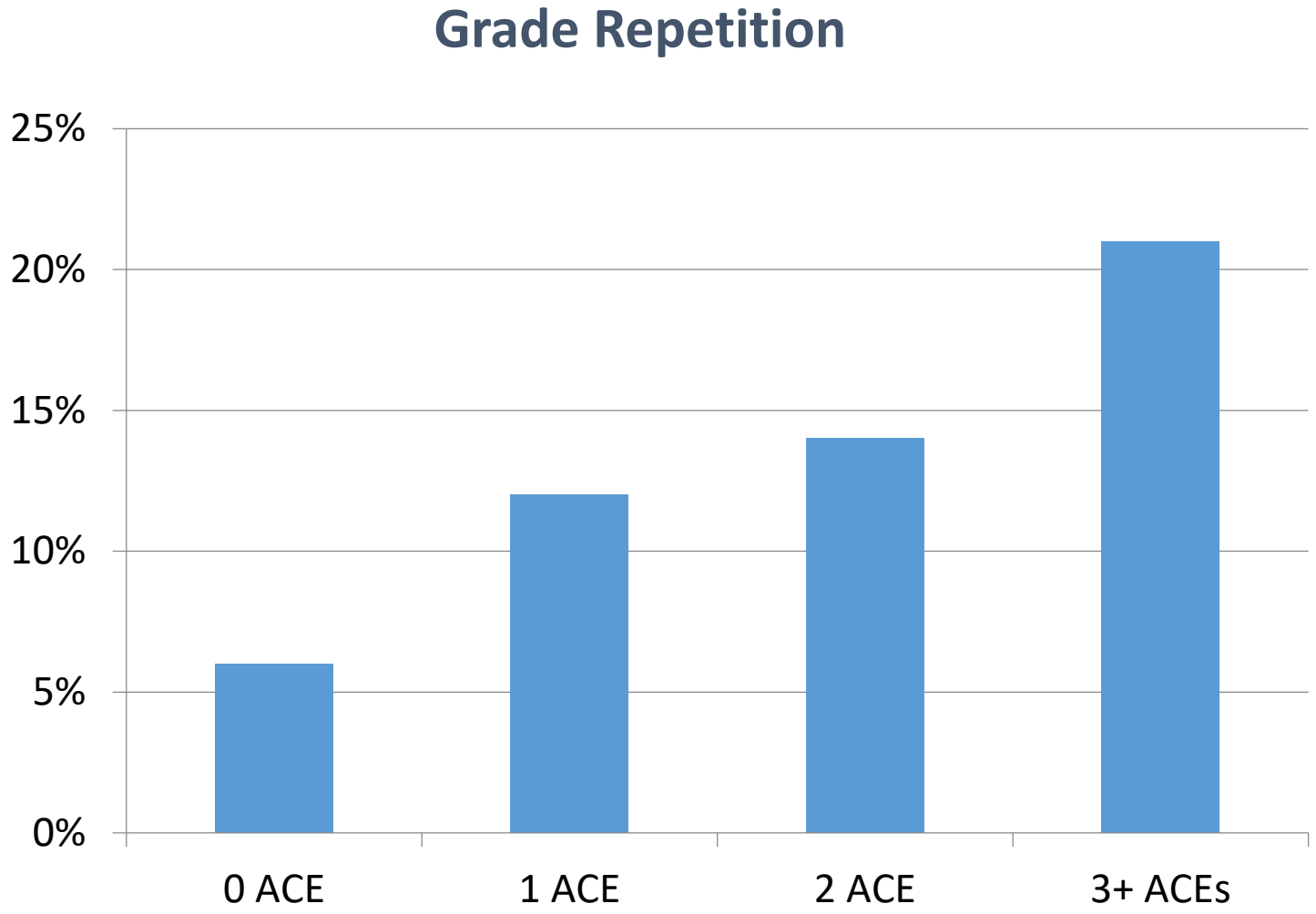


Does Not Finish Tasks Started



National Survey of Children's Health, Johns Hopkins University (2012)

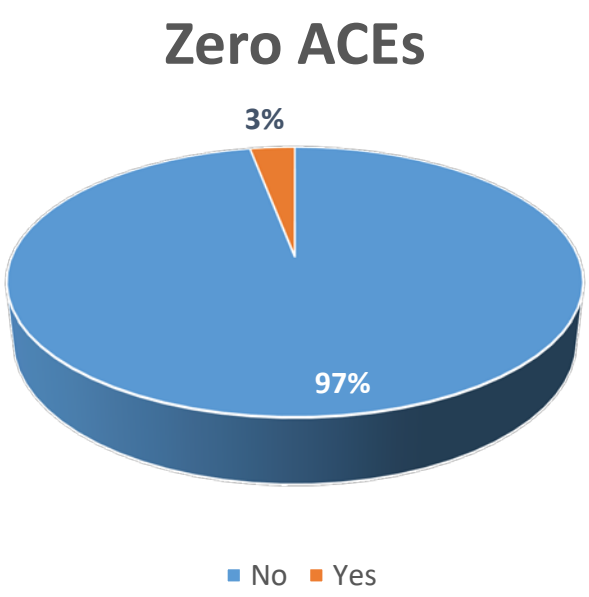
ACES IMPACTS RISK FACTORS FOR DROP OUT

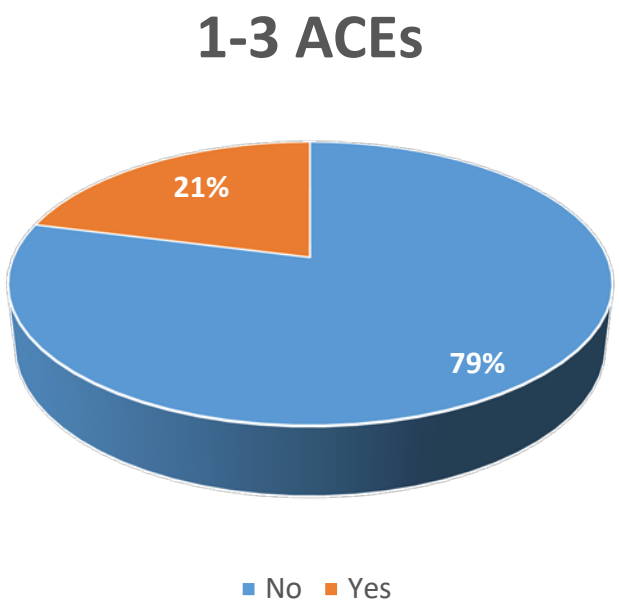


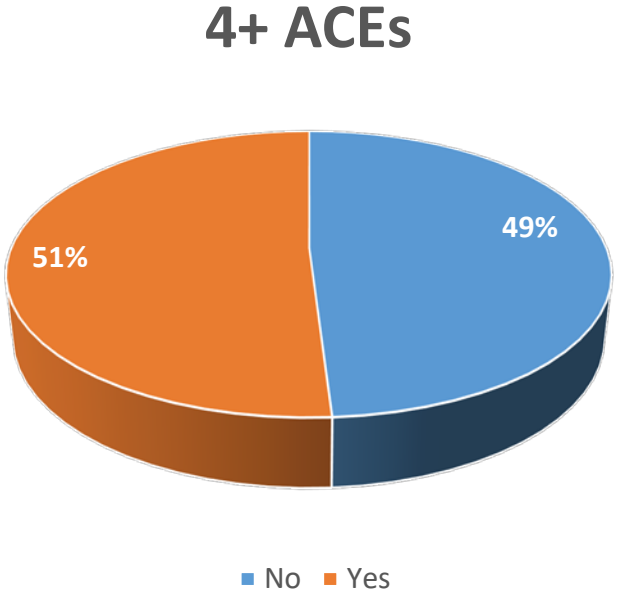
Source: National Survey of Children's Health, Johns Hopkins University (2012)

ACES IMPACT SCHOOL COSTS

NEED FOR ACADEMIC & BEHAVIORAL INTERVENTIONS







Burke, Nadine J. et al. "The Impact of Adverse Childhood Experiences on an Urban Pediatric Population." *Child abuse & neglect* 35.6 (2011): 408–413.

CLIENT OF CONCERN – 10 Minute Breakout Session

Think about a client for whom you have concern. Write down the following:

1. What worries do you have for this client?
2. What challenging behaviors does this client exhibit, if any?
3. Do you suspect this client has exposure to ACES?
4. **All behavior has a function. If we consider this client's behavior as a *personal solution* instead of a problem, what purpose might the behavior serve? How does the behavior help them to get their needs met?**

The link between Trauma & Health

Partial List of ACE Dose/Response Outcomes	
Alcoholism & alcohol abuse	School Drop-Out
Chronic obstructive pulmonary disease & ischemic heart disease	Significant Financial Problems
Depression and other MH issues	Sexually transmitted disease
Chronic Unemployment	Obesity
High risk sexual activity	Suicide attempts
Illicit drug use	Unintended pregnancy
Intimate partner violence	Early Death
Three or more marriages	Increased Emergency Room Use
Increased Pharmacy Use	Many more…

Why Trauma Awareness Matters

To put it simply, childhood experiences are the most powerful determinants of who we become as adults.

POPULATION ATTRIBUTABLE RISK

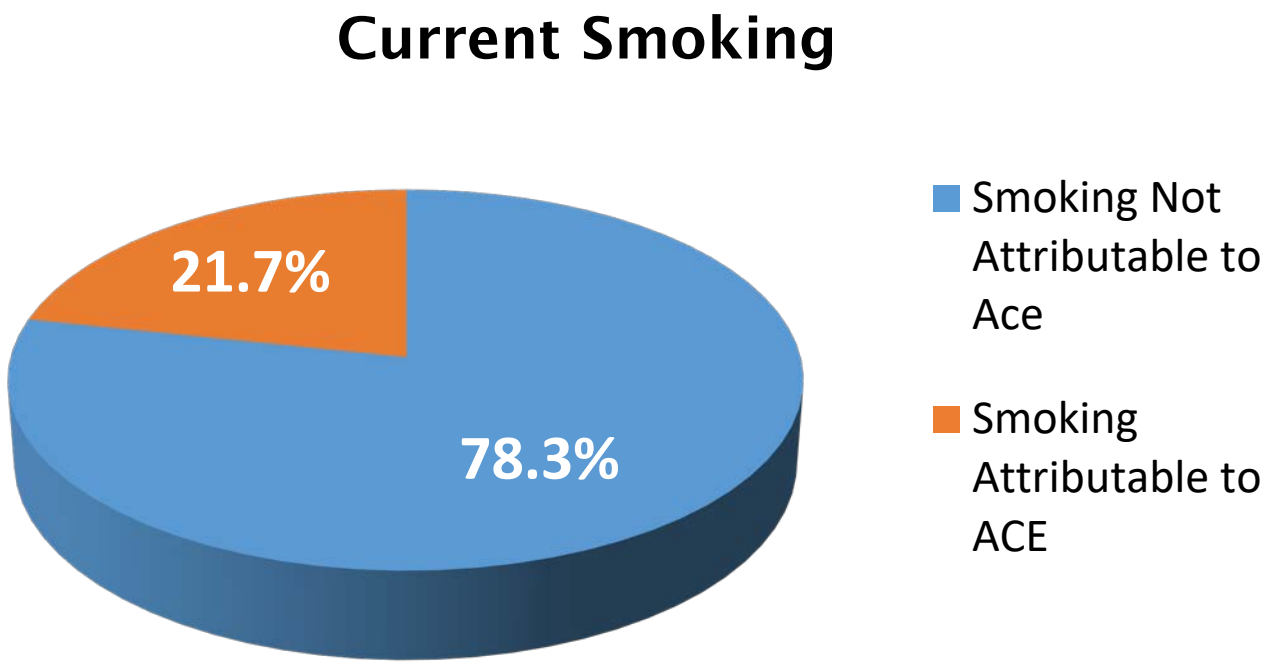
PAR = The difference in rate of a condition between an exposed population and an unexposed population.

In this case, it is a calculation used by the CDC to estimate the proportion of a health outcome caused by ACE.

Takes into account:

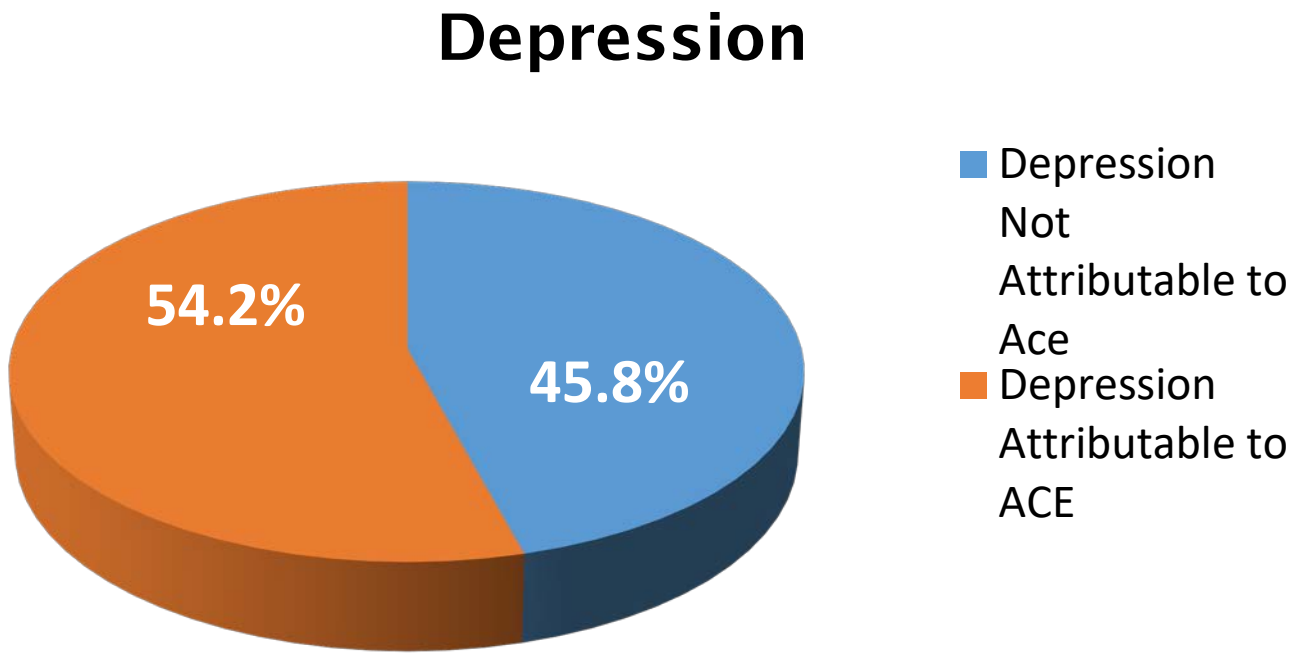
- The increased risk due to each level of ACE
- The prevalence of the number of ACE categories

POPULATION ATTRIBUTABLE RISK



Risk data from Felitti, et. al: PAR analysis: RE Voorhees

POPULATION ATTRIBUTABLE RISK



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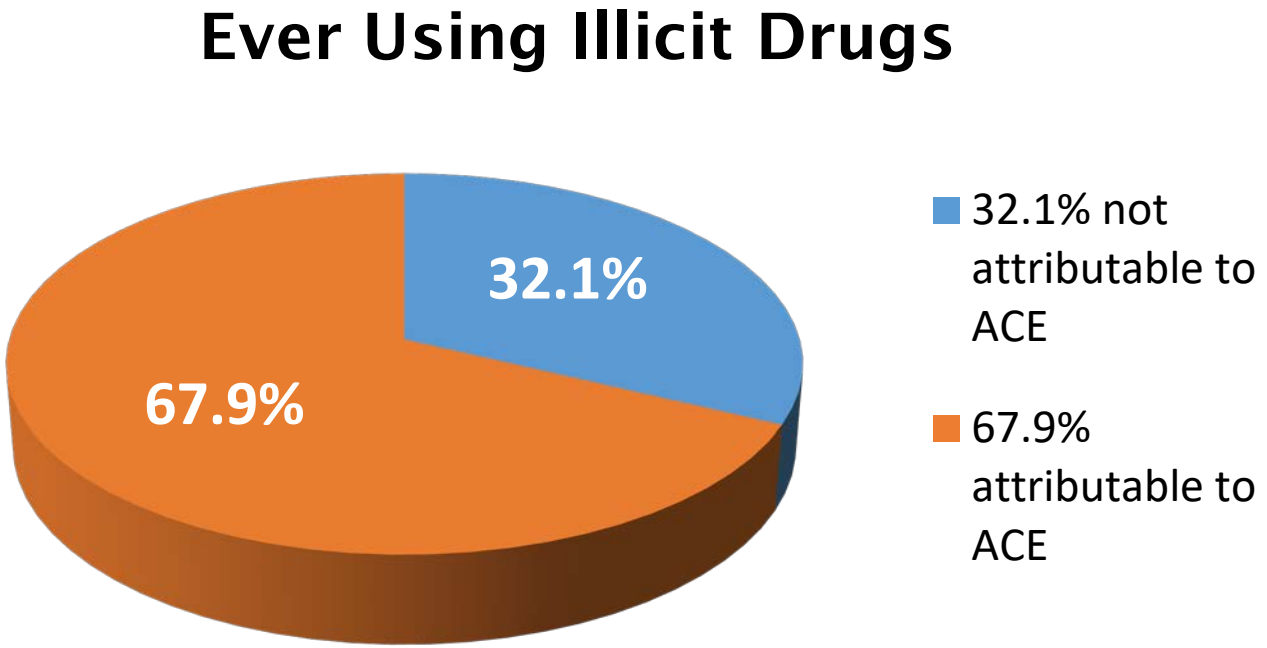

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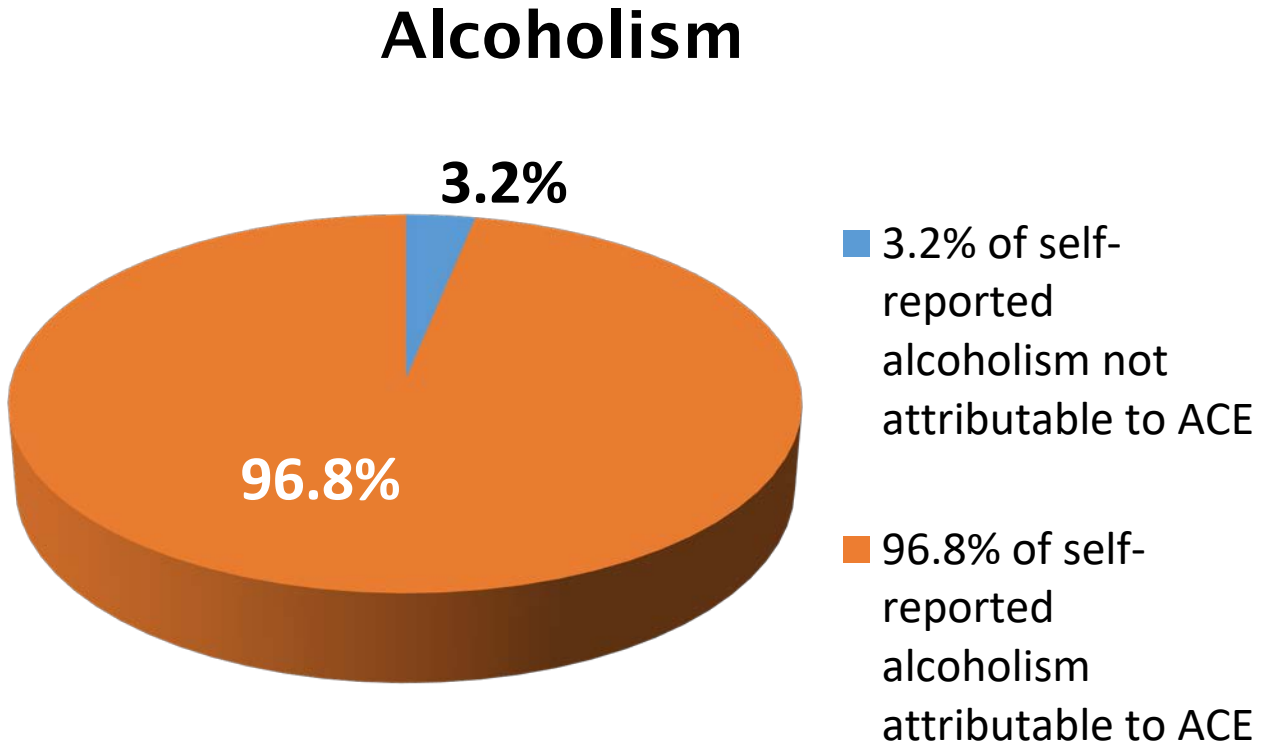

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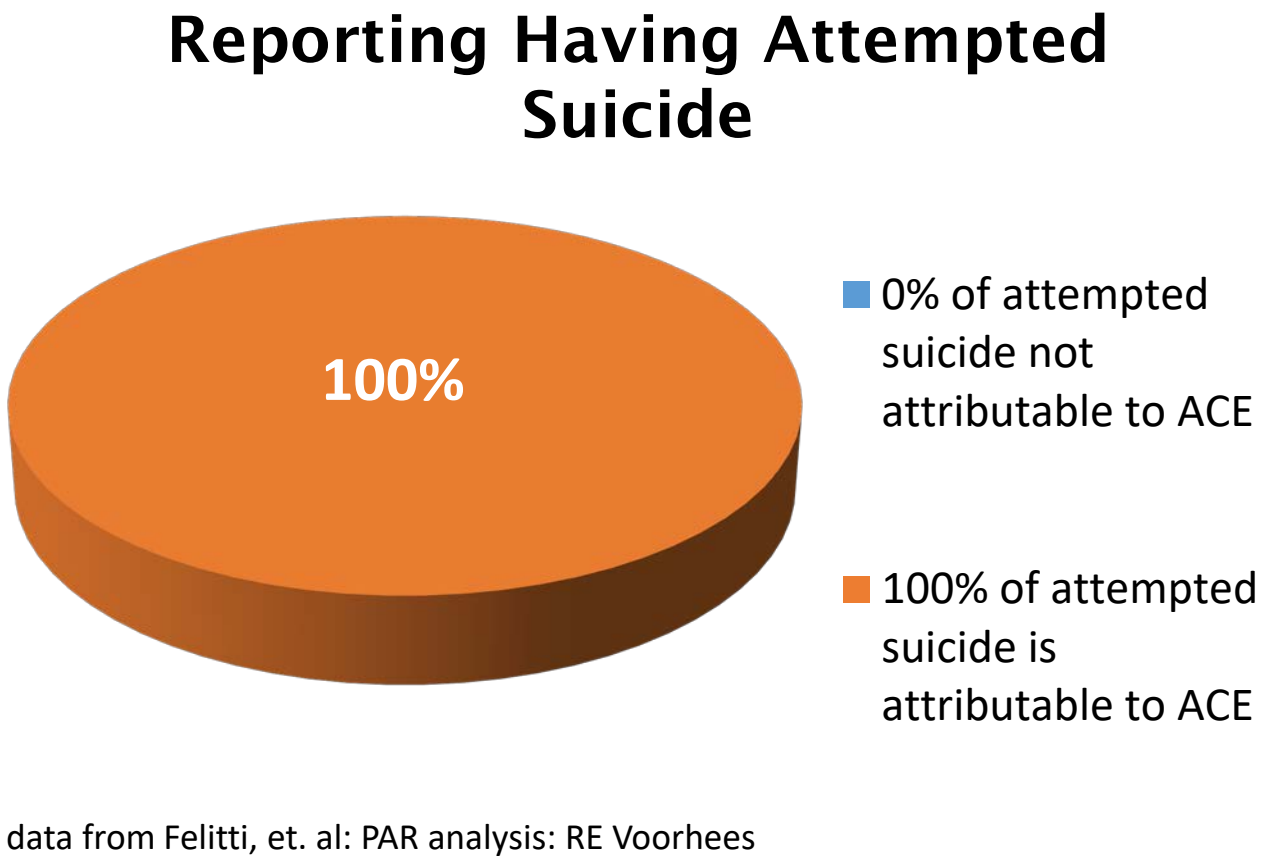

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The ACE Pyramid

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

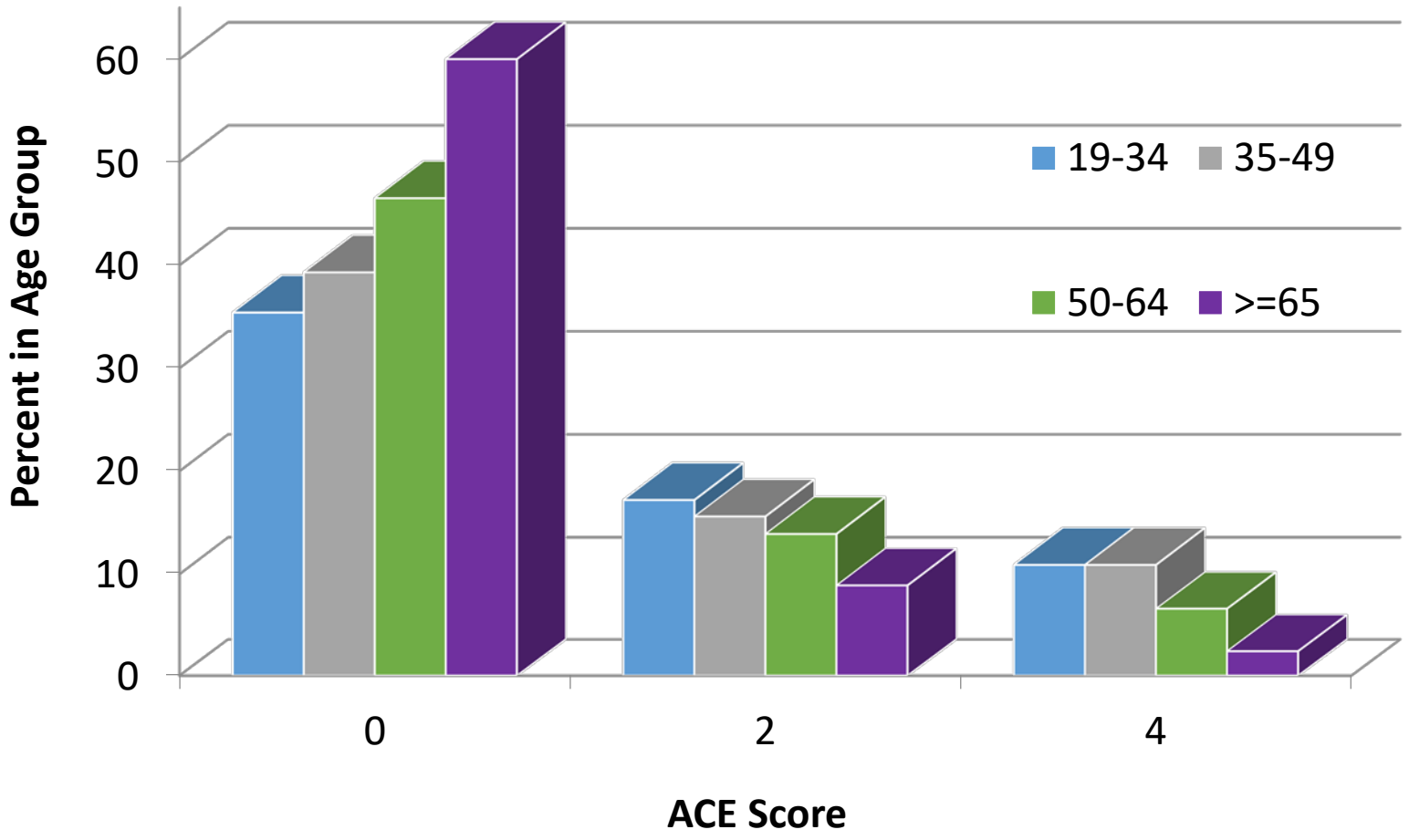
Without accounting for individual levels of resiliency, this pyramid depicts how impacts to health and well-being can occur over a lifetime as a result of exposure to Adverse Childhood Experiences.

The ACE study found links between ACEs and adult health risks, often leading to chronic health conditions.

Those with **4 or more ACEs** were found to be:

- **12.2x** as likely to have attempted suicide
- **7.4x** as likely to consider themselves to be an alcoholic
- **4.7x** as likely to have ever used illicit drugs
- **4.6x** as likely to have had 2 or more weeks of depressed mood in the past year
- **3.2x** as likely to have had 50 or more intercourse partners, and
- **2.3x** as likely to smoke

ACEs IMPACT MORTALITY

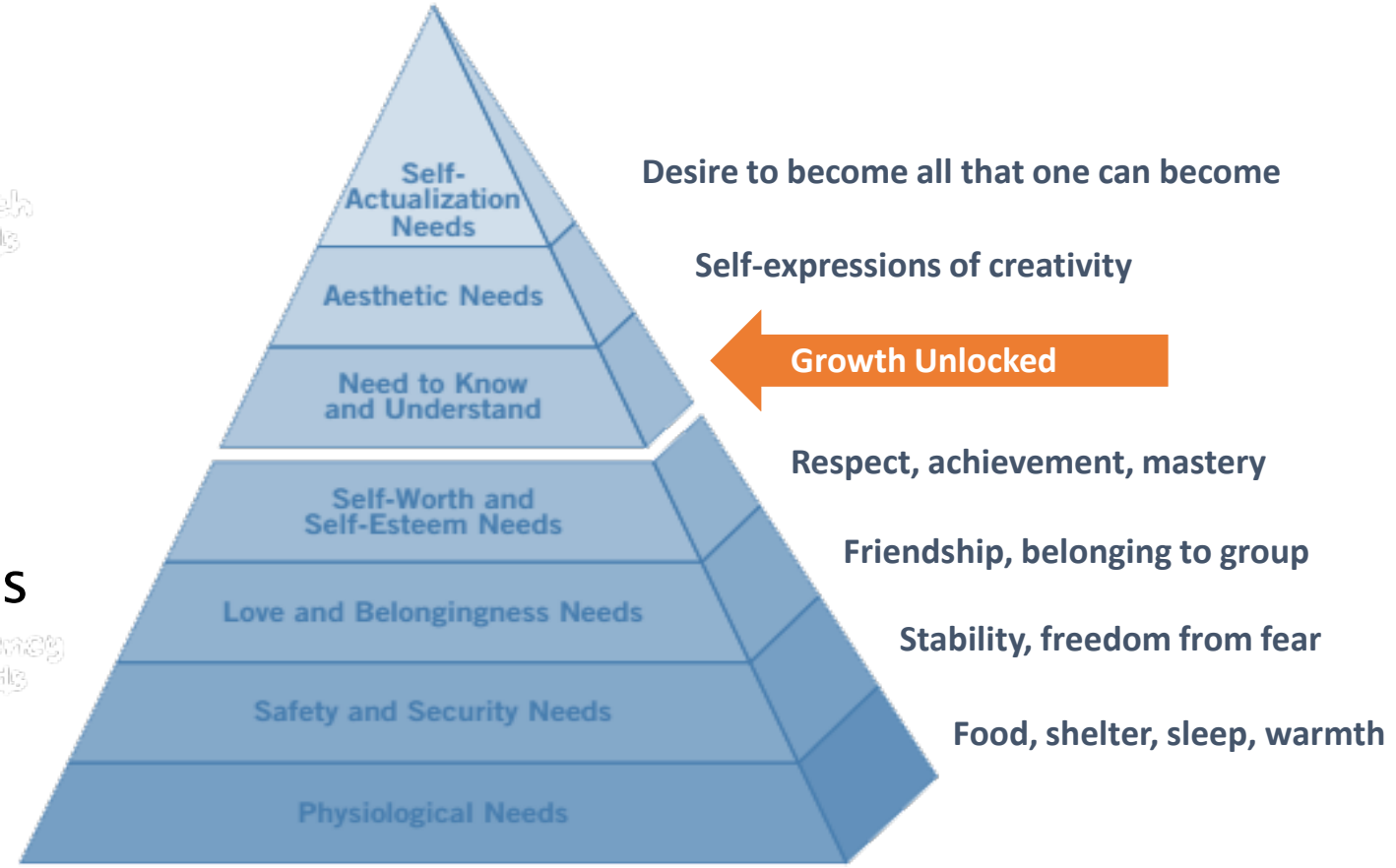


MASLOW MATTERS!

Maslow identified a hierarchy of needs to explain individual motivation.

Your clients must meet needs at the lower levels of the pyramid before tackling higher levels.

How do you intentionally address the Deficiency Needs of your clients to unlock your organization's mission?



You Matter!

Whether you like it or not, **most of you are on the ACEs frontline.** Without proper boundaries and self-care, you are likely to experience the **emotional residue** of working with trauma impacted clients.

- **Physical** – loss of sleep, not eating well, low energy
- **Emotional** – anxiety, sadness, numbness
- **Behavioral** – absent minded, losing things
- **Cognitive** – diminished concentration, loss of focus, hypervigilance
- **Interpersonal** – mistrust, withdrawal
- **Spiritual** – workplace frustration, feeling lack of support, not satisfied
- **Among social workers with only indirect exposure to trauma, the rate of PTSD is twice as high compared to the general public.**

Personal Impact - Compassion Fatigue

We experience compassion fatigue – a **profound emotional and physical erosion** – when we are unable to refuel and regenerate ourselves. This is when our empathy shuts down.

- **Wishing** a client would just get over it ("Suck it up.").
- **Blaming** clients for their problems.
- **Using anger** or sarcasm when trauma symptoms manifest.
- **Lacking Empathy** or fearing what the client will start to talk about next.
- **Ignoring** clear signs of trauma or avoiding the client altogether.

Self-Care is Client Care!

Taking care of yourself should be enjoyable. If it feels like a chore, try something else!

2 minutes

- Breathe
- Stretch
- Daydream
- Take your stress temperature
- Acknowledge an accomplishment
- Say no
- Compliment yourself
- Share a favorite joke

5 minutes

- Listen to music
- Have a cleansing cry
- Chat with a colleague
- Sing out loud
- Jot down dreams
- Step outside for fresh air
- Enjoy a snack or coffee

10 minutes

- Evaluate your day
- Write in a journal
- Call a friend
- Meditate
- Tidy your work area
- Assess your self-care
- Draw a picture
- Dance
- Listen to soothing sounds
- Surf the web (but avoid media)
- Read a magazine

30 minutes

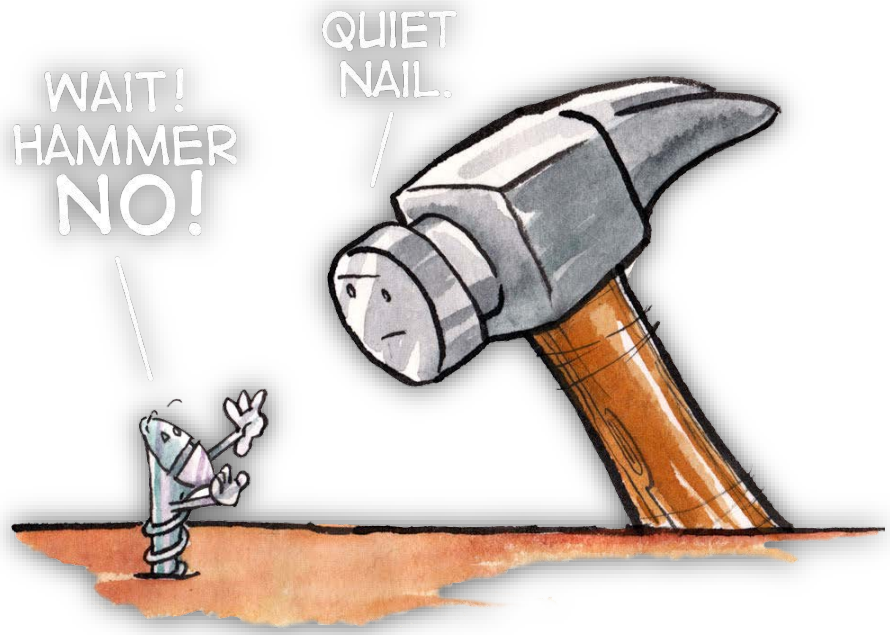
- Get a massage
- Exercise
- Eat lunch with a colleague
- Take a bubble bath
- Read non-work related literature
- Spend time in nature
- Go shopping
- Practice yoga
- Watch your favorite TV show.

There's Hope!

- **Trauma-informed organizations** create environments where injured brains have the best opportunity to thrive.
- **Research on resiliency and neuroplasticity** teach us that every person can bounce back from adversity.
- **Evidence-based Kernels** can lead us from intuitive responses to intentional action.

Five Minute Break

Looking Across Disciplines



"If all you have is a hammer,
everything looks like a nail."

- Abraham Maslow

How Wolves Change the Behavior of Rivers

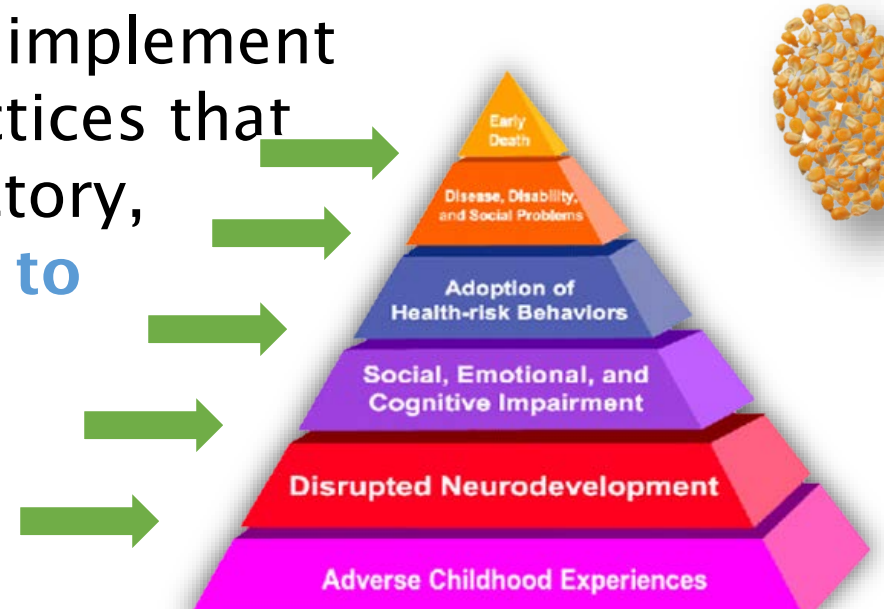
https://www.youtube.com/watch?v=ysa5OBhXz-Q

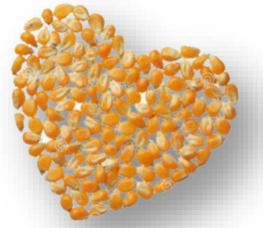
Let's Talk about Kernels

- Kernels are low or no-cost to evidence-based strategies recognized as fundamental units of behavioral influence.

- This means we can ***unleash access*** to strategies that support safety, relationship and skill building essential to our client's readiness to grow and learn.

- Kernels give us a way to implement simple but effective practices that interrupt the ACES trajectory, **move us from intuition to intention**, and improve outcomes.





What is a Kernel?

A kernel is the smallest unit of scientifically proven behavioral influence.

Kernels produce quick easily measured change that can grow into much bigger change over time.

They can be used alone **OR** combined with other kernels to create new programs, strategies or policies.

Combinations of Kernels are considered "behavioral vaccines."

"Planted" Kernels create a culture.

Managing Affect

- **Mood** is your internal emotional state.
- **Affect** is how you externalize your emotions through verbal and non-verbal cues.
- Research shows that **trauma-impacted people are particularly aware of changes in affect**, which triggers the survival brain, decreasing their capacity to think and learn.

Your Pain is My Pain

Mirror Neurons help us to instinctively understand the actions of others and prime us to imitate what we see.

This neural mechanism is involuntary and automatic.

Rubber Hand Illusion

https://www.youtube.com/watch?v=iPFSgLDCvAs

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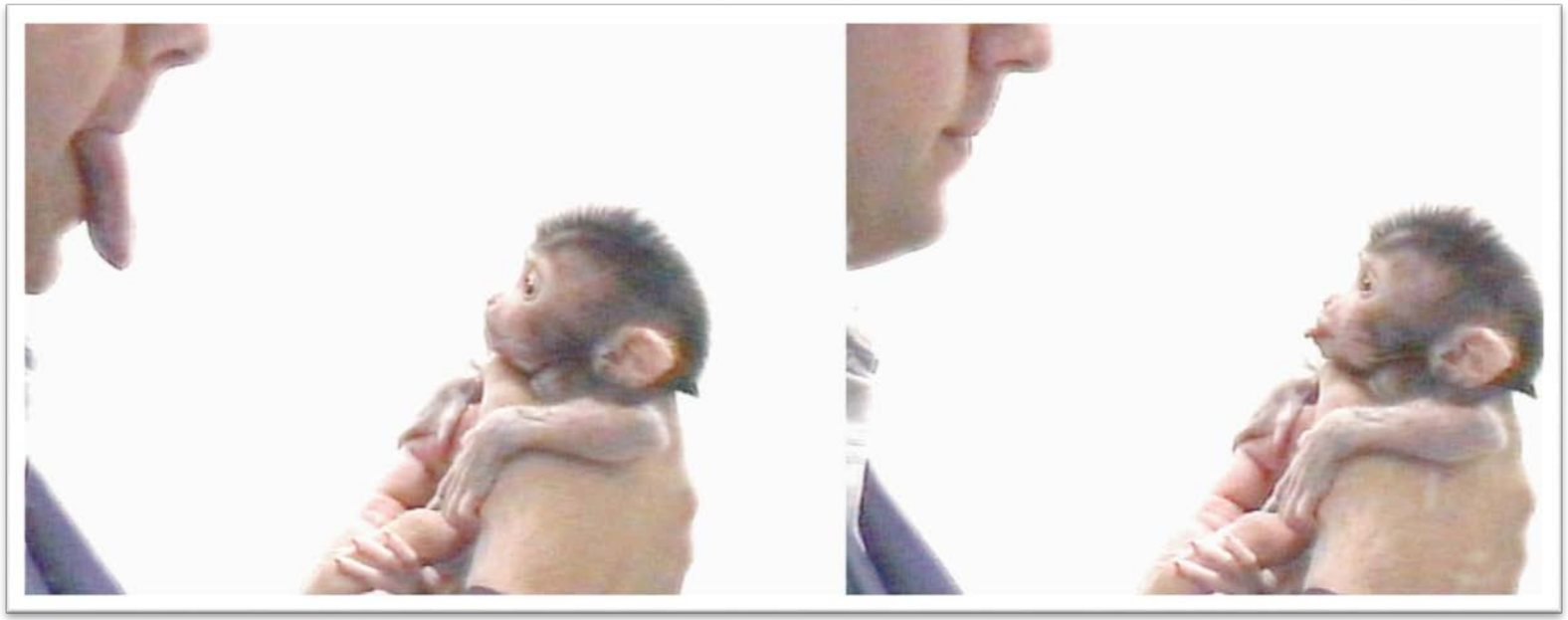

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Attunement

- Traumatized people, especially youth, often have difficulty communicating, so their behaviors may become a front for conveying unmet needs or dysregulated affect.

- We may respond to the most distressing symptom, rather than the client's underlying emotion or need.

- Ask - "What's happening here?" rather than, "What's wrong with this person?"

Consistency

Being predictable by having **consistent responses to client behavior** is vital to establishing safety and reducing your client's need to exert control.

An intentional focus on building success, rather than establishing limits – which may be associated with powerlessness or vulnerability – **should be your priority.**

Know that your most challenging clients may initially react with both negative or positive responses.

Routines and Rituals

- Building routines and rituals, particularly around trouble areas, can make meeting with you fun, safe and predictable.

- Research shows that establishing routines enhances client:

  - **Feelings of safety;**
  - **Ability to build trust and feelings of reliability within a relationship; and**
  - **Anticipation of an event, which reduces stress.**

From Concept to Application - 10 Minute Breakout Session

Consider the following evidence-based kernels:

- **Affect Management**
- **Attunement**
- **Consistency**
- **Establishing Routines and Rituals**

Discussion:

1. **How is your organization intentionally promoting or using these strategies among staff and with clients?**
2. **Are there any situations you can recall where the use of one of these strategies would have helped a client to be successful?**
3. **Brainstorm ideas about how these strategies can be incorporated into your work.**

Why Haven't We Heard this Before?

Play

- **Caretaker/child play** – is associated with lower rates of delinquency, substance abuse problems and psychiatric disorders such as depression and anxiety problems.
- **Physical play** – increases a child's ability to have healthy relationships by teaching basic skills for making and playing with friends.
- **Non-Directive Play** – improves the relationship with the parent, increases the happiness and contentment of the child, and results in greater attention span, improved creativity and resourcefulness.

Turtle Breathing

"Turtle Breathing" is a technique for helping children with controlling anger.

Trusted adults use this technique in conjunction with the scripted story, "Tucker Turtle Takes Time to Tuck and Think."

This technique:

- **Reduces anxiety**
- **Reduces temper tantrums**
- **Increases resiliency**
- **Increases self-control**

Turtle Breathing - Recipe

Model remaining calm

Teach the child the steps of how to control feelings and calm down

Step 1: Recognize your feeling(s)

Step 2: Think "stop"

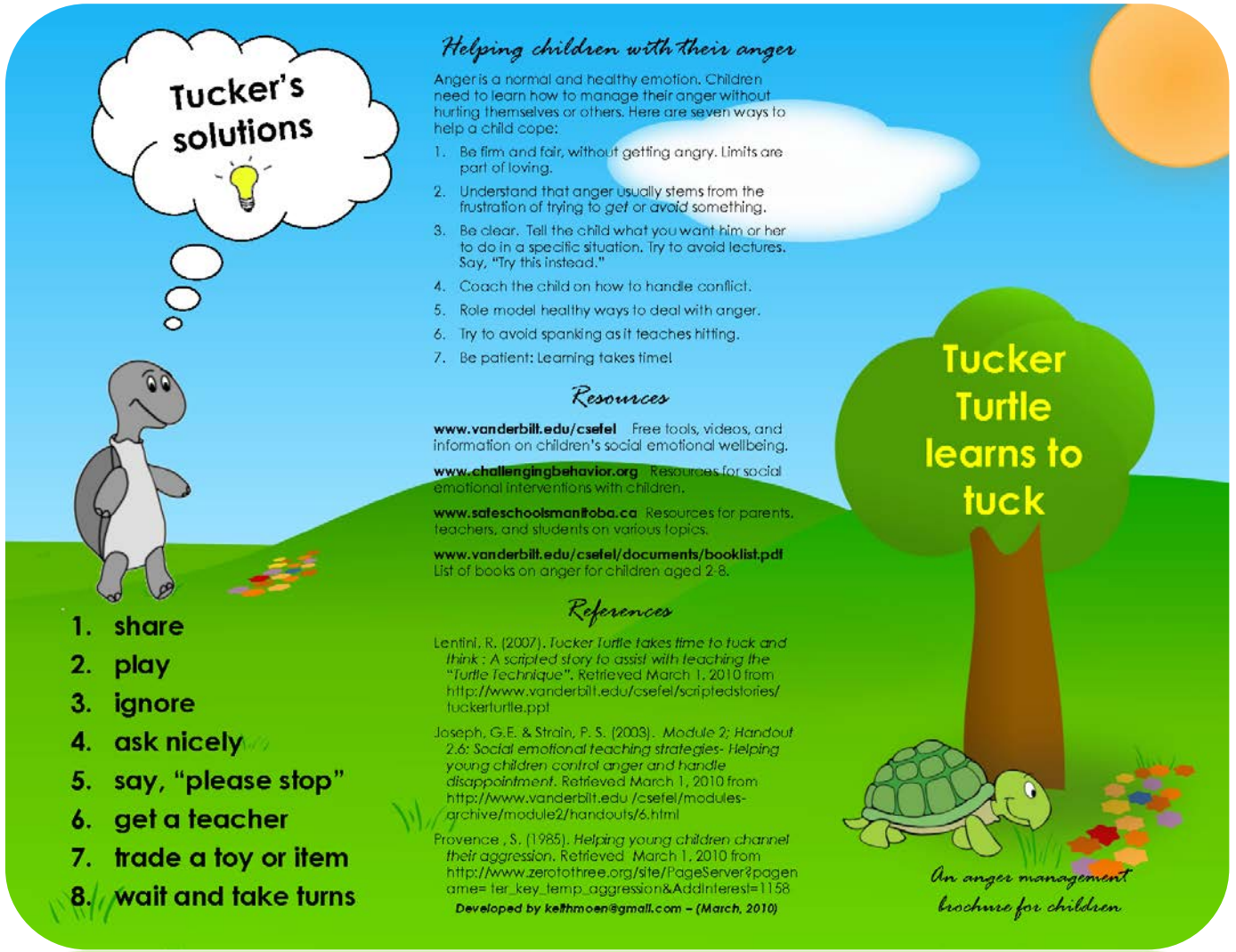
Step 3: Go inside your "shell" and take 3 deep breaths

Step 4: Come out when calm and think of a "solution"

Practice steps frequently

Recognize and comment when the child stays calm

Involve families: teach them the "Turtle Technique"


Tucker's solutions
1. share
2. play
3. ignore
4. ask nicely
5. say, "please stop"
6. get a teacher
7. trade a toy or item
8. wait and take turns
Helping children with their anger
Anger is a normal and healthy emotion. Children need to learn how to manage their anger without hurting themselves or others. Here are seven ways to help a child cope:
1. Be firm and fair, without getting angry. Limits are part of loving.
2. Understand that anger usually stems from the frustration of trying to get or avoid something.
3. Be clear. Tell the child what you want him or her to do in a specific situation. Try to avoid lectures. Say, "Try this instead."
4. Coach the child on how to handle conflict.
5. Role model healthy ways to deal with anger.
6. Try to avoid spanking as it teaches hitting.
7. Be patient: Learning takes time!
Resources
www.vanderbilt.edu/csefel Free tools, videos, and information on children's social emotional wellbeing.
www.challengingbehavior.org Resources for social emotional interventions with children.
www.safeschoolsmanitoba.ca Resources for parents, teachers, and students on various topics.
www.vanderbilt.edu/csefel/documents/booklist.pdf List of books on anger for children aged 2-8.
References
Lentini, R. (2007). Tucker Turtle takes time to tuck and think : A scripted story to assist with teaching the "Turtle Technique". Retrieved March 1, 2010 from http://www.vanderbilt.edu/csefel/scriptedstories/tuckerturtle.ppt
Joseph, G.E. & Strain, P. S. (2003). Module 2; Handout 2.6: Social emotional teaching strategies- Helping young children control anger and handle disappointment. Retrieved March 1, 2010 from http://www.vanderbilt.edu /csefel/modules-archive/module2/handouts/6.html
Provence , S. (1985). Helping young children channel their aggression. Retrieved March 1, 2010 from http://www.zerotothree.org/site/PageServer?pagename= ter_key_temp_aggression&AddInterest=1158
Developed by keithmoen@gmail.com – (March, 2010)
Tucker Turtle learns to tuck
An anger management brochure for children

Verbal Praise

When any person receives specific, spoken recognition for engagement in a target act or behavior, it is widely demonstrated to:

- **Improve school and work performance**
- **Improve prosocial interactions**
- **Improve organizational functioning**
- **Increase engagement in the noticed behavior**

Verbal Praise as a Social Reinforcer

What are the social reinforcers in your organization for this behavior?

Paying attention.

Verbal Praise as a Social Reinforcer

How about for this behavior?

Attention Seeking or Distracting

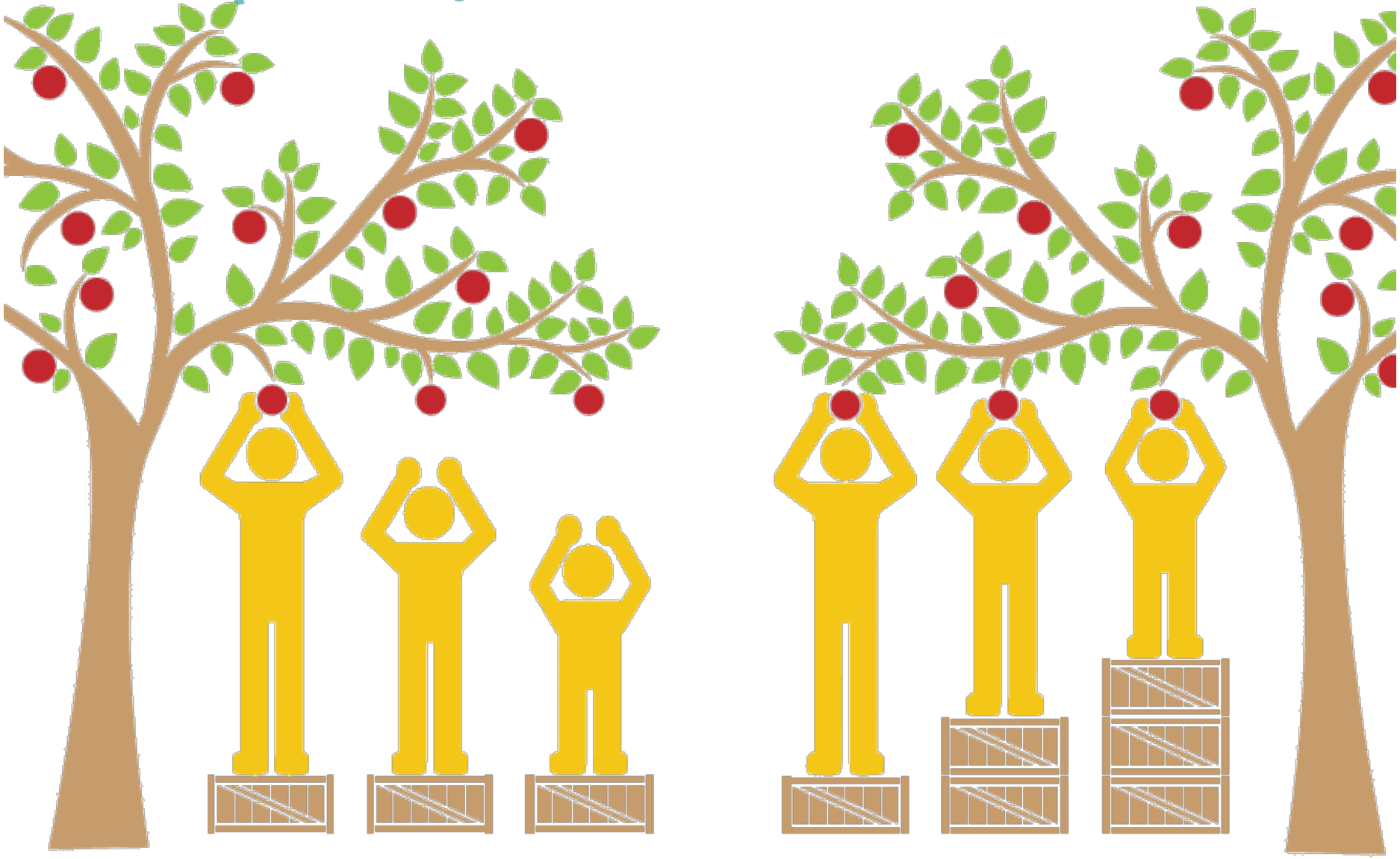
I - FEED - V

Use the I-Feed-V mnemonic to guide your use of praise (Loveless, 1997):

I = immediate
F = frequent
E = enthusiastic
E = eye contact
D = describe the behavior
V = variety

Ratio of praise to criticism = 4:1 *(Watson, 2004)*

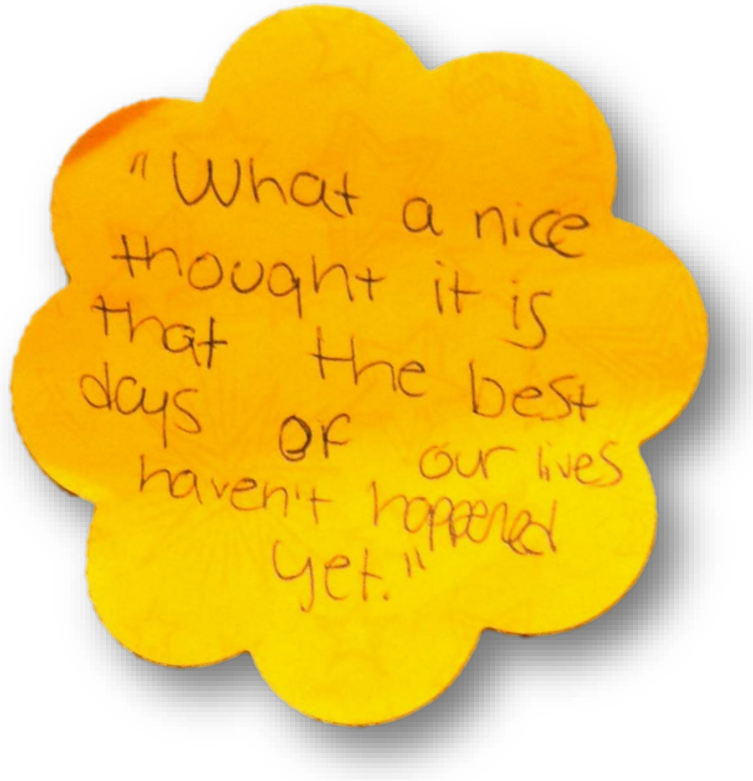
Equity or Equality



Written Praise

Notes from recognizing clients and coworkers for a **specific** action or behavior is demonstrated to help across the span of life:

- **Do better at school or work**
- **Be more socially competent**
- **Reduce symptoms of ADHD, aggression and problem behaviors**
- **Increase engagement in the noticed behavior**



Positive Note for Inhibiting a Challenging Behavior

If you work with children, a positive note sent home with a child for inhibiting an otherwise disruptive behavior is show to:

- **Reduce disruptive and aggressive behavior**
- **Reduce problems at home**
- **Increase engagement at school**

Peer to Peer Notes

Notes of praise written from one peer to another, then **read aloud** or **posted on a public display** is widely shown to:

- **Increase positive friendships**
- **Reduce neighborhood disorganization and crime**
- **Increase sense of safety**
- **Increase volunteerism**
- **Increase engagement in the noticed behavior**

From Concept to Application - 10 Minute Breakout Session

Consider the following evidence-based kernels:

- **Engaging in or Teaching Non-Directive Play**
- **Breathing Strategies**
- **Specific Verbal, Written and Public Praise and Recognition**

Discussion:

1. **How is your organization intentionally promoting or using these strategies among staff and with clients?**
2. **Are there any situations you can recall where the use of one of these strategies would have helped a client to be successful?**
3. **Brainstorm ideas about how these strategies can be incorporated into your work.**

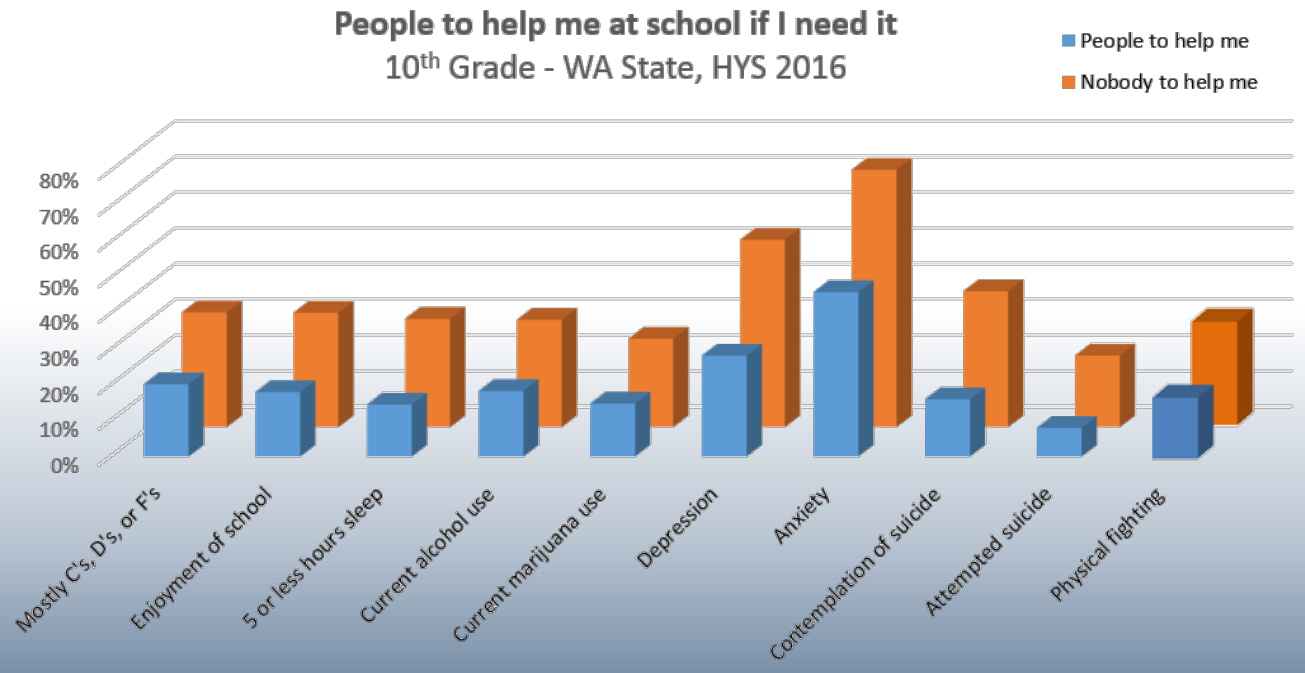
Five Minute Break

Building Relationship is Key

Connection and relationship
are vital to improving outcomes
for all clients.

*"Relationship is **the** evidence-based practice."*

– Chris Blodgett, WSU



Annotation Activity: What Do You Need to Be Successful?

Good Boss	Bad Boss
• Notices when I do a good job • Trusts me • Patient	• Controlling • Yells • Doesn't believe in me

Traits of Your Best Bosses

Traits of Your Worst Bosses

What Do Your Clients Need from You to be Successful?

Social Worker Good ~~Boss~~	Social Worker Bad ~~Boss~~
• Notices when I do a good job	• Controlling
• Trusts me	• Yells
• Patient	• Doesn't believe in me

The Marshmallow Experiment

- **Feelings of reliability** within a relationship improves self-control.

https://www.youtube.com/watch?v=JsQMdECFnUQ

Pleasant Greeting with Physical Touch

Also known as “handshakes.”

- Frequent friendly physical and verbal greetings **impact social status and perceptions of safety and harm.**
- They also affect **behavior streams of aggression, hostility and politeness.**

Active Listening

Active Listening is a structured form of listening and responding that focuses the attention on the speaker. Research shows this technique increases mutual understanding and respect, while building emotional support.

STEP 1

- Listen carefully to what the other person is saying while looking at them

STEP 2

- A) Repeat in your own words what they just said, ***OR***
- B) Guess at the meaning of what they said and tell them, ***OR***
- C) Say what you think they might be feeling

STEP 3

- Continue Steps 1 and 2 after they say something else

What's Your Stress Temperature – 10 Minute Breakout Session

Practice your active listening skills. Instructions:

Each person takes a turn at one of three roles: Speaker, Listener, Coach

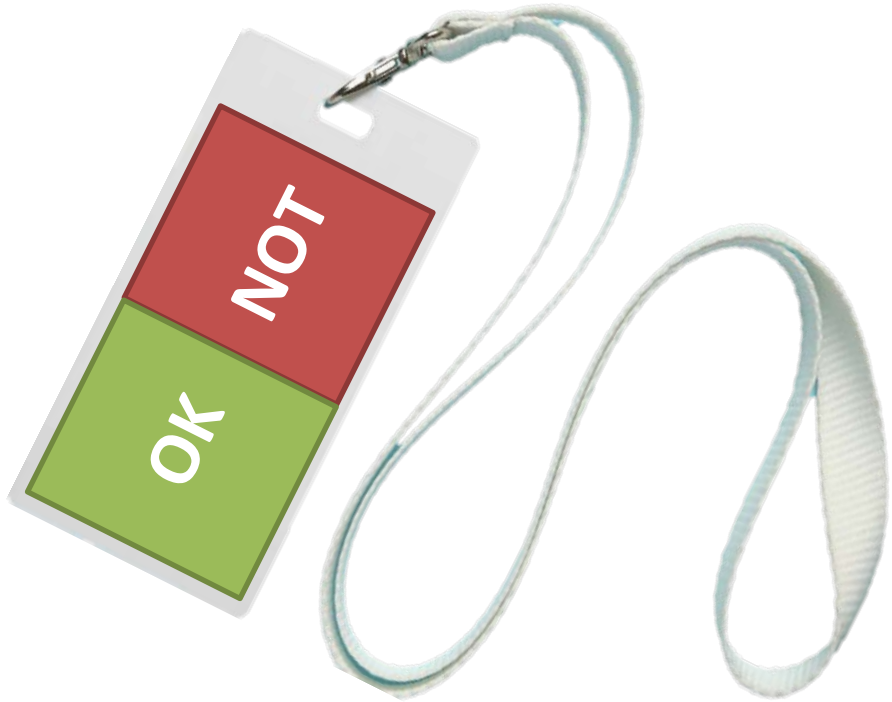
- **Speaker: Discuss your stress temperature from 0 degrees (life is like a Hawaiian vacation) to 100 degrees (I'm out of here and never coming back!). What's contributing to your temperature?**
- **Listener: Listen utilizing the active listening steps. Remember – you are listening, not sharing.**
- **Coach: Prompt the listener with active listening steps if the listener is struggling. Share what you observed.**

Private Reprimands

Public reprimands and humiliation can create a trauma response, especially in boys, that causes long lasting negative effects. Where possible, **low emotion** and **private reprimands** are a more effective strategy.

Research shows that this strategy:

- **Reduces aggression**
- **Reduces disruptive behavior**
- **Reduces emotional responding**



Auditory/Visual Signal for Transition

The attention kernel works for youth and adults. It results in:

- **Immediate reduction in transition time**
- **Increased academic engagement**
- **Reduced disruptive behavior**
- **Reduced aggression and bullying**
- **Reduced trauma response in traumatized people.**

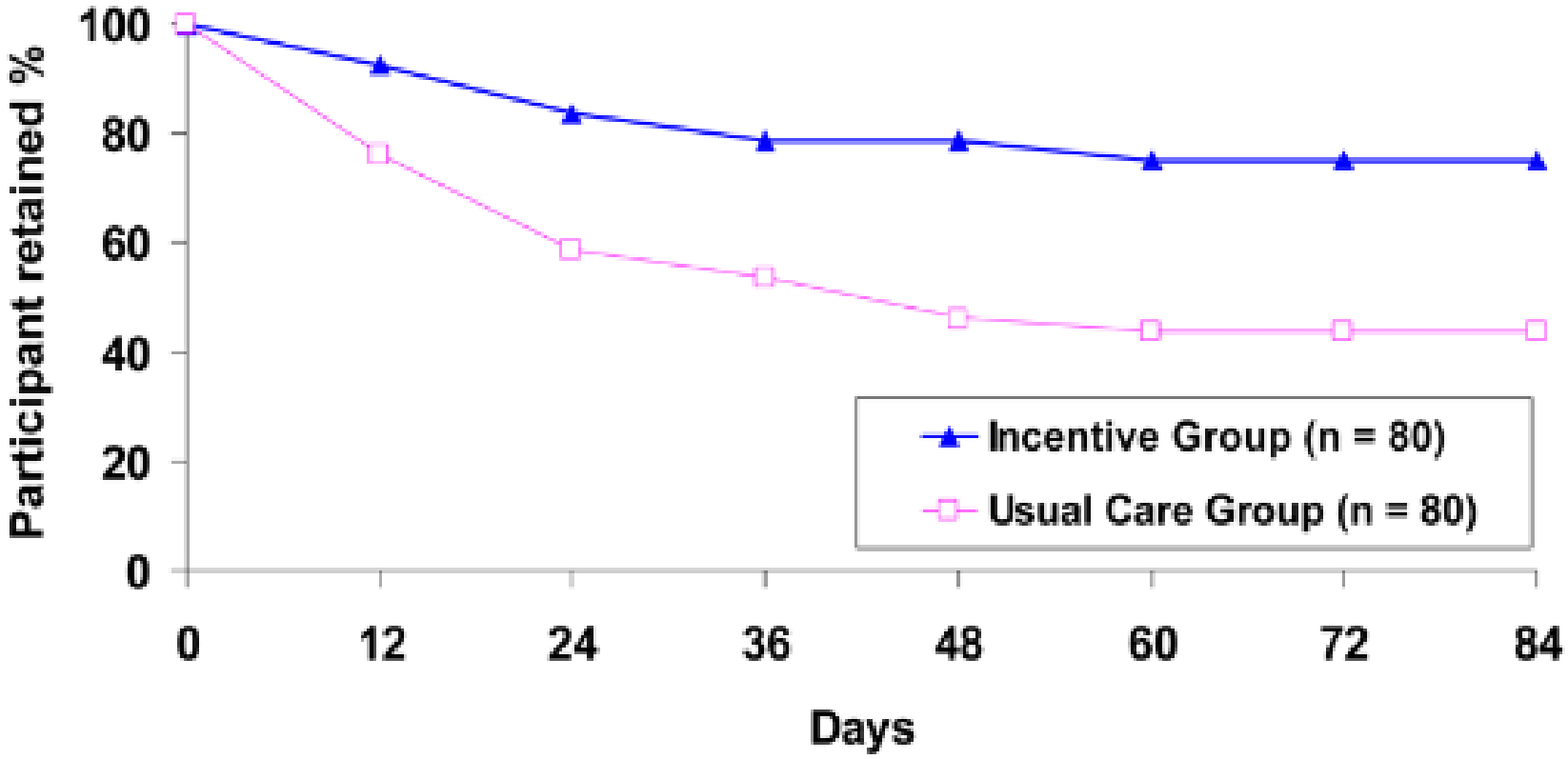
Premack's Principle

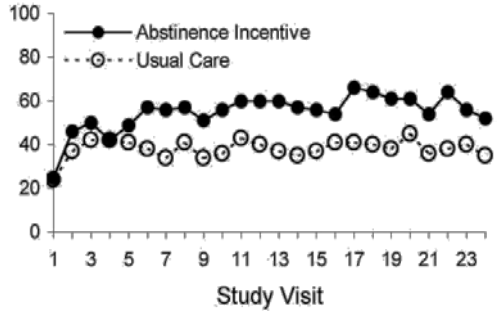
Also known as Contingency Management, the Mystery Motivator, Granny's Wacky Prizes, Prize Bowl and the Game of Life.

A praise strategy that uses activities as positive reinforcement instead of words. It results in:

- **Reduction in deviant behavior across the lifespan**
- **Reduction in problem behaviors at school**
- **Increases desirable behavior in all age groups**
- **Reduces addiction.**
- **Promotes self-regulation instead of excitement**

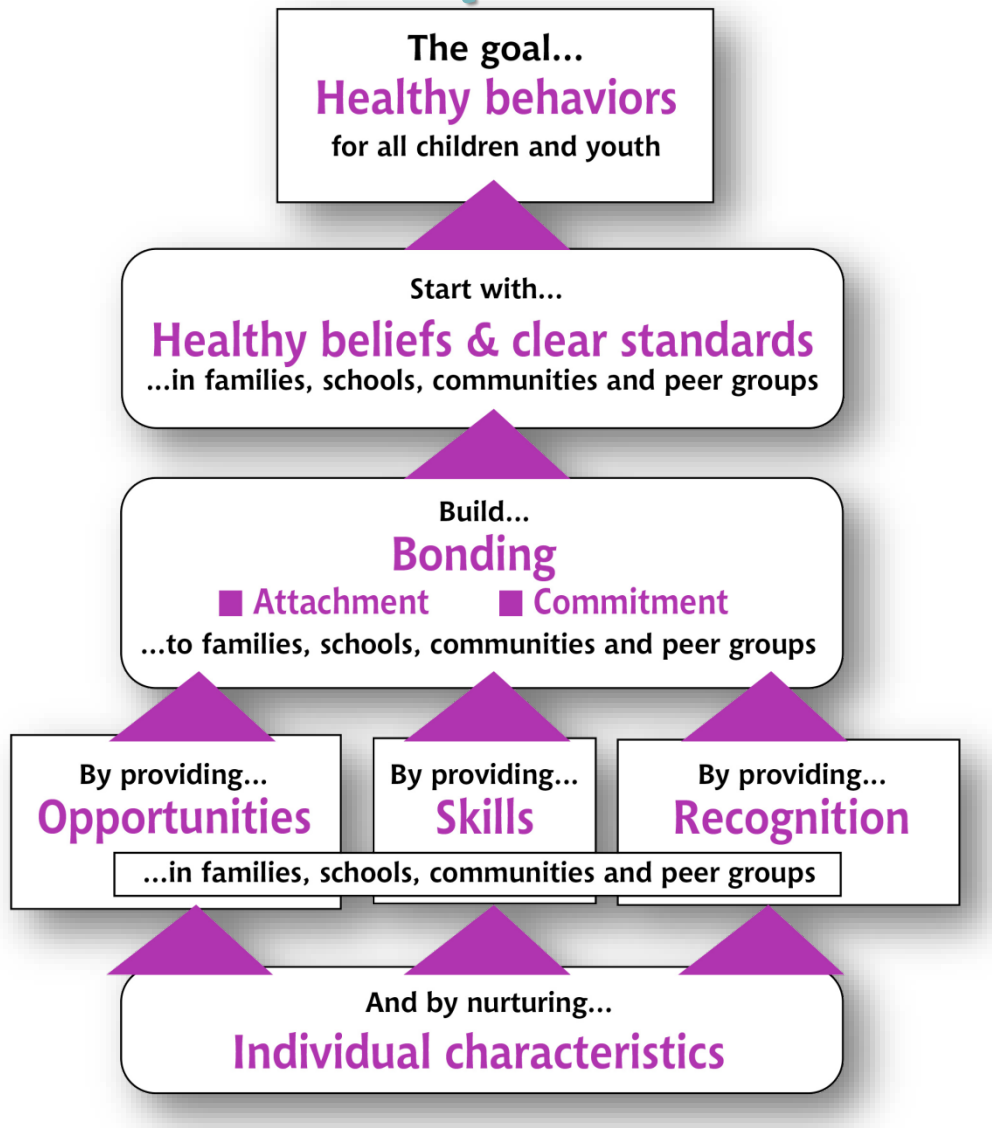
Premack's Principle





Effects of a randomized contingency management intervention on opiate abstinence and retention in methadone maintenance treatment in China.
Hser YI, Li J, Jiang H, Zhang R, Du J, Zhang C, Zhang B, Evans E, Wu F, Chang YJ, Peng C, Huang D, Stitzer ML, Roll J, Zhao M.
Addiction. 2011 Oct;106(10):1801-9. doi: 10.1111/j.1360-0443.2011.03490.x. Epub 2011 Jul 27.
PMID: 21793958

The Social Development Strategy

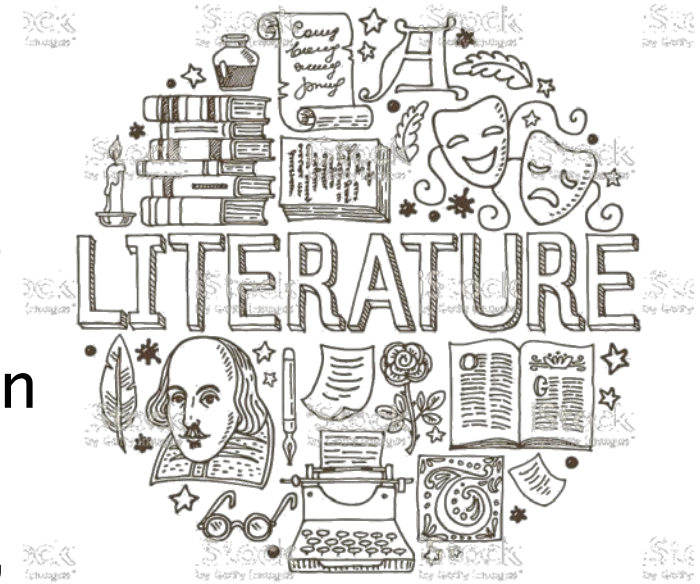


Detached Observer Phenomenon

Reading helps clients build resilience by introducing them to solutions that may be relevant to their needs.

Through identification with characters, the reader has a vicarious experience that facilitates insight and a release of their own emotions.

Because the reader is a detached observer, they are less defensive and more open to a new experience.



Authority Figure Lottery

When an authority figure like a club director **sends a note home** or **calls a parent** about a young person's positive behavior, research shows that action results in:

- **Increases in engagement**
- **Reductions in disruptive behavior**
- **Reductions in aggression**

Gratefulness Check-in

When people are asked and share what they are grateful for once per week, research shows:

- **Increase in happiness**
- **Improved sleep**

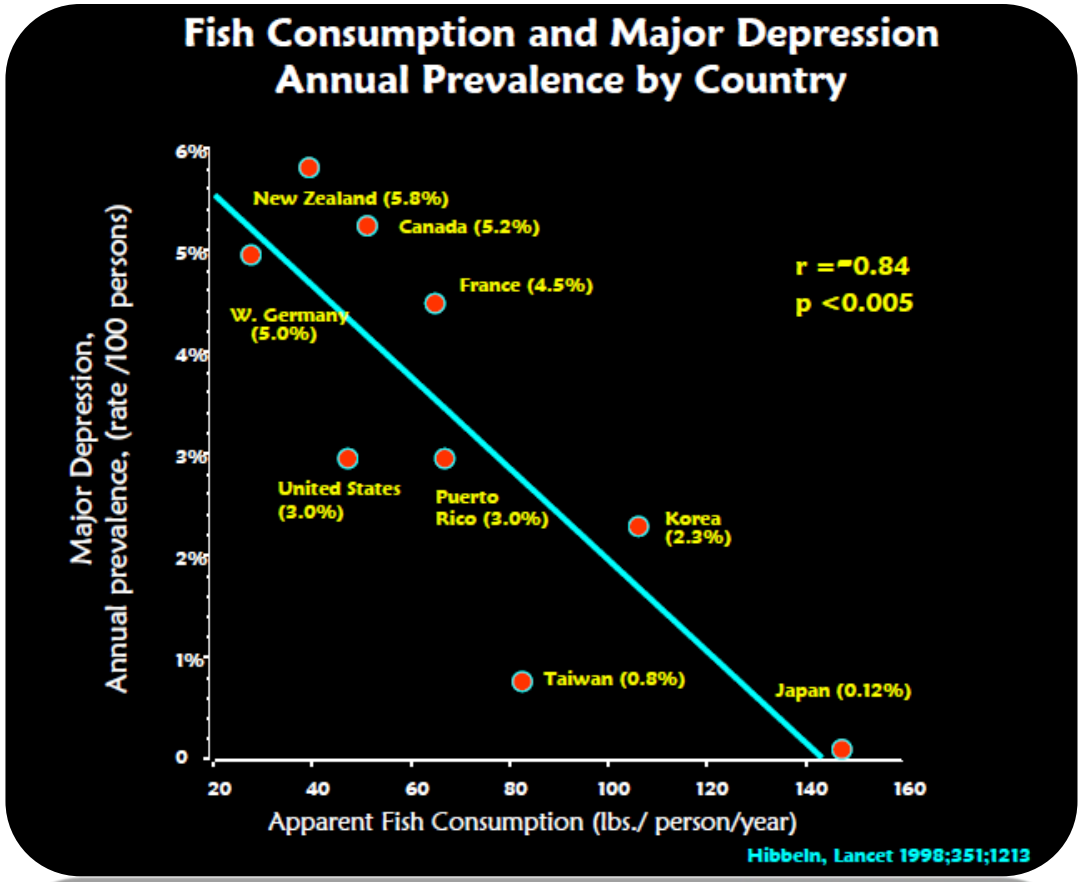
Brain Nutrient Deficiencies Impact Health Across the Globe

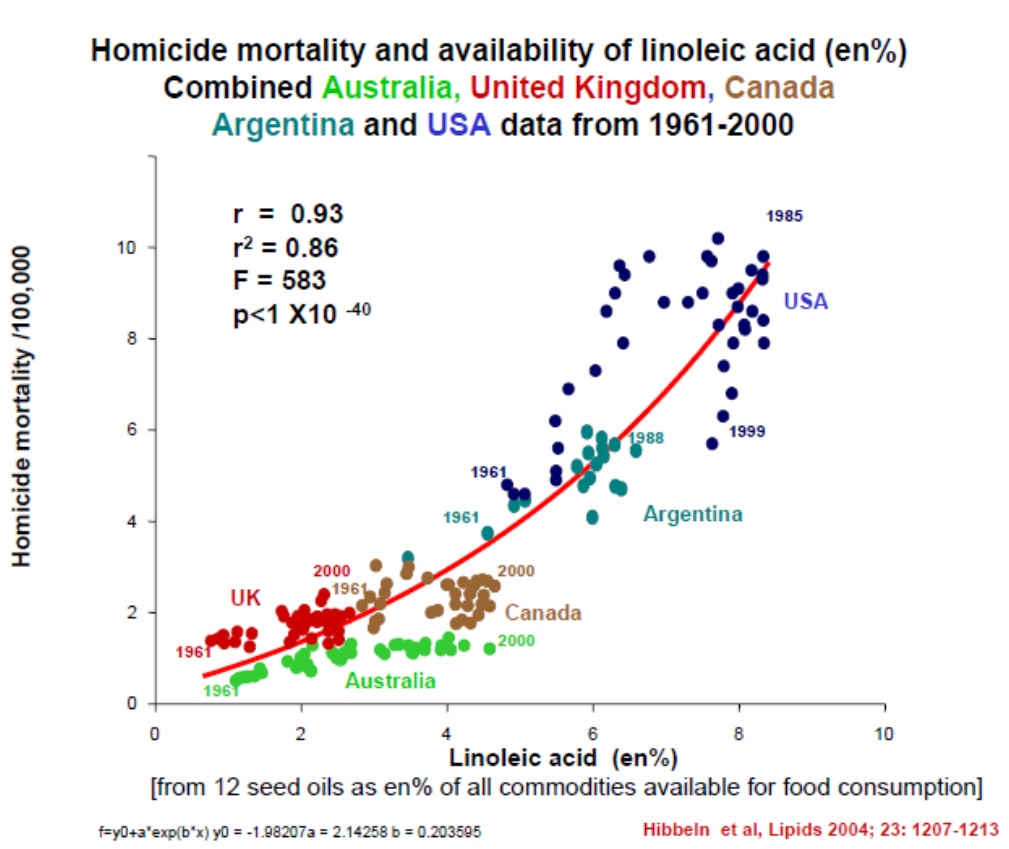
The alterations in brain chemistry that have resulted from our changing diet during the last 60 years contributes to trends of depression, bipolar disorder, autism, violence and academic problems.

Omega-3 Supplementation

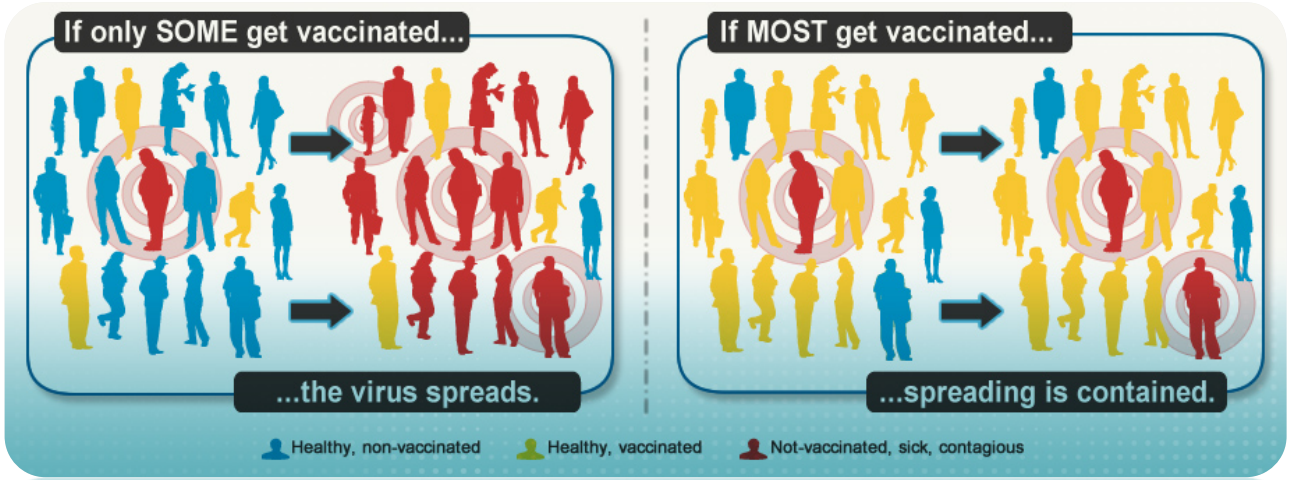
- Omega 3 has no harmful effects
- Well-documented evidence for Reducing aggression, depression, anxiety, bipolar disorder, post partum depression and borderline personality disorder
- 2002 Oxford University study and 2009 Dutch Corrections study of found Omega-3 supplementation achieved a 37% reduction in episodes of inmate aggression.
- **In 2006, the American Psychiatric Association recommend that all psychiatric patients receive at least 1 gram of omega-3 per day to reduce symptoms of mental illness.**

National Institute of Health

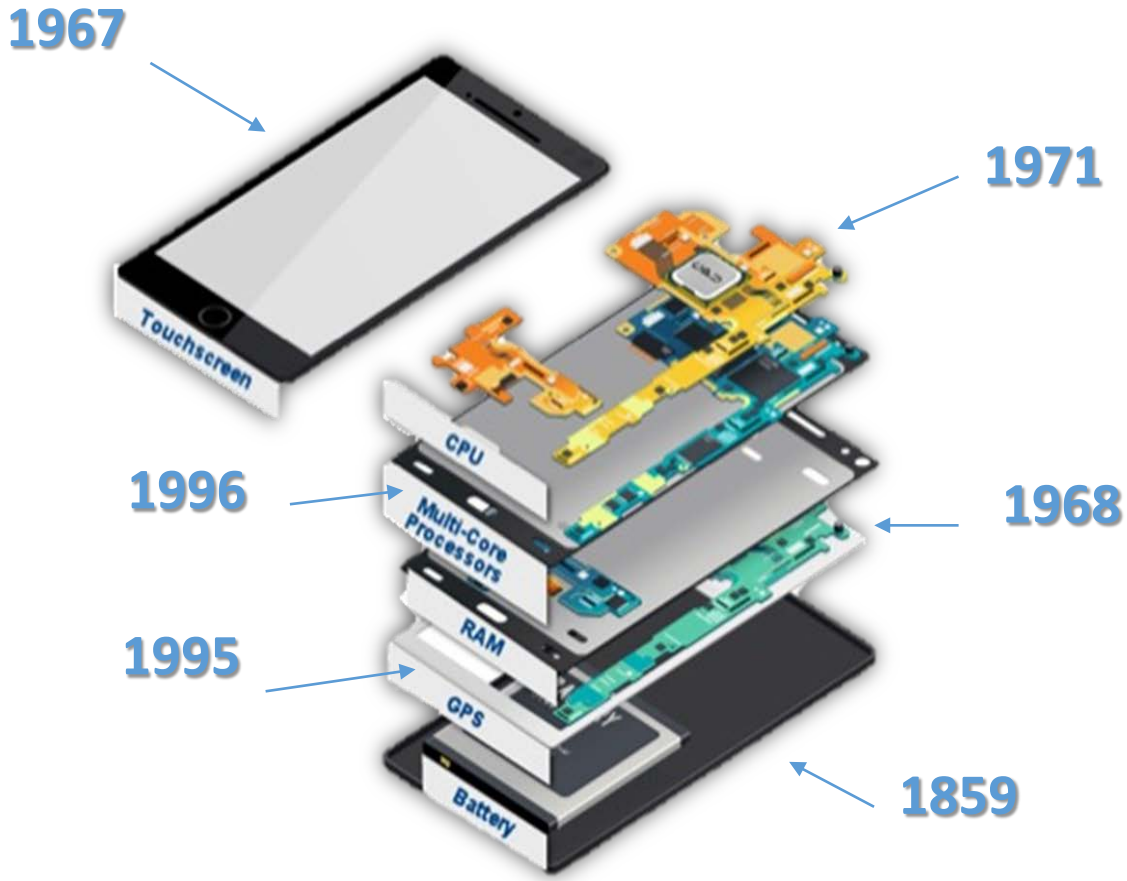




Behavioral Vaccines



If you work together to provide effective organization-wide behavioral vaccines for your clients, how will your resources and culture be impacted?



Seattle Social Development Strategy

Adults instructed to greet and shake hands with five kids NOT in their classroom each day. They also gave out "caught you being good" tickets every day. 10 years later, kids who received this simple strategy had:

- Reduced alcohol, tobacco and other drug initiation
- Reduced aggression
- Had significant improvement on achievement tests
- Were significantly less likely to have engaged in school misbehavior (i.e., cheating, truancy, or being removed from class for misbehavior)

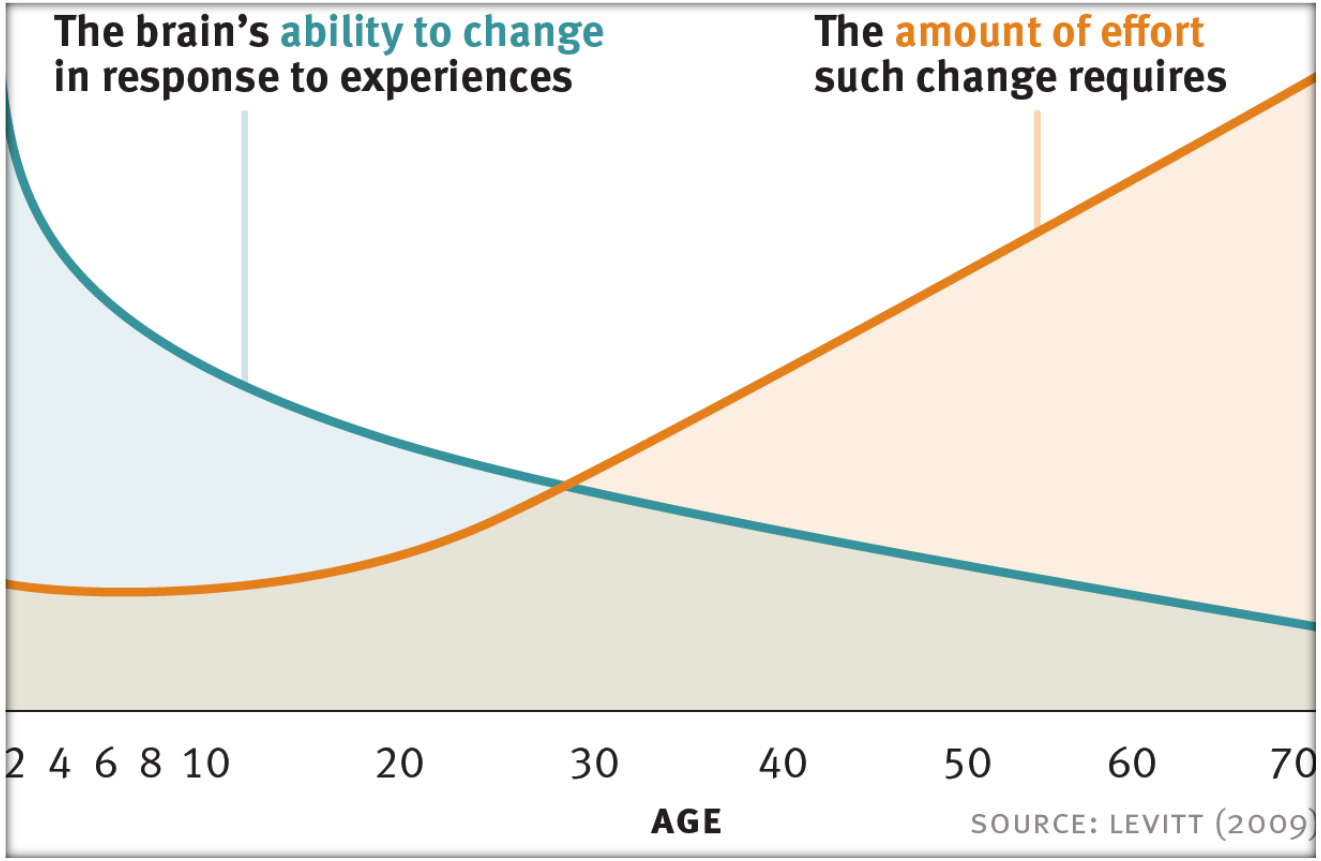
Timing Makes a Difference

As we age, it takes more effort for the brain to change in response to experiences.

The plasticity of our brains shrinks when our neurons struggle to form new connections (synapses) with other neurons.

Our brain's plasticity is the strongest in the first few years after birth. It is easier to form strong brain pathways during the early years and harder to repair pathways as we age.

That's why building resiliency through a community of CARE is so important!



What else can we do?

Be clear, consistent, predictable, and follow through

Maintain high expectations and assume positive intent, build on success rather than establishing limits

Provide guided opportunities to participate through voice and choice

Focus on the feeling of safety, building trust, and reliability of relationships

The Bottom Line

- Understanding ACES gives you the power to significantly impact the trauma trajectory of your clients.
- Remember Kaiser Permanente's diet and nutrition program dropouts? The researchers learned that their very successful intervention wasn't just treating nutrition problems, it was treating personal solutions!
- **If you take away a client's personal solution before teaching them a better one, you're just digging a hole for them to fall back into.**

Your Beliefs Matter!

https://www.youtube.com/watch?v=xQ6wr6vRfGo

Five Minute Break

Adverse Childhood Experiences Study (ACES)

ACES began as a weight-loss study in the 1990's by Kaiser-Permanente in San Diego, California. It became the largest study ever.

Over 17,000 people participated in a health examination, which ultimately assessed the social effects of traumatic childhood experiences over one's lifespan.

Most critically, we have learned there is a direct connection with traumatic experiences and health. The Centers for Disease Control and Prevention (CDC) recognizes ACES as a *public health crisis.*

ACES Participants were mostly:

- Middle class, average age of 57
- 80% White, 10% Black, 10% Asian
- 74% Some college
- 44% Graduated college
- 49.5% Men

But since the original ACE study, research indicates

that ACEs are more prevalent for those living in poverty…

THREE TYPES OF ACEs MEASURED

The original ACE study measured three types of ACEs through a 10 question assessment:

But, there's actually more than just these…

ABUSE

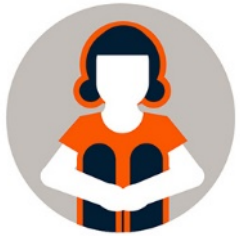
Physical

Emotional

Sexual

NEGLECT

Physical



Emotional

HOUSEHOLD DYSFUNCTION

Mental Illness

Mother treated violently

Divorce

Incarcerated Relative

Substance Abuse

Toxic Stress

Prolonged exposure to Cortisol and other stress hormones is toxic, and makes permanent changes to the brain.

This means you may encounter clients who are **perfectly adapted to survive** in their home environment, but who **cannot turn-off** their behavioral and stress response adaptations in your organization, community or other "normal" situations.

ACES LEAD TO THE 10 MOST COMMON CAUSES OF EARLY DEATH

alcoholism

violence

physical innactivity

illicit drug use

severe obesity

injected drug use

suicide attempts

smoking

depression

more than 30 sexual partners

REFRAMING OUR POINT OF VIEW

With an ACE score of 0, the majority of adults have few, if any, risk factors for the most common diseases leading to early death.

With an ACE score of 4 or more, the majority of adults have multiple risk factors for these diseases or the diseases themselves.

Much of what we see as problem behaviors should actually be viewed as a ***personal solution*** *to an unrecognized prior adversity.*

The ACE Pyramid

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

Without accounting for individual levels of resiliency, this pyramid depicts how impacts to health and well-being can occur over a lifetime as a result of exposure to Adverse Childhood Experiences.

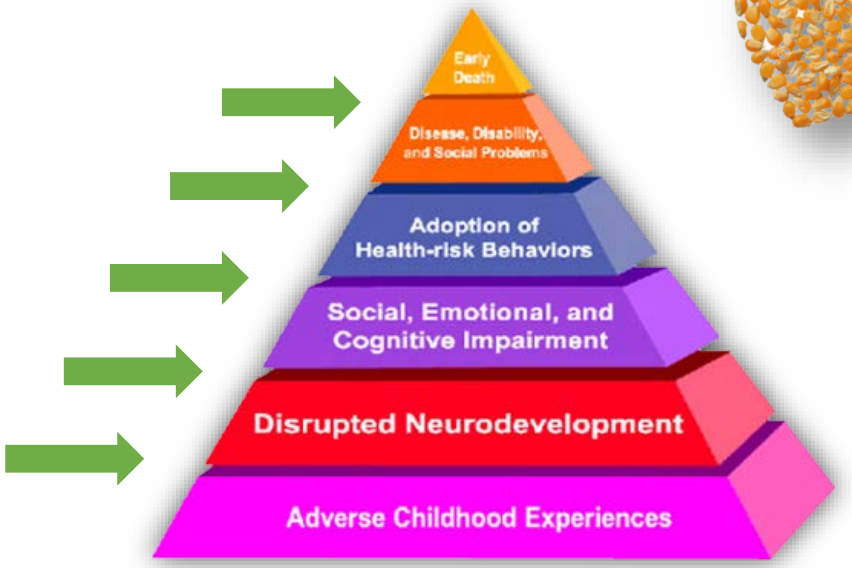
The ACE study found links between ACEs and adult health risks, often leading to chronic health conditions.

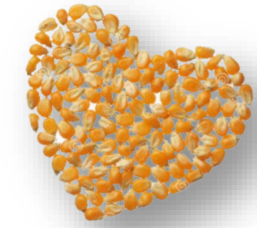
Those with **4 or more ACEs** were found to be:

- **12.2x** as likely to have attempted suicide
- **7.4x** as likely to consider themselves to be an alcoholic
- **4.7x** as likely to have ever used illicit drugs
- **4.6x** as likely to have had 2 or more weeks of depressed mood in the past year
- **3.2x** as likely to have had 50 or more intercourse partners, and
- **2.3x** as likely to smoke

Let's Talk about Kernels

- Kernels are low or no-cost to evidence-based strategies recognized as fundamental units of behavioral influence.
- This means we can ***unleash access*** to strategies that support safety, relationship and skill building essential to our client's readiness to grow and learn.
- Kernels give us a way to implement simple but effective practices that interrupt the ACES trajectory, **move us from intuition to intention**, and improve outcomes.





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Resources

CWC	www.snocochildrenswellnesscoalition.com
Kernels:	http://promiseneighborhoods.org/kernels/ Or http://bit.ly/embry_kernels
ACES:	http://www.cdc.gov/ace/index.htm Or http://www.acestudy.org/ Or http://www.fpc.wa.gov/ Or http://www.acestoohigh.com
ARC Training:	http://www.traumacenter.org/research/ascot.php

Heather Perry
Resiliency and Brain Science Trainer

Heather began her career in social services in California in 2001 where she worked with adolescent youth in residential treatment. Since that time, she has also worked with adults with co-occurring mental illness and drug addiction and completed a bachelor's degree in psychology from Antioch University in 2008. In 2010, Heather relocated to the Seattle area where she worked as a foster home licensor and then a supervisor for a therapeutic foster care program. Heather joined the Coordinated Care team as a Community Educator for Apple Health Core Connections in 2015. In 2019 Apple Health Core Connections earned their C.A.R.E designation in Snohomish County, and Heather participated in the internal trauma informed leadership team in achieving this designation.

Trauma 101 & Resiliency

Presented by
Heather Perry

Thank You for your participation and partnership!

coordinated care

Heather Perry, B.A.

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Compassion ○ Appreciation ○ Resilience ○ Empowerment

Trauma 101


Compassion
Appreciation
Resilience
Empowerment
Community
CARE

Trauma 101

- Types of Trauma
- Trauma and the brain
- Understanding Trauma responses
- Trauma reminders
- Maximize Safety

Why Focus on Trauma?

- Trauma affects an individuals behavior, feelings, relationships and view of the world in profound ways
- Trauma often leads to physical problems
- Trauma impairs learning
- Clients bring their trauma with them
- Our client's trauma affects you too! Secondary Traumatic Stress, Compassion fatigue, burnout etc.

What Is Traumatic Stress?

- The physical and emotional responses to threatening situations
- Trauma can have a long-term, cumulative effect on a person's development
  - Ability to trust others
  - Sense of personal safety
  - Effectiveness in navigating life changes

- A individual's response to a traumatic event may have a profound effect on their perception of self, others, the world, and the future

Trauma: Types of Exposure

Acute	Chronic	Complex
• Single traumatic event • Limited in time	• Multiple traumatic event exposures • Effects are cumulative	• Exposure to chronic trauma, usually caused by adults entrusted with the child's care • Impacts development

(Chadwick Center, 2015)

What About Neglect?

- Failure to provide for a someone's basic needs
- Perceived as trauma by someone who is completely dependent on others for care
- Opens the door to other traumatic events
- May reduce an individual's ability to recover from trauma

Other Types of Trauma

- Historical Trauma
  - A personal or historical event or prolonged experience that continues to have an impact over several generations
- Medical Trauma
  - Ongoing or chronic illness, medical exams, medical treatments or procedures
- System-related Trauma
  - Multiple placements, experiences in detention or residential settings

Other Sources of Ongoing Stress

- Poverty
- Discrimination
- Separations from family
- Frequent moves
- School problems
- Traumatic grief and loss
- Refugee or Immigrant Experiences

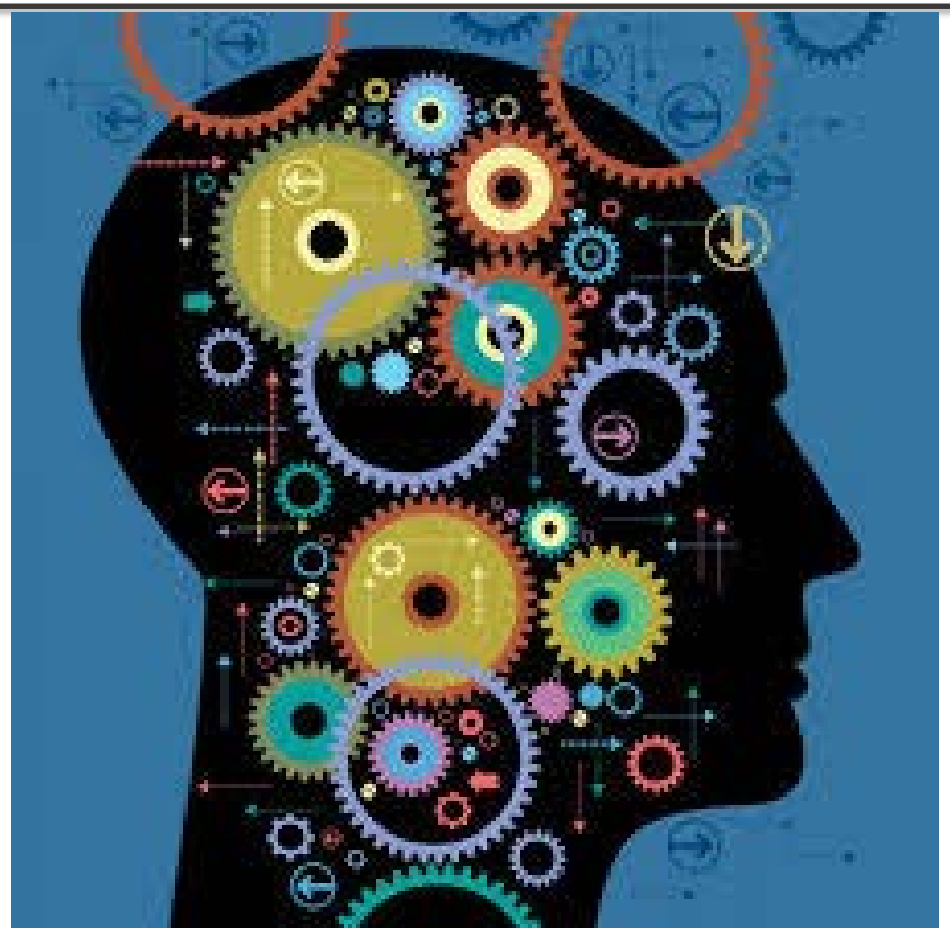
Breakout Room Discussion

What types of trauma are you observing in your role?

Effects of Trauma Exposure

- Attachment
- Biology
- Mood Issues
- Dissociation
- Behavioral Control
- Cognition
- Self Concept

Trauma and the Brain

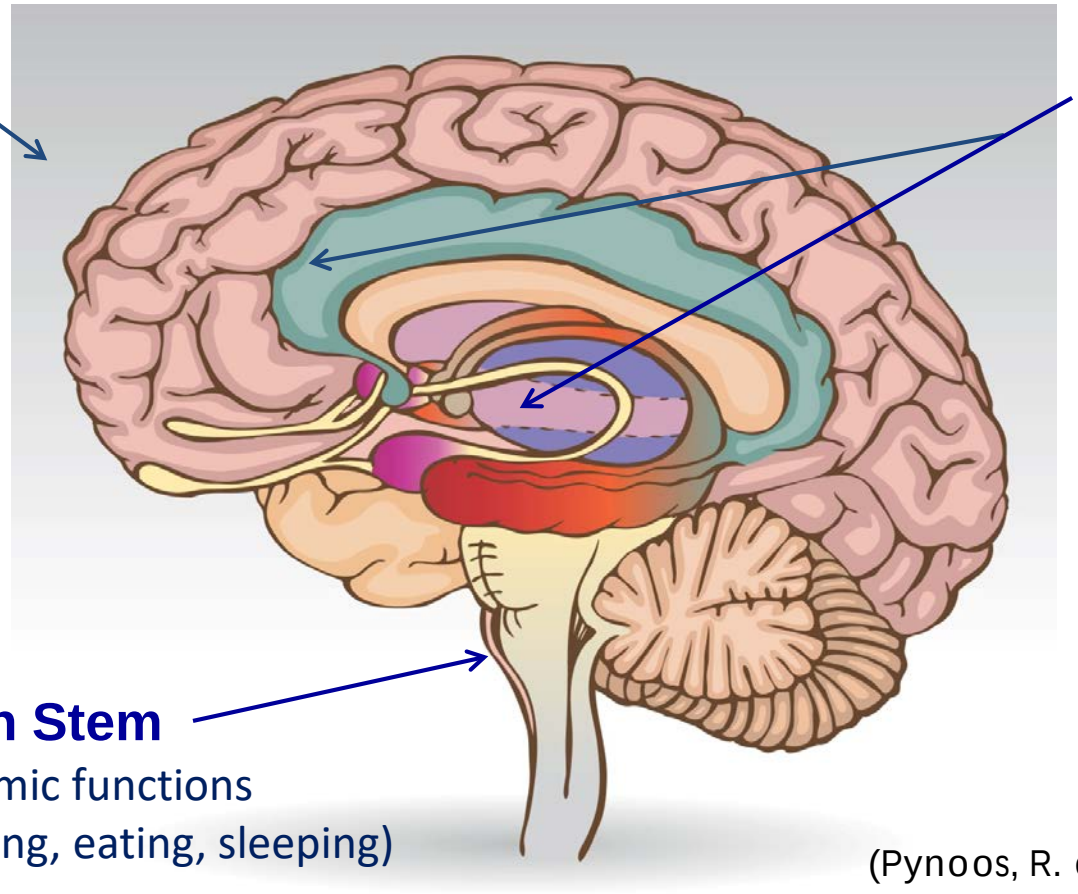


Trauma and the Brain

- Alterations in biological stress systems can adversely affect brain development
- Trauma-exposed youth display changes in their levels of stress hormones similar to those seen in combat veterans
- Plasticity means the brain continues to change in response to repeated stimulation
- Risk and opportunity: impact of trauma but also corrective experiences

Prefrontal Cortex

Abstract thought,
logic,
factual memory,
planning,
ability to inhibit
action



Limbic System

Emotional regulation & memories, "value" of emotion

Brain Stem

Autonomic functions
(breathing, eating, sleeping)

(Pynoos, R. et. al.,1997)

Flip the Lid (Hand Model of the Brain)

Make a **Fist** with your thumb tucked inside your fingers. This is a model of your brain.

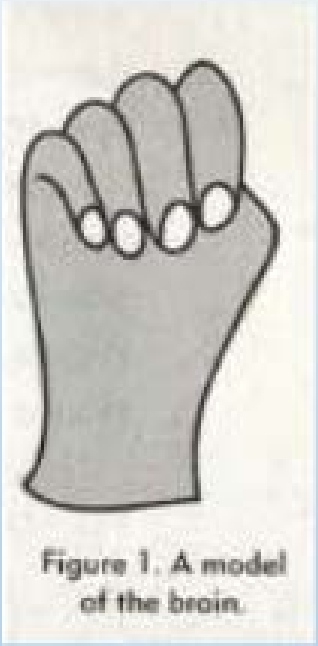


Figure 1. A model of the brain.

Thumb = Midbrain (Stem & Limbic) = Emotional Brain. This is where emotions and memories are processed. This is where the fight, flight & freeze is triggered.

Fingers = Cerebral Cortex = Rational Brain. Houses our ability to think and reason.

Fingernails = Prefrontal Cortex = Problem-Solving

When something triggers us, we are prone to **"Flip our Lid"** which means the Prefrontal Cortex (Fingernails) have a very poor connection with the Midbrain (Thumb), and we're not able to access the logical, problem-solving part of our brain. Our emotions are overriding our ability to think clearly.

-Dr. Dan Siegal

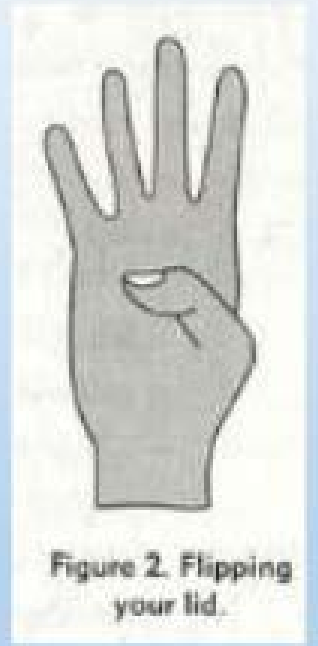


Figure 2. Flipping your lid.

Compassion ○ Appreciation ○ Resilience ○ Empowerment

Trauma and the Brain

- Trauma can have a serious impact on the normal development of children's brains. It can alter the chemicals in their brain and nervous system.
- Changes in the way our bodies handle stress can cause harm to the growing brain. It also can cause delays learning and language.
- These chemical changes may affect the way their brain responds to future stress in their lives and may also negatively impact their health for many years to come.

Break

The Impact of Trauma on Behavior and Relationships

- Understanding trauma responses
- Maximize the sense of safety

Understanding Responses to Trauma

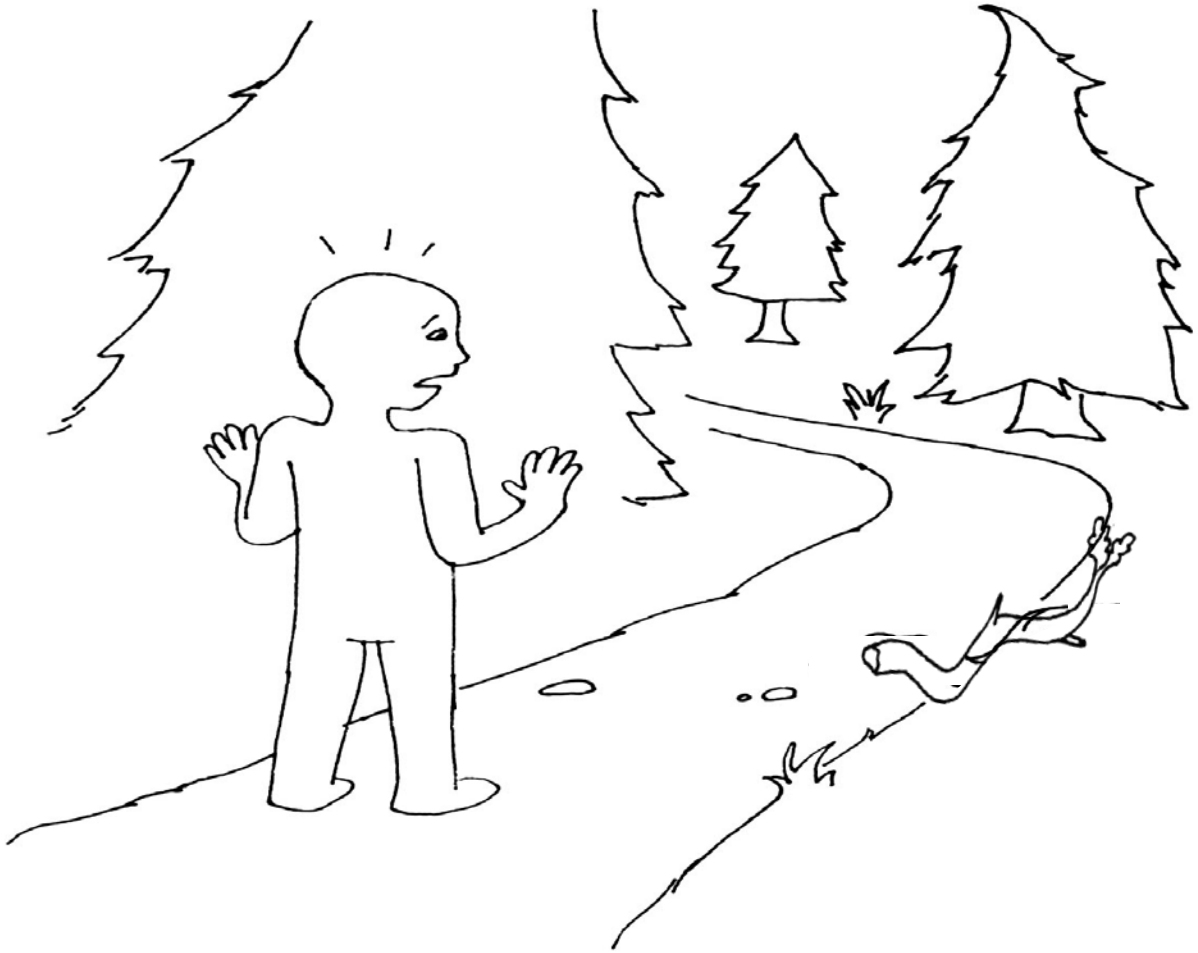
- Those who have experienced trauma often exhibit extremely challenging behaviors and reactions
- When we label these behaviors as “good” or “bad,” we forget that the behavior is reflective of their experience
- Many of the most challenging behaviors are strategies that in the past may have helped the individual survive in the presence of trauma

We Learn by Experience

Compassion ○ Appreciation ○ Resilience ○ Empowerment

We Learn by Experience (Continued)

We Learn by Experience (Continued)



Re-experiencing Trauma

- Intrusive images, sensations, dreams
- Intrusive memories of the traumatic event or events

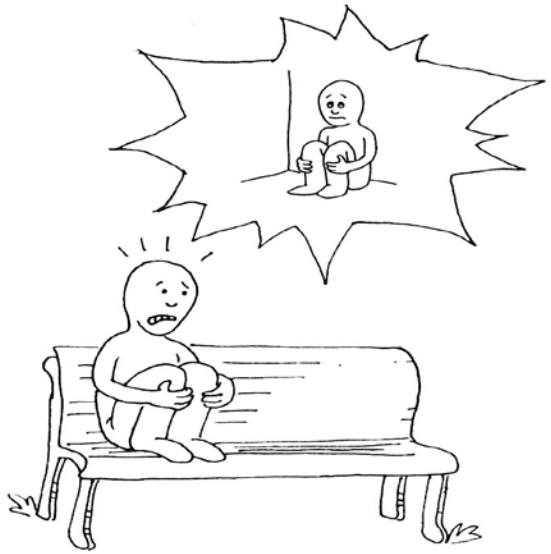
Compassion ○ Appreciation ○ Resilience ○ Empowerment

Hyper-arousal

- Nervousness
- Jumpiness
- Quickness to startle

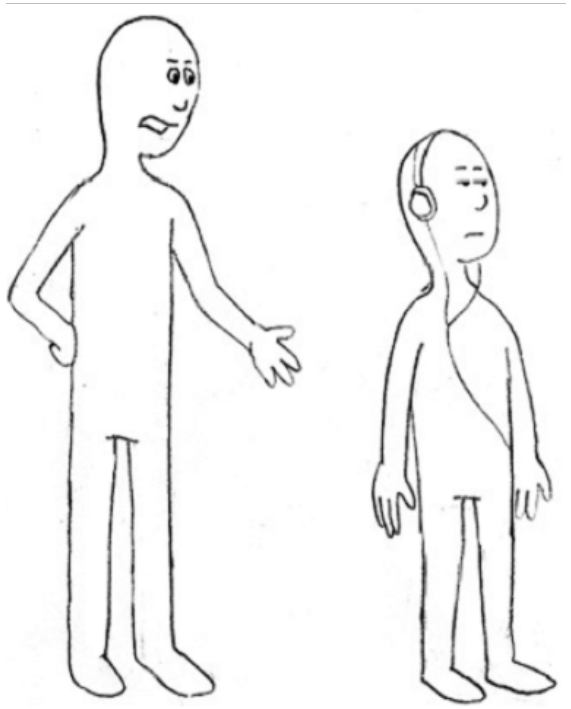
Re-experiencing Trauma

- Intrusive images, sensations, dreams
- Intrusive memories of the traumatic event or events



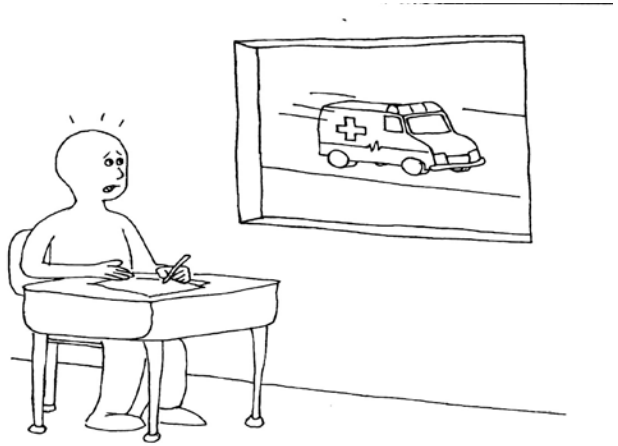
Avoidance and withdrawal

- Feeling numb, shut down, or separated from normal life
- Pulling away from activities and relationships
- Avoiding things that prompt memories of the trauma



Trauma Reminders

Things, events, situations, places, sensations, and even people that an individual associates with a traumatic event



May result in:

- Re-experiencing
- Withdrawal
- Disassociation

Breakout Room Discussion

What traumatic stress responses have you observed in your role?

- Hyper-arousal
- Re-experiencing
- Avoidance/withdrawal
- Trauma Reminders

Maximize the Sense of Safety

- Traumatic stress overwhelms a individual's feeling of safety. It can lead to a number of survival strategies for coping.
- Safety is not just about *physical* safety. Safety also includes *psychological* safety.
- A sense of safety is very important for a child's physical and emotional growth.
- When talking about painful things in their past, make sure they feel emotionally safe.

BREAK

Resiliency


Compassion
Appreciation
Resilience
Empowerment
Community
CARE

Resiliency

- Human Adaptive Process
- Core Protective Systems & Activity
- Healing From Trauma
- Rage Pathway v. Seeking Pathway
- Key “I” Messages

Ways to Define Resilience

A class of phenomena characterized by good outcomes in spite of serious threats to adaptation or development. – *Ann Masten*

Resilience:
We live on, but we also live with. - *Gonzales*

Human Adaptive Processes

- Attachment
- Agency, Self-efficacy and mastery motivation system
- Intelligence: central nervous systems for problem-solving and information processing
- Regulatory systems for controlling arousal, affect, attention, and action
- Microsystems, including family, peers, classroom and work
- Community-level systems and collective efficacy
- Macrosystems: Culture, media, and national and international organizations

Video Options

Rita Pierson
"Every Kid Needs a Champion"

Josh Shipp
"EVERY KID IS ONE CARING ADULT AWAY FROM A SUCCESS STORY"

Patrick Willis
"ESPN Presents Patrick Willis"

Or find your own!

Compassion ○ Appreciation ○ Resilience ○ Empowerment

Breakout Room Discussion

What elements of the human adaptive process did you observe in the video clip that contributed to resilience?

Break

"Resilience does not come from rare and special qualities but from the everyday magic of the ordinary, normative human resources in the minds, brains, and bodies of children, in their families and relationships and their communities." *-Ann Masten*

Core Protective Systems

Nurturing the healthy development of these protective systems affords the most important preparation or 'inoculation' for overcoming potential threats and adversities in human development. Similarly, damage or destruction of these systems has dire consequences for the positive adaptive capacity of individuals." -

- Ann Masten, 2009

Core Protective Systems

- Intellectual & employable skills
- Self regulation – self control, executive function, flexible thinking
- Ability to direct & control attention, emotion, behavior
- Positive self view, efficacy

- Bonds with parents and/or caregivers
- Positive relationships with competent and nurturing adults
- Friends or romantic partners who provide a sense of security & belonging, help with emotion coaching

- Faith, hope, sense of meaning
- Engagement with effective orgs – schools, work, pro-social groups
- Network of supports/services & opportunity to help others
- Cultures providing positive standards, expectations, rituals, relationships & supports

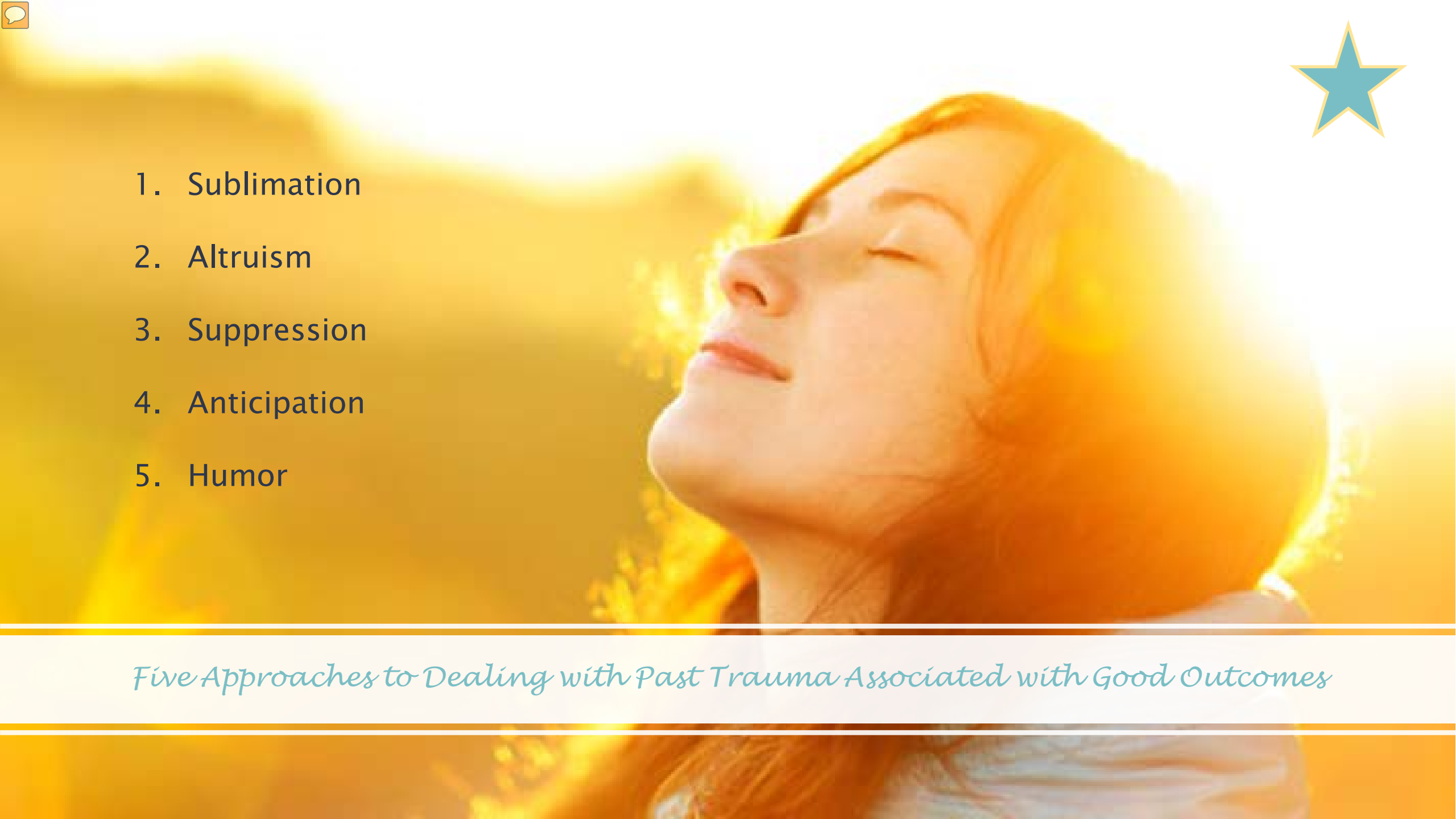
- Ann Masten, 2009

Think of a time when you were struggling…

What/who helped you through?

Find a Partner and tell the story… write "what/who helped you" on a sticky note

Compassion ○ Appreciation ○ Resilience ○ Empowerment



1. Sublimation
2. Altruism
3. Suppression
4. Anticipation
5. Humor

Five Approaches to Dealing with Past Trauma Associated with Good Outcomes

Rage Pathway vs. Seeking Pathway

Rage Pathway – Mechanism in the brain that causes one to fight

Seeking Pathway – Assertive goal-directedness

Children who are resilient see themselves as:

Safe

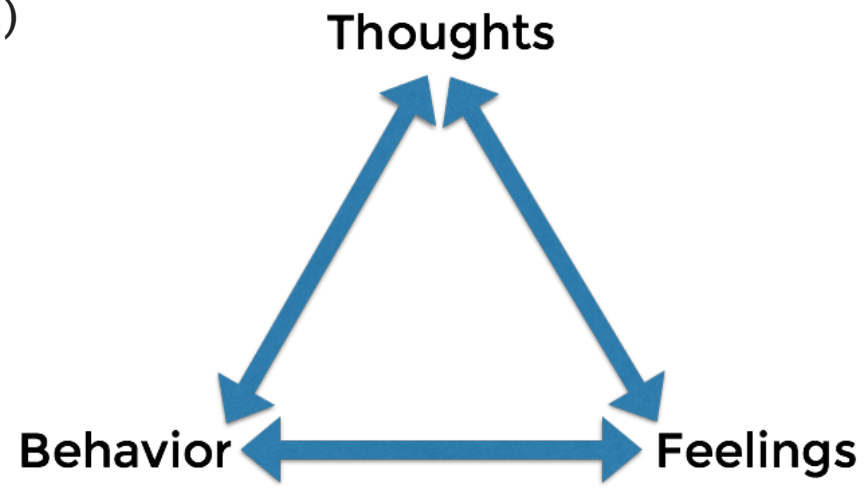
Capable

Loveable

Compassion ○ Appreciation ○ Resilience ○ Empowerment

Five Key "I" Messages

- I AM (likeable, capable, unique and valued)
- I CAN (treat others the way I want to be treated, achieve and do unique things)
- I HAVE (strengths, capabilities and people who care about me)
- I WILL (make healthy choices and achieve my dreams)
- I BELIEVE (I have a purpose)



Breakout Room

Share your personal “I message” with the group

References

Surviving Survival; The Art and Science of Resilience
by Laurence Gonzales 2012

Ordinary Magic; Resilience in Development
by Ann S Masten 2014

Resiliency and Brain Science Resources

- ACEs and Resilience Questionnaire
- InBrief – The Science of Resilience
- Family Resilience and Traumatic Stress
- Glossary of Terms Related to Trauma-Informed, Integrated Healthcare
- SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach
- San Diego Youth Services (SDYS)
- Trauma Informed Approach Concept
- NCTSN Trauma and the Brain
- Coping with Trauma Reminders

What's Your ACE Score? What's Your Resilience Score?

There are 10 types of childhood trauma measured in the ACE Study.

Five are personal — physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect.

Five are related to other family members: a parent who's an alcoholic, a mother who's a victim of domestic violence, a family member in jail, a family member diagnosed with a mental illness, and the disappearance of a parent through divorce, death or abandonment. Each type of trauma counts as one.

There are, of course, many other types of childhood trauma — watching a sibling being abused, losing a caregiver (grandmother, mother, grandfather, etc.), homelessness, surviving and recovering from a severe accident, witnessing a father being abused by a mother, witnessing a grandmother abusing a father, etc.

The ACE Study included only those 10 childhood traumas because those were mentioned as most common by a group of about 300 Kaiser members; those traumas were also well studied individually in the research literature.

The most important thing to remember is that the ACE score is meant as a guideline: If you experienced other types of toxic stress over months or years, then those would likely increase your risk of health consequences.

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
   No___ If Yes, enter 1 __

2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
   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 Attempt or actually have oral, anal, or vaginal intercourse with you?
   No___ If Yes, enter 1 __

4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?
   No___ If Yes, enter 1 __

5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   No___ If Yes, enter 1 __

6. Was a biological parent ever lost to you through divorce, abandonment, or other reason?
   No___ If Yes, enter 1 __

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her? or
   Sometimes, often, or very 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?
   No___ If Yes, enter 1 __

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
   No___ If Yes, enter 1 __

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   No___ If Yes, enter 1 __

10. Did a household member go to prison?
    No___ If Yes, enter 1 __

Now add up your "Yes" answers: This is your ACE Score _____

http://acestoohigh.com/got-your-ace-score/

RESILIENCE Questionnaire

Please circle the most accurate answer under each statement:

1. I believe that my mother loved me when I was little.
   Definitely true Probably true Not sure Probably Not True Definitely Not True

2. I believe that my father loved me when I was little.
   Definitely true Probably true Not sure Probably Not True Definitely Not True

3. When I was little, other people helped my mother and father take care of me and they seemed to love me.
   Definitely true Probably true Not sure Probably Not True Definitely Not True

4. I've heard that when I was an infant someone in my family enjoyed playing with me, and I enjoyed it, too.
   Definitely true Probably true Not sure Probably Not True Definitely Not True

5. When I was a child, there were relatives in my family who made me feel better if I was sad or worried.
   Definitely true Probably true Not sure Probably Not True Definitely Not True

6. When I was a child, neighbors or my friends' parents seemed to like me.
   Definitely true Probably true Not sure Probably Not True Definitely Not True

7. When I was a child, teachers, coaches, youth leaders or ministers were there to help me.
   Definitely true Probably true Not sure Probably Not True Definitely Not True

8. Someone in my family cared about how I was doing in school.
   Definitely true Probably true Not sure Probably Not True Definitely Not True

9. My family, neighbors and friends talked often about making our lives better.
   Definitely true Probably true Not sure Probably Not True Definitely Not True

10. We had rules in our house and were expected to keep them.
    Definitely true Probably true Not sure Probably Not True Definitely Not True

11. When I felt really bad, I could almost always find someone I trusted to talk to.
    Definitely true Probably true Not sure Probably Not True Definitely Not True

12. As a youth, people noticed that I was capable and could get things done.
    Definitely true Probably true Not sure Probably Not True Definitely Not True

13. I was independent and a go-getter.
    Definitely true Probably true Not sure Probably Not True Definitely Not True

14. I believed that life is what you make it.
    Definitely true Probably true Not sure Probably Not True Definitely Not True

How many of these 14 protective factors did I have as a child and youth? (How many of the 14 were circled “Definitely True” or “Probably True”?) _____

Of these circled, how many are still true for me? _____

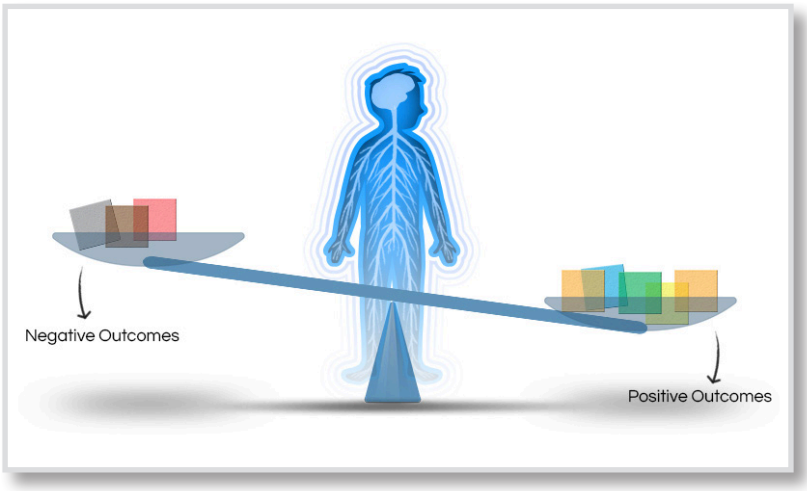
http://acestoohigh.com/got-your-ace-score/

A series of brief summaries of essential findings from recent scientific publications and presentations by the Center on the Developing Child at Harvard University.

Reducing the effects of significant adversity on young children's healthy development is critical to the progress and prosperity of any society. Yet not all children experience lasting harm as a result of adverse early experiences. Some may demonstrate "resilience," or an adaptive response to serious hardship. A better understanding of why some children do well despite early adversity is important because it can help us design policies and programs that help more children reach their full potential.

One way to understand the development of resilience is to visualize a balance scale or seesaw (see image below). Protective experiences and adaptive skills on one side counterbalance significant adversity on the other. Resilience is evident when a child's health and development are tipped in the positive direction, even when a heavy load of factors is stacked on the negative side. Understanding all of the influences that might tip the scale in the positive direction is critical to devising more effective strategies for promoting healthy development in the face of significant disadvantage.

1 Resilience requires supportive relationships and opportunities for skill-building. No matter the source of hardship, the single most common factor for children who end up doing well is having the support of at least one stable and committed relationship with a parent, caregiver, or other adult. These relationships are the active ingredient in building resilience: they provide the personalized responsiveness, scaffolding, and protection that can buffer children from developmental disruption. Relationships also help children develop key capacities—such as the ability to plan, monitor, and regulate behavior, and adapt to changing circumstances—that better enable them to respond to adversity when they face it. This combination of supportive relationships, adaptive skill-building, and positive experiences constitutes the foundation of resilience.



When positive experiences outweigh negative experiences, a child's "scale" tips toward positive outcomes.

2 Resilience results from a dynamic interaction between internal predispositions and external experiences. Children who do well in the face of significant hardship typically show some degree of natural resistance to adversity *and* strong relationships with the important adults in their family and community. Indeed, it is this *interaction* between biology and environment that builds the capacities to cope with adversity and overcome threats to healthy development. Resilience, therefore, is the result of a combination of protective factors. Neither individual characteristics nor social environments alone are likely to produce positive outcomes for children who experience prolonged periods of toxic stress.

3 Learning to cope with manageable threats to our physical and social well-being is critical for the development of resilience. Not all stress is harmful. There are numerous opportunities

in every child's life to experience manageable stress—and with the help of supportive adults, this "positive stress" can be beneficial. Over time, both our bodies and our brains begin to perceive these stressors as increasingly manageable and we become better able to cope with life's obstacles and hardships, both physically and mentally. However, when adversity feels overwhelming and supportive relationships are not available, stress can turn toxic and "tip the scale" toward negative outcomes.

4 Some children respond in more extreme ways to both negative and positive experiences. These highly sensitive individuals show increased vulnerability in stressful circumstances but respond in exceptionally positive ways within environments that provide warmth and support. Therefore, programs that effectively provide responsive relationships to children facing serious hardship may see dramatic turnarounds in the very children who seem to be doing the worst.

5 Individuals never completely lose their ability to improve their coping skills, and they often learn how to adapt to new challenges. The brain and other biological systems are most adaptable early in life, and the development that occurs in the earliest years lays the foundation for a wide range of resilient behaviors. However, resilience is shaped throughout life by the accumulation of experiences—both good and bad—and the continuing development of adaptive coping skills connected to those experiences. What happens early may matter most, but it is never too late to build resilience.

For more information, see "Supportive Relationships and Active Skill-Building Strengthen the Foundations of Resilience: Working Paper 13." *www.developingchild.harvard.edu/resources/*

IMPLICATIONS FOR POLICY AND PRACTICE

- **The capabilities that underlie resilience can be strengthened at any age.** Age-appropriate activities that have widespread health benefits can also improve resilience. For example, regular physical exercise and stress-reduction practices, as well as programs that actively build executive function and self-regulation skills, can improve the abilities of children and adults to cope with, adapt to, and even prevent adversity in their lives. Adults who strengthen these skills in themselves can model positive behaviors for their children, thereby improving the resilience of the next generation.
- **We can prevent most forms of severe hardship that young children and their parents face.** Extreme adversity, such as war or environmental devastation, nearly always generates serious problems that require treatment. More common—and preventable—triggers of toxic stress in families and communities include the often interrelated threats of poverty, crime, mental illness, substance abuse, discrimination, and community violence. Strategies that build child and adult capacities work best when they are integrated within complementary policies that collectively lower the burden of stress on families. For example, home-visiting programs that coach new parents on how to interact positively with children could be coordinated with therapeutic interventions for substance abuse or mental illness and high-quality early care and education.
- **Research has identified a set of factors that help children achieve positive outcomes in the face of significant adversity.** Individuals who demonstrate resilience in response to one form of adversity may not necessarily do so in response to another. Yet when communities and families strengthen these factors, they optimize resilience across multiple contexts. Factors include:

(1) providing supportive adult-child relationships;
(2) scaffolding learning so the child builds a sense of self-efficacy and control;
(3) helping strengthen adaptive skills and self-regulatory capacities; and
(4) using faith and cultural traditions as a foundation for hope and stability.

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THE INBRIEF SERIES:

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NCTSN The National Child Traumatic Stress Network

Family Resilience and Traumatic Stress

A Guide for Mental Health Providers

What is family resilience?

Family resilience is the family's ability to maintain or resume effective functioning—including care of its members—following potentially traumatic events.

Family resilience involves adaptation over time. Indeed, some traumatic stressors set off a cascade of difficulties, such as when a natural disaster leads to major disruption in housing, school, transportation, and/or family income. Sometimes families can "bounce back" to the way they were before the traumatic events; at other times resilience involves "bouncing forward"—making changes to allow successful functioning under changed circumstances.

Family resilience will vary depending on several factors: the challenges from the current stressors, the level of pre-existing stress and everyday hassles, the family's coping skills, and the resources available from family members as well as other sources such as the community.

Stressful events present different challenges as families change in membership, in the developmental level of their members, or in the care requirements of members with special needs. For example, tasks and community resource needs differ for families with young children versus adolescents, or for families with a frail elderly grandparent or a child with a developmental disability. Roles and resources shift with changes in family composition, such as the launching of an adolescent, the temporary absence of a parent due to military service or other work assignment, or loss due to divorce or death of a family member.

Community and cultural context can influence family resilience. Community-wide stressors such as poverty or community violence add to family stress. Community supports—both formal programs and informal social supports—can foster resilience. Cultural/social belief systems about dealing with adversity often affect families' beliefs and coping strategies.

What are some types of traumatic stress that can affect family functioning?

Some traumatic events may be experienced by the whole family—for example, natural disasters such as a hurricane or flood, events such as war or terrorism, or community or domestic violence.

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

Sometimes traumatic stress is due to a high level of ongoing stressors, such as those associated with poverty and chronic community violence. Stress from a major traumatic event such as a natural disaster can combine with that of pre-existing and subsequent adversities, as happened for many families after Hurricane Katrina.

Sometimes an event initially affects one family member but then causes a ripple effect throughout the family. For example, a family member's medical crisis or victimization can cause family concern, disrupt the family's sense of security about their ability to keep members safe, and threaten to overwhelm family functioning and resources.

Often stressful or traumatic events have dissimilar effects on different individuals within the family. However, family resilience refers to the ability to maintain family functions, including providing support for all family members.

How is family resilience related to individual resilience?

Individual resilience is the ability of a child or adult to recover from and show effective adaptation following traumatic events or an accumulation of adverse circumstances. (See *NCTSN Resilience and Child Traumatic Stress* fact sheet.) One important factor contributing to children's resilience is the presence of a supportive adult.

After a major stressor or loss, family resilience involves maintaining family functioning to the extent possible in four basic areas: membership (keeping the family intact), educating and nurturing the young, taking care of vulnerable members (such as the young, sick, or frail elderly), and providing economic support (Patterson, 2002). Family resilience in turn supports the individual resilience of its members.

What characteristics contribute to family resilience?

Families that are resilient tend to share the following characteristics: (a) They have beliefs and attitudes that facilitate coping. (b) They do their best to maintain routines and rituals but with flexibility. (c) They use effective communication about both information and feelings. (d) They show adaptive problem solving. These four characteristics are described further below.

Regarding beliefs and attitudes, families are more likely to be resilient when their approach to the situation includes the following:

- Viewing crises as shared challenges for the family to face together. Family members support each other and look out for the needs of all, even if one person, such as a child who has experienced a traumatic event, may need special attention at some points in time.
- Accepting that distress and/or difficulties are understandable under stressful circumstances.
- Possessing hope that is realistic. The family maintains hope for a desired outcome that is also possible, but can shift goals when confronted by irreversible circumstances. One example of this is a family's hope for a seriously injured member's recovery, but acceptance when that member's injuries are too extensive for survival and then shifting to activities that allow saying a good goodbye. A second example is that following a disaster, a family may be working toward rebuilding their damaged home; however, when the devastation from the disaster coupled with future risk prevent rebuilding, they are able to shift to finding a good way to relocate.

Resilient families posses hope that is realistic.

- Avoiding preoccupation with blame, shame, and/or guilt.
- Connecting to broader pro-social belief systems, such as religious beliefs or other social or community value systems.
- Drawing positive meaning from adversity, such as with time seeing ways that the family has become stronger.

Resilient families preserve their routines, rituals, and family roles to the extent possible, but incorporate short- and long-term modifications (ranging from minor adjustments to major changes) when necessary to meet new circumstances and new family needs.

- Routines: For example, when a caregiving parent is temporarily unavailable because of family illness or other crises, the substitute caregivers (another parent or household adult, extended family members, or family friends) try to maintain the children's schedule of activities, bedtimes and bedtime rituals, and other routines as close to normal as possible.
- Rituals: For example, when circumstances prevent preparing customary food (or gifts), family members still gather and celebrate holidays with available food (or more modest gifts). They keep other aspects of family traditions to the extent possible—such as using the family's traditional songs, prayers, roles, and ritual objects or decorations if they are available.
- Family Roles: A frequent example is that children may need to take on more responsibilities at times of crisis, such as an older child's having increased responsibility for a younger sibling. Nevertheless, adults ensure that children's tasks fit their developmental levels and that adults remain in charge overall and protect the children. When assistance is needed from extended family members or outside helpers (such as relief workers or medical aides), the family finds a way to incorporate this assistance while preserving the family's sense of identity, control, and privacy.

Resilient families preserve their routines, rituals, and family roles to the extent possible, but modify them when necessary.

Resilient families share information, but do so in a way that is developmentally appropriate for the family's children.

Adults limit young children's exposure to adult conversations and media coverage that is likely to confuse or distress them. However, adults answer children's questions and address their concerns, giving accurate information while selecting an appropriate level of detail to fit the children's needs and providing explanations that are developmentally appropriate. This includes being prepared to give answers that may be painful (such as about loss or deaths). Even when clear answers are not available, adults respond to children's questions, doing their best to do so in a supportive way. For instance, children may wonder when they can go home after a disaster. They may need to be told that the authorities have not yet determined when it will be safe to do so, but that adults will let children know when the adults are informed.

Resilient families allow expression of a range of emotions, while respecting individual differences and tolerating negative emotions. For example, after a loss, a family accepts that an activity can be a comforting reminder for one member but upsetting for another. Families find opportunities to express positive emotions, such as attending to moments of joy or gratitude. The adults model appropriate expression of negative emotions, such as disappointment, anger, or sadness. Finally, many families find that humor provides useful emotional release.

Regarding problem-solving skills, resilient families can identify problems and use appropriate coping strategies, including identifying and accessing appropriate resources within the family and, when needed, from the extended family and the community.

Families may face challenges when they need to deal with unfamiliar providers or officials, such as medical personnel or officials overseeing disaster response. Family members may need to be flexible in both communication style and problem-solving skills when dealing with unfamiliar procedures or new terminology.

Resilient families allow expression of a range of emotions, respecting individual differences, with adults modeling appropriate expression of negative emotions.

Do the processes important for family resilience change over time?

Different processes may be particularly relevant at different phases of adjustment. One study (Leitz, 2007) found the following shifts over time:

At the time of a major crisis and immediately afterwards, families found that it was important, as they focused on survival, to provide support to one another within the family, and to receive support from outside the family when needed. It was also important to find ways to take charge of the situation and to find comfort, strength, and direction from faith/belief systems.

As they continued to cope, families discovered that it was important to find the flexibility to adjust to new circumstances and to have family members share their thoughts and feelings with each other.

When they had to accept that some changes were permanent, families benefited from continuing to share their thoughts and feelings, being able to laugh together, and turning to their belief systems to find a greater purpose in their struggles. With time, these families reported that they could reflect on the changes and identify ways in which they had become stronger and/or gained a sense of purpose from their struggles.

Once they felt strong enough, many families wanted to help others and felt further strengthened when they were able to do so.

How can providers support family resilience?

It can be helpful to view family resilience as the maintenance or restoration of the family's balance between demands/stressors and resources/coping strategies. Thus providers can support resilience with interventions that help families to:

1. Reduce the number and intensity of stressors.
2. Increase/improve their coping strategies.
3. Increase access to resources.
4. Reappraise the situation and adjust expectations of the situation and/or themselves.

Sources:

Lietz, C. A. (2007). Uncovering stories of family resilience: A mixed method study of resilient families, part 2. *Families in Society, 88(1)*, 147-155.

Patterson, J. (2002). Integrating family resilience and family stress theory. *Journal of Marriage and Family,* 64, 349-360.

Vogel, J. M. & Pfefferbaum, B. (2014). Family resilience after disasters and terrorism: Examining the concept. In R. Pat-Horeczyk, D. Brom, & J. M. Vogel. (Eds). *Helping children cope with trauma: Individual, family, and community perspectives* (pp. 81-100). NY: Routledge.

Walsh, F. (2006). *Strengthening family resilience, 2nd edition*. New York: Guilford Press.

Additional Resource:

Webinar available on the NCTSN Learning Center: *Family Resilience*, originally presented by William Saltzman and Juliet Vogel on 1/12/2012, part of Family Systems Speaker Series.

Suggested Citation:

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About the National Child Traumatic Stress Network:

Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.

NCTSN The National Child Traumatic Stress Network

Glossary of Terms Related to Trauma-Informed, Integrated Healthcare

Terms to Describe the Event

Psychological Trauma
Psychological trauma occurs when a child experiences an intense, recurring and/or prolonged event(s) that threatens or causes harm to his or her emotional and/or physical well-being *(NCTSN Factsheet, 2003, "What is Child Traumatic Stress").*

Physical Trauma
Physical trauma refers to an injury of sudden onset and severity which requires immediate medical attention. Physical traumatic injuries are the result of a wide variety of blunt, penetrating, and burn mechanisms. They include motor vehicle collisions, sports injuries, falls, natural disasters, and a multitude of other physical injuries which can occur at home, on the street, or at work or school and require immediate care. *(Adapted from University of Florida Health website, https://ufhealth.org/traumatic-injury)*

Adverse Childhood Experiences (ACEs)
Adverse Childhood Experiences include emotional, physical, or sexual abuse; emotional or physical neglect; domestic violence; parental substance use; parental mental illness; parental separation or divorce; or incarcerated household member. Such experiences are linked to long term health outcomes in a series of studies *(Felitti et al, 1998)*. Recent additions include death of a parent, community violence, and poverty.

Terms to Reaction/Response

Child Traumatic Stress
Child traumatic stress (CTS) refers to the intense fear and stress response occurring when children are exposed to traumatic events which overwhelm their ability to cope with what they have experienced. While some children "bounce back" after adversity, traumatic experiences can result in significant disruption of child development with profound long-term consequences. They may show signs of intense emotional and physiological distress—disturbed sleep, difficulty paying attention and concentrating, anger and irritability, withdrawal, repeated and intrusive thoughts, and extreme distress when confronted by reminders of the trauma. Children who experience CTS may also be diagnosed with PTSD, depression, anxiety, or behavioral disorders. Repeated exposure to traumatic experiences can affect the child's brain and nervous system and increase risk of low academic performance, engagement in high-risk behaviors, and difficulties in peer or family relationships. *(Understanding Child Traumatic Stress, NCTSN)*

Complex Trauma
The term *complex trauma* describes both children's exposure to multiple types of pervasive and chronic traumatic events that involve violence, betrayal, exploitation, and loss, such as maltreatment and living in unsafe family, community, or school settings, as well as the wide-ranging, long-term impact of this exposure. Complex trauma can disrupt the child's secure bonding with caregiver(s), as well as the development and formation of crucial competencies, positive relationships, and a clear sense of self.

Developmental Trauma Disorder
Developmental trauma disorder (DTD) is a proposed diagnosis based on evidence that children exposed to complex trauma are at risk for severe disruptions in their development in the domains of emotion, bodily health, attention, cognition, learning, behavior, interpersonal relationships, and development of a clear sense of self. DTD formally describes problems in self-regulation that occur as a result of trauma-related developmental impairments, including dysregulation of (a) emotion and physiology; (b) attention/cognition and behavior (including aggression, oppositionality, and suicidality and intentional self-harm); and (c) interpersonal functioning and identity. DTD symptoms overlap or co-occur with several posttraumatic stress disorder (PTSD) symptoms, but DTD involves a wider range of types of dysregulation and is more strongly related to complex trauma than PTSD.
(Complex Trauma and DTD definitions adapted from Complex Trauma and DTD Collaborative Group)

Epigenetic Changes
Emerging evidence suggests that trauma and chronic stress cause biochemical changes that alter gene expression, which may result in long term and potentially heritable changes in neuroanatomy, physiology, and behavior. Trauma appears to affect areas of the genes "above" or upon (thus "epi") the gene that control how genes are read, and therefore, which or how many proteins are produced. Specific alterations studied include DNA methylation, histone modifications, noncoding RNA regulation, and alternative splicing of mRNA.

Pediatric Medical Traumatic Stress
Pediatric medical traumatic stress is a reaction that children and parents may have to pain, injury, serious illness, medical procedures, or invasive or frightening treatment experiences. These traumatic stress reactions can include psychological and physiological symptoms of arousal, re-experiencing, and avoidance. Other reactions may include behavioral changes or symptoms of depression or anxiety. (NCTSN, Pediatric Medical Traumatic Stress: A Comprehensive Guide)

Post-Traumatic Stress Disorder
PTSD is a formal psychiatric diagnosis that is made when specific criteria about the number, duration, and intensity of symptoms are met. PTSD shares many characteristics of Child Traumatic Stress (CTS), but CTS is not a formal diagnosis. PTSD is a set of psychiatric symptoms meeting DSM-5 criteria after a person has experienced, witnessed, or learned of a close family member experiencing an event involving actual or threatened death, serious injury, or sexual violation.

Toxic Stress
A *toxic stress* response can occur when a child experiences strong, frequent, and/or prolonged adversity—such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship—without adequate adult support. This kind of prolonged activation of the stress response systems can disrupt the development of brain architecture and other organ systems and increase the risk for stress-related disease and cognitive impairment well into the adult years. *(Center on the Developing Child, Harvard University, http://developingchild.harvard.edu/key_concepts/toxic_stress_response/)*

Terms to Identify/Understand a Child/Youth's Response

Trauma Screening
Trauma screening refers to a tool or process that is a brief, focused inquiry to determine whether an individual has experienced one or multiple traumatic events, has reactions to such experiences, has specific mental or behavioral health needs, and/or needs a referral for a comprehensive trauma-informed mental health assessment. Trauma screening is designed to be able to be administered to every child within a given system (such as healthcare). The results of the screening are used to determine whether further assessment is warranted (see below).

Trauma-Informed Mental Health Assessment
A *trauma-Informed mental health assessment* refers to a process that includes a clinical interview, standardized measures, and/or behavioral observations designed to gather an in-depth understanding of the nature, timing, and severity of the traumatic experiences, the effects of those events, current trauma-related symptoms, and functional impairment(s). Clinicians use this to understand a child's trauma history and symptom profile; to determine whether a child is developmentally on target in the social, emotional, and behavioral domains; to inform case conceptualization and drive treatment planning; and to monitor progress over time. Information from such an assessment can be used to coordinate treatment and do case planning with other service providers, including healthcare providers.
(Adapted from http://www.nctsn.org/resources/topics/trauma-informed-screening-assessment/general-info)

Trauma Surveillance
Surveillance is an on-going, flexible, longitudinal process whereby knowledgeable professionals use skilled observation during the provision of health care, to look for symptoms of traumatic stress or to monitor the impact of previously known traumatic experiences. Surveillance is guided by the developmental stage of the child and the concerns of the family. Information gleaned during surveillance is used in conversations with parents and/or youth involving guidance, further assessment, and intervention within primary care and referral for specialty care (e.g. mental health).

Adapted from: Garg, Arvin, and Paul H. Dworkin. "Applying surveillance and screening to family psychosocial issues: implications for the medical home." *Journal of developmental and behavioral pediatrics: JDBP* 32.5 (2011): 418.

Terms Related to Caring for Children and Families Who Have Experienced Trauma in Healthcare Settings

Integrated Care
Integrated care refers to the coordination of physical and behavioral health care. *(Johns Hopkins)*

Trauma-Informed Care
Trauma-informed Care is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma and seeking to employ practices that do not traumatize or re-traumatize. Trauma-informed care also emphasizes physical, psychological, and emotional safety; trustworthiness and transparency; collaboration and mutuality; empowerment; and cultural sensitivity and responsiveness.
(Adapted from Johns Hopkins and SAMHSA)

Patient-Centered Care

Patient-centered care refers to care that is respectful of and responsive to individual patient preferences, needs, and values, and that ensures that patient values guide all clinical decisions. *(Adapted from Institute of Medicine)*

Family-Centered Care

In pediatrics, *family-centered care* is based on the understanding that the family is the child's primary source of strength and support. Further, this approach to care recognizes that the perspectives and information provided by families, children, and young adults are essential in clinical decision-making. *(American Academy of Pediatrics)*

Medical Home

The *medical home* is a concept introduced by the American Academy of Pediatrics (AAP) and is a team-based health care delivery model for a child's medical and non-medical care. It is a cultivated partnership among the patient, family, and primary provider in cooperation with specialists and support from the community. The AAP joined with the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA) to develop the Joint Principles of the Patient-Centered Medical Home, which describes the features of medical home as follows:

- Patient-centered: A partnership among practitioners, patients, and their families ensures that decisions respect patients' wants, needs, and preferences, and that patients have the education and support they need to make decisions and participate in their own care.
- Comprehensive: A team of care providers is wholly accountable for a patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care.
- Coordinated: Care is organized across all elements of the broader health care system, including specialty care, hospitals, home health care, community services and supports.
- Accessible: Patients are able to access services with shorter waiting times, "after hours" care, 24/7 electronic or telephone access, and strong communication through health IT innovations.
- Committed to quality and safety: Clinicians and staff enhance quality improvement to ensure that patients and families make informed decisions about their health. (Johns Hopkins; https://www.pcpcc.org/about/medical-home)

Trauma-Informed Integrated Care

Trauma-informed integrated healthcare is integrated care in which all parties involved assess, recognize, and respond to the effects of traumatic stress on those who have contact with the healthcare system including children, caregivers, and general and behavioral healthcare providers. It requires that health, behavioral health, and other partners involved with the child and family effectively communicate and collaborate with each other and caregivers in the care of the child and family. Programs and agencies within such a healthcare system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies and use the best available science to facilitate and support the recovery and resiliency of the child and family.

SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

Prepared by

SAMHSA's Trauma and Justice Strategic Initiative

July 2014

Contents

Introduction

Trauma is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography or sexual orientation. It is an almost universal experience of people with mental and substance use disorders. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. ***In order to maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.***

The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders.[1,2,3,4,5] Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences.[6,7,8,9] However, most people go without these services and supports. Unaddressed trauma significantly increases the risk of mental and substance use disorders and chronic physical diseases.[1,10,11]

With appropriate supports and intervention, people can overcome traumatic experiences.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. Studies of people in the juvenile and criminal justice system reveal high rates of mental and substance use disorders and personal histories of trauma.[12,13] Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems.[5,14] Young people bring their experiences of trauma into the school systems, often interfering with their school success. And many patients in primary care similarly have significant trauma histories which has an impact on their health and their responsiveness to health interventions.[15,16,17]

In addition, the public institutions and service systems that are intended to provide services and supports to individuals are often themselves trauma-inducing. The use of coercive practices, such as seclusion and restraints, in the behavioral health system; the abrupt removal of a child from an abusing family in the child welfare system; the use of invasive procedures in the medical system; the harsh disciplinary practices in educational/school systems; or intimidating practices in the criminal justice system can be re-traumatizing for individuals who already enter these systems with significant histories of trauma. These program or system practices and policies often interfere with achieving the desired outcomes in these systems.

Thus, the pervasive and harmful impact of traumatic events on individuals, families and communities and the unintended but similarly widespread re-traumatizing of individuals within our public institutions and service systems, makes it necessary to rethink doing "business as usual." In public institutions and service systems, there is increasing recognition that many of the individuals have extensive histories of trauma that, left unaddressed, can get in the way of achieving good health and well-being. For example, a child who suffers from maltreatment or neglect in the home may not be able to concentrate on school work and be successful in school; a women victimized by domestic violence may have trouble performing in the work setting; a jail inmate repeatedly exposed to violence on the street may have difficulty refraining from retaliatory violence and re-offending; a sexually abused homeless youth may engage in self-injury and high risk behaviors to cope with the effects of sexual abuse; and, a veteran may use substances to mask the traumatic memories of combat. The experiences of these individuals are compelling and, unfortunately, all too common. Yet, until recently, gaining a better understanding of how to address the trauma experienced by these individuals and how to mitigate the re-traumatizing effect of many of our public institutions and service settings was not an integral part of the work of these systems. Now, however, there is an increasing focus on the impact of trauma and how service systems may help to resolve or exacerbate trauma-related issues. These systems are beginning to revisit how they conduct their "business" under the framework of a trauma-informed approach.

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Purpose and Approach: Developing a Framework for Trauma and a Trauma-Informed Approach

PURPOSE

The purpose of this paper is to develop a working concept of trauma and a trauma-informed approach and to develop a shared understanding of these concepts that would be acceptable and appropriate across an array of service systems and stakeholder groups. SAMHSA puts forth a framework for the behavioral health specialty sectors, that can be adapted to other sectors such as child welfare, education, criminal and juvenile justice, primary health care, the military and other settings that have the potential to ease or exacerbate an individual's capacity to cope with traumatic experiences. In fact, many people with behavioral health problems receive treatment and services in these non-specialty behavioral health systems. SAMHSA intends this framework be relevant to its federal partners and their state and local system counterparts and to practitioners, researchers, and trauma survivors, families and communities. The desired goal is to build a framework that helps systems "talk" to each other, to understand better the connections between trauma and behavioral health issues, and to guide systems to become trauma-informed.

APPROACH

SAMHSA approached this task by integrating three significant threads of work: trauma focused research work; practice-generated knowledge about trauma interventions; and the lessons articulated by survivors

of traumatic experiences who have had involvement in multiple service sectors. It was expected that this blending of the research, practice and survivor knowledge would generate a framework for improving the capacity of our service systems and public institutions to better address the trauma-related issues of their constituents.

To begin this work, SAMHSA conducted an environmental scan of trauma definitions and models of trauma informed care. SAMHSA convened a group of national experts who had done extensive work in this area. This included trauma survivors who had been recipients of care in multiple service system; practitioners from an array of fields, who had experience in trauma treatment; researchers whose work focused on trauma and the development of trauma-specific interventions; and policymakers in the field of behavioral health.

From this meeting, SAMHSA developed a working document summarizing the discussions among these experts. The document was then vetted among federal agencies that conduct work in the field of trauma. Simultaneously, it was placed on a SAMHSA website for public comment. Federal agency experts provided rich comments and suggestions; the public comment site drew just over 2,000 respondents and 20,000 comments or endorsements of others' comments. SAMHSA reviewed all of these comments, made revisions to the document and developed the framework and guidance presented in this paper.

The key questions addressed in this paper are:

- **What do we mean by trauma?**
- **What do we mean by a trauma-informed approach?**
- **What are the key principles of a trauma-informed approach?**
- **What is the suggested guidance for implementing a trauma-informed approach?**
- **How do we understand trauma in the context of community?**

SAMHSA's approach to this task has been an attempt to integrate knowledge developed through research and clinical practice with the voices of trauma survivors. This also included experts funded through SAMHSA's trauma-focused grants and initiatives, such as SAMHSA's National Child Traumatic Stress Initiative, SAMHSA's National Center for Trauma Informed Care, and data and lessons learned from other grant programs that did not have a primary focus on trauma but included significant attention to trauma, such as SAMHSA's: Jail Diversion Trauma Recovery grant program; Children's Mental Health Initiative; Women, Children and Family Substance Abuse Treatment Program; and Offender Reentry and Adult Treatment Drug Court Programs.

Background: Trauma — Where We Are and How We Got Here

The concept of traumatic stress emerged in the field of mental health at least four decades ago. Over the last 20 years, SAMHSA has been a leader in recognizing the need to address trauma as a fundamental obligation for public mental health and substance abuse service delivery and has supported the development and promulgation of trauma-informed systems of care. In 1994, SAMHSA convened the Dare to Vision Conference, an event designed to bring trauma to the foreground and the first national conference in which women trauma survivors talked about their experiences and ways in which standard practices in hospitals re-traumatized and often, triggered memories of previous abuse. In 1998, SAMHSA funded the Women, Co-Occurring Disorders and Violence Study to generate knowledge on the development and evaluation of integrated services approaches for women with co-occurring mental and substance use disorders who also had histories of physical and or sexual abuse. In 2001, SAMHSA funded the National Child Traumatic Stress Initiative to increase understanding of child trauma and develop effective interventions for children exposed to different types of traumatic events.

The American Psychiatric Association (APA) played an important role in defining trauma. Diagnostic criteria for traumatic stress disorders have been debated through several iterations of the Diagnostic and Statistical Manual of Mental Disorders (DSM) with a new category of Trauma- and Stressor-Related Disorders, across the life-span, included in the recently released DSM-V (APA, 2013). Measures and inventories of trauma exposure, with both clinical and research applications, have proliferated since the 1970's.[18,19,20,21] National trauma research and practice centers have conducted significant work in the past few decades, further refining the concept of trauma, and developing effective trauma assessments and treatments.[22,23,24,25] With the advances in neuroscience, a biopsychosocial approach to traumatic experiences has begun to delineate the mechanisms in which neurobiology, psychological processes, and social attachment interact and contribute to mental and substance use disorders across the life-span.[3,25]

Simultaneously, an emerging trauma survivors movement has provided another perspective on the understanding of traumatic experiences. Trauma survivors, that is, people with lived experience of trauma, have powerfully and systematically documented their paths to recovery.[26] Traumatic experiences complicate a child's or an adult's capacity to make sense of their lives and to create meaningful consistent relationships in their families and communities.

Trauma survivors have powerfully and systematically documented their paths to recovery.

The convergence of the trauma survivor's perspective with research and clinical work has underscored the central role of traumatic experiences in the lives of people with mental and substance use conditions. The connection between trauma and these conditions offers a potential explanatory model for what has happened to individuals, both children and adults, who come to the attention of the behavioral health and other service systems.[25,27]

People with traumatic experiences, however, do not show up only in behavioral health systems. Responses to these experiences often manifest in behaviors or conditions that result in involvement with the child welfare and the criminal and juvenile justice system or in difficulties in the education, employment or primary care system. Recently, there has also been a focus on individuals in the military and increasing rates of posttraumatic stress disorders.[28,29,30,31]

With the growing understanding of the pervasiveness of traumatic experience and responses, a growing number of clinical interventions for trauma responses have been developed. Federal research agencies, academic institutions and practice-research partnerships have generated empirically-supported interventions. In SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) alone there are over 15 interventions focusing on the treatment or screening for trauma.

These interventions have been integrated into the behavioral health treatment care delivery system; however, from the voice of trauma survivors, it has become clear that these clinical interventions are not enough. Building on lessons learned from SAMHSA's Women, Co-Occurring Disorders and Violence Study; SAMHSA's National Child Traumatic Stress Network; and SAMHSA's National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraints, among other developments in the field, it became clear that the organizational climate and conditions in which services are provided played a significant role in maximizing the outcomes of interventions and contributing to the healing and recovery of the people being served. SAMHSA's National Center for Trauma-Informed Care has continued to advance this effort, starting first in the behavioral health sector, but increasingly responding to technical assistance requests for organizational change in the criminal justice, education, and primary care sectors.

FEDERAL, STATE AND LOCAL LEVEL TRAUMA-FOCUSED ACTIVITIES

The increased understanding of the pervasiveness of trauma and its connections to physical and behavioral health and well-being, have propelled a growing number of organizations and service systems to explore ways to make their services more responsive to people who have experienced trauma. This has been happening in state and local systems and federal agencies.

States are elevating a focus on trauma. For example, Oregon Health Authority is looking at different types of trauma across the age span and different population groups. Maine's "Thrive Initiative" incorporates a trauma-informed care focus in their children's systems of care. New York is introducing a trauma-informed initiative in the juvenile justice system. Missouri is exploring a trauma-informed approach for their adult mental health system. In Massachusetts, the Child Trauma Project is focused on taking trauma-informed care statewide in child welfare practice. In Connecticut the Child Health and Development Institute with the state Department of Children and Families is building a trauma-informed system of care throughout the state through policy and workforce development. SAMHSA has supported the further development of trauma-informed approaches through its Mental Health Transformation Grant program directed to State and local governments.

Increasing examples of local level efforts are being documented. For example, the City of Tarpon Springs in Florida has taken significant steps in becoming a trauma-informed community. The city made it its mission to promote a widespread awareness of the costly effects of personal adversity upon the wellbeing of the community. The Family Policy Council in Washington State convened groups to focus on the impact of adverse childhood experiences on the health and well-being of its local communities and tribal communities. Philadelphia held a summit to further its understanding of the impact of trauma and violence on the psychological and physical health of its communities.

SAMHSA continues its support of grant programs that specifically address trauma.

At the federal level, SAMHSA continues its support of grant programs that specifically address trauma and technical assistance centers that focus on prevention, treatment and recovery from trauma.

Other federal agencies have increased their focus on trauma. The Administration on Children Youth and Families (ACYF) has focused on the complex trauma of children in the child welfare system and how screening and assessing for severity of trauma and linkage with trauma treatments can contribute to improved well-being for these youth. In a joint effort among ACYF, SAMHSA and the Centers for Medicare and Medicaid Services (CMS), the three agencies developed and issued through the CMS State Directors' mechanism, a letter to all State Child Welfare Administrators, Mental Health Commissioners, Single State Agency Directors for Substance Abuse and State Medicaid Directors discussing trauma, its impact on children, screening, assessment and treatment interventions and strategies for paying for such care. The Office of Juvenile Justice and Delinquency Prevention has specific recommendations to address trauma in their Children Exposed to Violence Initiative. The Office of Women's Health has developed a curriculum to train providers in primary care on how to address trauma issues in health care for women. The Department of Labor is examining trauma and the workplace through a federal interagency workgroup. The Department of Defense is honing in on prevention of sexual violence and trauma in the military.

As multiple federal agencies representing varied sectors have recognized the impact of traumatic experiences on the children, adults, and families they serve, they have requested collaboration with SAMHSA in addressing these issues. The widespread recognition of the impact of trauma and the burgeoning interest in developing capacity to respond through trauma-informed approaches compelled SAMHSA to revisit its conceptual framework and approach to trauma, as well as its applicability not only to behavioral health but also to other related fields.

SAMHSA's Concept of Trauma

Decades of work in the field of trauma have generated multiple definitions of trauma. Combing through this work, SAMHSA developed an inventory of trauma definitions and recognized that there were subtle nuances and differences in these definitions.

Desiring a concept that could be shared among its constituencies — practitioners, researchers, and trauma survivors, SAMHSA turned to its expert panel to help craft a concept that would be relevant to public health agencies and service systems. SAMHSA aims to provide a viable framework that can be used to support people receiving services, communities, and stakeholders in the work they do. A review of the existing definitions and discussions of the expert panel generated the following concept:

> ***Individual trauma results from an* event*, series of events, or set of circumstances that is* experienced *by an individual as physically or emotionally harmful or life threatening and that has lasting adverse* effects *on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.***

THE THREE "E'S" OF TRAUMA: EVENT(S), EXPERIENCE OF EVENT(S), AND EFFECT

Events and circumstances may include the actual or extreme threat of physical or psychological harm (i.e. natural disasters, violence, etc.) or severe, life-threatening neglect for a child that imperils healthy development. These events and circumstances may occur as a single occurrence or repeatedly over time. This element of SAMHSA's concept of trauma is represented in the fifth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which requires all conditions classified as "trauma and stressor-related disorders" to include exposure to a traumatic or stressful event as a diagnostic criterion.

The individual's **experience** of these events or circumstances helps to determine whether it is a traumatic event. A particular event may be experienced as traumatic for one individual and not for another (e.g., a child removed from an abusive home experiences this differently than their sibling; one refugee may experience fleeing one's country differently from another refugee; one military veteran may experience deployment to a war zone as traumatic while another veteran is not similarly affected). How the individual labels, assigns meaning to, and is disrupted physically and psychologically by an event will contribute to whether or not it is experienced as traumatic. Traumatic events by their very nature set up a power differential where one entity (whether an individual, an event, or a force of nature) has power over another. They elicit a profound question of "why me?" The individual's experience of these events or circumstances is shaped in the context of this powerlessness and questioning. Feelings of humiliation, guilt, shame, betrayal, or silencing often shape the experience of the event. When a person experiences physical or sexual abuse, it is often accompanied by a sense of humiliation, which can lead the person to feel as though they are bad or dirty, leading to a sense of self blame, shame and guilt. In cases of war or natural disasters, those who survived the traumatic event may blame themselves for surviving when others did not. Abuse by a trusted caregiver frequently gives rise to feelings of betrayal, shattering a person's trust and leaving them feeling alone. Often, abuse of children and domestic violence are accompanied by threats that lead to silencing and fear of reaching out for help.

How the event is experienced may be linked to a range of factors including the individual's cultural beliefs (e.g., the subjugation of women and the experience of domestic violence), availability of social supports (e.g., whether isolated or embedded in a supportive family or community structure), or to the developmental stage of the individual (i.e., an individual may understand and experience events differently at age five, fifteen, or fifty).[1]

The long-lasting adverse **effects** of the event are a critical component of trauma. These adverse effects may occur immediately or may have a delayed onset. The duration of the effects can be short to long term. In some situations, the individual may not recognize the connection between the traumatic events and the effects. Examples of adverse effects include an individual's inability to cope with the normal stresses and strains of daily living; to trust and benefit from relationships; to manage cognitive processes, such as memory, attention, thinking; to regulate behavior; or to control the expression of emotions. In addition to these more visible effects, there may be an altering of one's neurobiological make-up and ongoing health and well-being. Advances in neuroscience and an increased understanding of the interaction of neurobiological and environmental factors have documented the effects of such threatening events.[1,3] Traumatic effects, which may range from hyper-vigilance or a constant state of arousal, to numbing or avoidance, can eventually wear a person down, physically, mentally, and emotionally. Survivors of trauma have also highlighted the impact of these events on spiritual beliefs and the capacity to make meaning of these experiences.

SAMHSA's Trauma-Informed Approach: Key Assumptions and Principles

Trauma researchers, practitioners and survivors have recognized that the understanding of trauma and trauma-specific interventions is not sufficient to optimize outcomes for trauma survivors nor to influence how service systems conduct their business.

The context in which trauma is addressed or treatments deployed contributes to the outcomes for the trauma survivors, the people receiving services, and the individuals staffing the systems. Referred to variably as "trauma-informed care" or "trauma-informed approach" this framework is regarded as essential to the context of care.[22,32,33] SAMHSA's concept of a trauma-informed approach is grounded in a set of four assumptions and six key principles.

A program, organization, or system that is trauma-informed* realizes *the widespread impact of trauma and understands potential paths for recovery;* recognizes *the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and* responds *by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively* resist re-traumatization*.

A trauma informed approach is distinct from trauma-specific services or trauma systems. A trauma informed approach is inclusive of trauma-specific interventions, whether assessment, treatment or recovery supports, yet it also incorporates key trauma principles into the organizational culture.

Referred to variably as "trauma-informed care" or "trauma-informed approach" this framework is regarded as essential to the context of care.

THE FOUR "R'S: KEY ASSUMPTIONS IN A TRAUMA-INFORMED APPROACH

In a trauma-informed approach, all people at all levels of the organization or system have a basic **realization** about trauma and understand how trauma can affect families, groups, organizations, and communities as well as individuals. People's experience and behavior are understood in the context of coping strategies designed to survive adversity and overwhelming circumstances, whether these occurred in the past (i.e., a client dealing with prior child abuse), whether they are currently manifesting (i.e., a staff member living with domestic violence in the home), or whether they are related to the emotional distress that results in hearing about the firsthand experiences of another (i.e., secondary traumatic stress experienced by a direct care professional).There is an understanding that trauma plays a role in mental and substance use disorders and should be systematically addressed in prevention, treatment, and recovery settings. Similarly, there is a realization that trauma is not confined to the behavioral health specialty service sector, but is integral to other systems (e.g., child welfare, criminal justice, primary health care, peer–run and community organizations) and is often a barrier to effective outcomes in those systems as well.

People in the organization or system are also able to **recognize** the signs of trauma. These signs may be gender, age, or setting-specific and may be manifest by individuals seeking or providing services in these settings. Trauma screening and assessment assist in the recognition of trauma, as do workforce development, employee assistance, and supervision practices.

The program, organization, or system **responds** by applying the principles of a trauma-informed approach to all areas of functioning. The program, organization, or system integrates an understanding that the experience of traumatic events impacts all people involved, whether directly or indirectly. Staff in every part of the organization, from the person who greets clients at the door to the executives and the governance board, have changed their language, behaviors and policies to take into consideration the experiences of trauma among children and adult users of the services and among staff providing the services. This is accomplished through staff training, a budget that supports this ongoing training, and leadership that realizes the role of trauma in the lives of their staff and the people they serve. The organization has practitioners trained in evidence-based trauma practices. Policies of the organization, such as mission statements, staff handbooks and manuals promote a culture based on beliefs about resilience, recovery, and healing from trauma. For instance, the agency's mission may include an intentional statement on the organization's commitment to promote trauma recovery; agency policies demonstrate a commitment to incorporating perspectives of people served through the establishment of client advisory boards or inclusion of people who have received services on the agency's board of directors; or agency training includes resources for mentoring supervisors on helping staff address secondary traumatic stress. The organization is committed to providing a physically and psychologically safe environment. Leadership ensures that staff work in an environment that promotes trust, fairness and transparency. The program's, organization's, or system's response involves a universal precautions approach in which one expects the presence of trauma in lives of individuals being served, ensuring not to replicate it.

A trauma-informed approach seeks to **resist re-traumatization** of clients as well as staff. Organizations often inadvertently create stressful or toxic environments that interfere with the recovery of clients, the well-being of staff and the fulfillment of the organizational mission.[27] Staff who work within a trauma-informed environment are taught to recognize how organizational practices may trigger painful memories and re-traumatize clients with trauma histories. For example, they recognize that using restraints on a person who has been sexually abused or placing a child who has been neglected and abandoned in a seclusion room may be re-traumatizing and interfere with healing and recovery.

SIX KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH

A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific.

SIX KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH

1. **Safety**
2. **Trustworthiness and Transparency**
3. **Peer Support**
4. **Collaboration and Mutuality**
5. **Empowerment, Voice and Choice**
6. **Cultural, Historical, and Gender Issues**

From SAMHSA's perspective, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Consistent with SAMHSA's definition of recovery, services and supports that are trauma-informed build on the best evidence available and consumer and family engagement, empowerment, and collaboration.

The six key principles fundamental to a trauma-informed approach include:[24,36]

1. **Safety:** Throughout the organization, staff and the people they serve, whether children or adults, feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety. Understanding safety as defined by those served is a high priority.

2. **Trustworthiness and Transparency:** Organizational operations and decisions are conducted with transparency with the goal of building and maintaining trust with clients and family members, among staff, and others involved in the organization.

3. **Peer Support:** Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing their stories and lived experience to promote recovery and healing. The term "Peers" refers to individuals with lived experiences of trauma, or in the case of children this may be family members of children who have experienced traumatic events and are key caregivers in their recovery. Peers have also been referred to as "trauma survivors."

4. **Collaboration and Mutuality:** Importance is placed on partnering and the leveling of power differences between staff and clients and among organizational staff from clerical and housekeeping personnel, to professional staff to administrators, demonstrating that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach. As one expert stated: "one does not have to be a therapist to be therapeutic."[12]

5. **Empowerment, Voice and Choice:** Throughout the organization and among the clients served, individuals' strengths and experiences are recognized and built upon. The organization fosters a belief in the primacy of the people served, in resilience, and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. The organization understands that the experience of trauma may be a unifying aspect in the lives of those who run the organization, who provide the services, and/or who come to the organization for assistance and support. As such, operations, workforce development and services are organized to foster empowerment for staff and clients alike. Organizations understand the importance of power differentials and ways in which clients, historically, have been diminished in voice and choice and are often recipients of coercive treatment. Clients are supported in shared decision-making, choice, and goal setting to determine the plan of action they need to heal and move forward. They are supported in cultivating self-advocacy skills. Staff are facilitators of recovery rather than controllers of recovery.[34] Staff are empowered to do their work as well as possible by adequate organizational support. This is a parallel process as staff need to feel safe, as much as people receiving services.

6. **Cultural, Historical, and Gender Issues:** The organization actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, religion, gender-identity, geography, etc.); offers, access to gender responsive services; leverages the healing value of traditional cultural connections; incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; and recognizes and addresses historical trauma.

Guidance for Implementing a Trauma-Informed Approach

Developing a trauma-informed approach requires change at multiples levels of an organization and systematic alignment with the six key principles described above. The guidance provided here builds upon the work of Harris and Fallot and in conjunction with the key principles, provides a starting point for developing an organizational trauma-informed approach.[20] While it is recognized that not all public institutions and service sectors attend to trauma as an aspect of how they conduct business, understanding the role of trauma and a trauma-informed approach may help them meet their goals and objectives. Organizations, across service-sectors and systems, are encouraged to examine how a trauma-informed approach will benefit all stakeholders; to conduct a trauma-informed organizational assessment and change process; and to involve clients and staff at all levels in the organizational development process.

The guidance for implementing a trauma-informed approach is presented in the ten domains described below. This is not provided as a "checklist" or a prescriptive step-by-step process. These are the domains of organizational change that have appeared both in the organizational change management literature and among models for establishing trauma-informed care.[35,36,37,38] What makes it unique to establishing a trauma-informed organizational approach is the cross-walk with the key principles and trauma-specific content.

TEN IMPLEMENTATION DOMAINS

1. **Governance and Leadership**
2. **Policy**
3. **Physical Environment**
4. **Engagement and Involvement**
5. **Cross Sector Collaboration**
6. **Screening, Assessment, Treatment Services**
7. **Training and Workforce Development**
8. **Progress Monitoring and Quality Assurance**
9. **Financing**
10. **Evaluation**

GOVERNANCE AND LEADERSHIP: The leadership and governance of the organization support and invest in implementing and sustaining a trauma-informed approach; there is an identified point of responsibility within the organization to lead and oversee this work; and there is inclusion of the peer voice. A champion of this approach is often needed to initiate a system change process.

POLICY: There are written policies and protocols establishing a trauma-informed approach as an essential part of the organizational mission. Organizational procedures and cross agency protocols, including working with community-based agencies, reflect trauma-informed principles. This approach must be "hard-wired" into practices and procedures of the organization, not solely relying on training workshops or a well-intentioned leader.

PHYSICAL ENVIRONMENT OF THE ORGANIZATION: The organization ensures that the physical environment promotes a sense of safety and collaboration. Staff working in the organization and individuals being served must experience the setting as safe, inviting, and not a risk to their physical or psychological safety. The physical setting also supports the collaborative aspect of a trauma informed approach through openness, transparency, and shared spaces.

ENGAGEMENT AND INVOLVEMENT OF PEOPLE IN RECOVERY, TRAUMA SURVIVORS, PEOPLE RECEIVING SERVICES, AND FAMILY MEMBERS RECEIVING SERVICES: These groups have significant involvement, voice, and meaningful choice at all levels and in all areas of organizational functioning (e.g., program design, implementation, service delivery, quality assurance, cultural competence, access to trauma-informed peer support, workforce development, and evaluation.) This is a key value and aspect of a trauma-informed approach that differentiates it from the usual approaches to services and care.

CROSS SECTOR COLLABORATION: Collaboration across sectors is built on a shared understanding of trauma and principles of a trauma-informed approach. While a trauma focus may not be the stated mission of various service sectors, understanding how awareness of trauma can help or hinder achievement of an organization's mission is a critical aspect of building collaborations. People with significant trauma histories often present with a complexity of needs, crossing various service sectors. Even if a mental health clinician is trauma-informed, a referral to a trauma-insensitive program could then undermine the progress of the individual.

SCREENING, ASSESSMENT, AND TREATMENT SERVICES: Practitioners use and are trained in interventions based on the best available empirical evidence and science, are culturally appropriate, and reflect principles of a trauma-informed approach. Trauma screening and assessment are an essential part of the work. Trauma-specific interventions are acceptable, effective, and available for individuals and families seeking services. When trauma-specific services are not available within the organization, there is a trusted, effective referral system in place that facilitates connecting individuals with appropriate trauma treatment.

TRAINING AND WORKFORCE DEVELOPMENT: On-going training on trauma and peer-support are essential. The organization's human resource system incorporates trauma-informed principles in hiring, supervision, staff evaluation; procedures are in place to support staff with trauma histories and/or those experiencing significant secondary traumatic stress or vicarious trauma, resulting from exposure to and working with individuals with complex trauma.

PROGRESS MONITORING AND QUALITY ASSURANCE: There is ongoing assessment, tracking, and monitoring of trauma-informed principles and effective use of evidence-based trauma specific screening, assessments and treatment.

FINANCING: Financing structures are designed to support a trauma-informed approach which includes resources for: staff training on trauma, key principles of a trauma-informed approach; development of appropriate and safe facilities; establishment of peer-support; provision of evidence-supported trauma screening, assessment, treatment, and recovery supports; and development of trauma-informed cross-agency collaborations.

EVALUATION: Measures and evaluation designs used to evaluate service or program implementation and effectiveness reflect an understanding of trauma and appropriate trauma-oriented research instruments.

To further guide implementation, the chart on the next page provides sample questions in each of the ten domains to stimulate change-focused discussion. The questions address examples of the work to be done in any particular domain yet also reflect the six key principles of a trauma-informed approach. Many of these questions and concepts were adapted from the work of Fallot and Harris, Henry, Black-Pond, Richardson, & Vandervort, Hummer and Dollard, and Penney and Cave.[39, 40, 41,42]

While the language in the chart may seem more familiar to behavioral health settings, organizations across systems are encouraged to adapt the sample questions to best fit the needs of the agency, staff, and individuals being served. For example, a juvenile justice agency may want to ask how it would incorporate the principle of safety when examining its physical environment. A primary care setting may explore how it can use empowerment, voice, and choice when developing policies and procedures to provide trauma-informed services (e.g. explaining step by step a potentially invasive procedure to a patient at an OBGYN office).

SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH

KEY PRINCIPLES					
Safety	**Trustworthiness and Transparency**	**Peer Support**	**Collaboration and Mutuality**	**Empowerment, Voice, and Choice**	**Cultural, Historical, and Gender Issues**
10 IMPLEMENTATION DOMAINS					
Governance and Leadership	• How does agency leadership communicate its support and guidance for implementing a trauma-informed approach? • How do the agency's mission statement and/or written policies and procedures include a commitment to providing trauma-informed services and supports? • How do leadership and governance structures demonstrate support for the voice and participation of people using their services who have trauma histories?				
Policy	• How do the agency's written policies and procedures include a focus on trauma and issues of safety and confidentiality? • How do the agency's written policies and procedures recognize the pervasiveness of trauma in the lives of people using services, and express a commitment to reducing re-traumatization and promoting well-being and recovery? • How do the agency's staffing policies demonstrate a commitment to staff training on providing services and supports that are culturally relevant and trauma-informed as part of staff orientation and in-service training? • How do human resources policies attend to the impact of working with people who have experienced trauma? • What policies and procedures are in place for including trauma survivors/people receiving services and peer supports in meaningful and significant roles in agency planning, governance, policy-making, services, and evaluation?				

SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH *(continued)*

10 IMPLEMENTATION DOMAINS *continued*	
Physical Environment	• How does the physical environment promote a sense of safety, calming, and de-escalation for clients and staff? • In what ways do staff members recognize and address aspects of the physical environment that may be re-traumatizing, and work with people on developing strategies to deal with this? • How has the agency provided space that both staff and people receiving services can use to practice self-care? • How has the agency developed mechanisms to address gender-related physical and emotional safety concerns (e.g., gender-specific spaces and activities).
Engagement and Involvement	• How do people with lived experience have the opportunity to provide feedback to the organization on quality improvement processes for better engagement and services? • How do staff members keep people fully informed of rules, procedures, activities, and schedules, while being mindful that people who are frightened or overwhelmed may have a difficulty processing information? • How is transparency and trust among staff and clients promoted? • What strategies are used to reduce the sense of power differentials among staff and clients? • How do staff members help people to identify strategies that contribute to feeling comforted and empowered?
Cross Sector Collaboration	• Is there a system of communication in place with other partner agencies working with the individual receiving services for making trauma-informed decisions? • Are collaborative partners trauma-informed? • How does the organization identify community providers and referral agencies that have experience delivering evidence-based trauma services? • What mechanisms are in place to promote cross-sector training on trauma and trauma-informed approaches?
Screening, Assessment, Treatment Services	• Is an individual's own definition of emotional safety included in treatment plans? • Is timely trauma-informed screening and assessment available and accessible to individuals receiving services? • Does the organization have the capacity to provide trauma-specific treatment or refer to appropriate trauma-specific services? • How are peer supports integrated into the service delivery approach? • How does the agency address gender-based needs in the context of trauma screening, assessment, and treatment? For instance, are gender-specific trauma services and supports available for both men and women? • Do staff members talk with people about the range of trauma reactions and work to minimize feelings of fear or shame and to increase self-understanding? • How are these trauma-specific practices incorporated into the organization's ongoing operations?

SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH *(continued)*

10 IMPLEMENTATION DOMAINS *continued*	
Training and Workforce Development	• How does the agency address the emotional stress that can arise when working with individuals who have had traumatic experiences? • How does the agency support training and workforce development for staff to understand and increase their trauma knowledge and interventions? • How does the organization ensure that all staff (direct care, supervisors, front desk and reception, support staff, housekeeping and maintenance) receive basic training on trauma, its impact, and strategies for trauma-informed approaches across the agency and across personnel functions? • How does workforce development/staff training address the ways identity, culture, community, and oppression can affect a person's experience of trauma, access to supports and resources, and opportunities for safety? • How does on-going workforce development/staff training provide staff supports in developing the knowledge and skills to work sensitively and effectively with trauma survivors. • What types of training and resources are provided to staff and supervisors on incorporating trauma-informed practice and supervision in their work? • What workforce development strategies are in place to assist staff in working with peer supports and recognizing the value of peer support as integral to the organization's workforce?
Progress Monitoring and Quality Assurance	• Is there a system in place that monitors the agency's progress in being trauma-informed? • Does the agency solicit feedback from both staff and individuals receiving services? • What strategies and processes does the agency use to evaluate whether staff members feel safe and valued at the agency? • How does the agency incorporate attention to culture and trauma in agency operations and quality improvement processes? • What mechanisms are in place for information collected to be incorporated into the agency's quality assurance processes and how well do those mechanisms address creating accessible, culturally relevant, trauma-informed services and supports?
Financing	• How does the agency's budget include funding support for ongoing training on trauma and trauma-informed approaches for leadership and staff development? • What funding exists for cross-sector training on trauma and trauma-informed approaches? • What funding exists for peer specialists? • How does the budget support provision of a safe physical environment?
Evaluation	• How does the agency conduct a trauma-informed organizational assessment or have measures or indicators that show their level of trauma-informed approach? • How does the perspective of people who have experienced trauma inform the agency performance beyond consumer satisfaction survey? • What processes are in place to solicit feedback from people who use services and ensure anonymity and confidentiality? • What measures or indicators are used to assess the organizational progress in becoming trauma-informed?

Next Steps: Trauma in the Context of Community

Delving into the work on community trauma is beyond the scope of this document and will be done in the next phase of this work. However, recognizing that many individuals cope with their trauma in the safe or not-so safe space of their communities, it is important to know how communities can support or impede the healing process.

Trauma does not occur in a vacuum. Individual trauma occurs in a context of community, whether the community is defined geographically as in neighborhoods; virtually as in a shared identity, ethnicity, or experience; or organizationally, as in a place of work, learning, or worship. How a community responds to individual trauma sets the foundation for the impact of the traumatic event, experience, and effect. Communities that provide a context of understanding and self-determination may facilitate the healing and recovery process for the individual. Alternatively, communities that avoid, overlook, or misunderstand the impact of trauma may often be re-traumatizing and interfere with the healing process. Individuals can be re-traumatized by the very people whose intent is to be helpful. This is one way to understand trauma in the context of a community.

A second and equally important perspective on trauma and communities is the understanding that communities as a whole can also experience trauma. Just as with the trauma of an individual or family, a community may be subjected to a community-threatening event, have a shared experience of the event, and have an adverse, prolonged effect. Whether the result of a natural disaster (e.g., a flood, a hurricane or an earthquake) or an event or circumstances inflicted by one group on another (e.g., usurping homelands, forced relocation, servitude, or mass incarceration, ongoing exposure to violence in the community), the resulting trauma is often transmitted from one generation to the next in a pattern often referred to as historical, community, or intergenerational trauma.

Communities can collectively react to trauma in ways that are very similar to the ways in which individuals respond. They can become hyper-vigilant, fearful, or they can be re-traumatized, triggered by circumstances resembling earlier trauma. Trauma can be built into cultural norms and passed from generation to generation. Communities are often profoundly shaped by their trauma histories. Making sense of the trauma experience and telling the story of what happened using the language and framework of the community is an important step toward healing community trauma.

Many people who experience trauma readily overcome it and continue on with their lives; some become stronger and more resilient; for others, the trauma is overwhelming and their lives get derailed. Some may get help in formal support systems; however, the vast majority will not. The manner in which individuals and families can mobilize the resources and support of their communities and the degree to which the community has the capacity, knowledge, and skills to understand and respond to the adverse effects of trauma has significant implications for the well-being of the people in their community.

Conclusion

As the concept of a trauma-informed approach has become a central focus in multiple service sectors, SAMHSA desires to promote a shared understanding of this concept. The working definitions, key principles, and guidance presented in this document represent a beginning step toward clarifying the meaning of this concept. This document builds upon the extensive work of researchers, practitioners, policymakers, and people with lived experience in the field. A standard, unified working concept will serve to advance the understanding of trauma and a trauma-informed approach for public institutions and service sectors.

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San Diego Youth Services embraces a trauma-informed approach; kids do better, staff stay longer, programs more effective

December 14, 2014 By Alicia St. Andrewsin ACE Study, Adverse childhood experiences, Child trauma, Community prevention programs, Solutions5 Comments

Staff of the San Diego Youth Services TAY Academy welcome all Transition Age Youth (TAY) to drop-in. Left to right: Vanessa Arteaga, Indie Landrum, Stephen Carroll, and Gillian Leal.

In 2010, 16-year-old Indie Landrum ran away from an unstable home where he lived with his mom and his grandmother. His older sister ran away when she was 16, and both of his brothers were incarcerated. Indie sought emergency housing at the San Diego Youth Services (SDYS) Storefront shelter, and lived there for several months before going into a long-term group home.

During his time at Storefront, SDYS began a dramatic transformation: the process of becoming a trauma-informed organization. Basically, that means instead of a staff member angrily asking a youth who's acting out, "What's wrong with you?" and punishing the behavior, staff members ask, "What happened to you?" and work with the kid on healing and recovery.

The results? Significant. Youth who were less likely to use the services now do, and more often. Police involvement and foster home/group home placements are down. And SDYS staff turnover has dropped. When Indie first arrived, "there were very specific rules that had to be followed to stay in shelter. If you weren't in by 7:30 p.m., you couldn't stay the night," says Indie. "It's not that they didn't care, it just didn't matter why you weren't there."

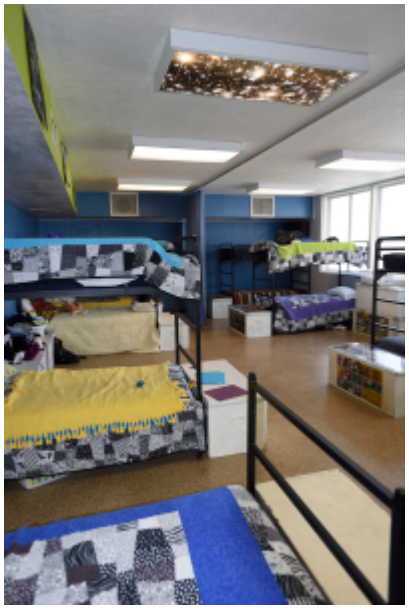
At that time, SDYS shelter staff worked with youth on a system of rules and rewards: You made your bed, you got a point. It's the way most youth shelters across the U.S. work. If a kid loses a certain number of points, the kid gets put on a seven-day restriction phase. It's modeled after how parents discipline kids when they mess up at home — no phone, no TV, no video games. Kids are still required to go to dinner, group meetings, and shower, but they have to spend their hour and a half of free time in bed. If the kid continues to lose points while on restriction, they are asked to leave the shelter. Lose points on the first day of restriction? Out for the remaining six days and nights.

"The belief was that when kids have to fend for themselves outside of shelter it makes them appreciate being in shelter to the point that they change their behavior," says Michelle Atkins, Storefront Shelter program manager from 2007 to 2011.

It was a belief that was challenged by Gabriella Grant, director of the California Center of Excellence for Trauma-Informed Care, in 2009. After attending Grant's workshop, Atkins and her team reviewed the files of hundreds of youth who had been on restriction over a three-year period.

"We could prove it wasn't working," says Atkins. In fact, they found the policy had a success rate of zero. It was effective for *no* kids. "Kids were most often asked to leave because they didn't have the daily living skills or behavior management required to stay in shelter, and the restriction phase didn't help with either," says Atkins.

The question became: How can we make more effective policies? Instead of going straight to consequences, staff members started talking with kids who were breaking the rules about why they were having problems doing so. If a youth coming off the streets wasn't oriented to daily living skills — personal hygiene, making a bed, doing a chore, being on time, being respectful — a staff member volunteered to model the skill and do it with the youth. To keep shaming, blaming, and ostracizing the youth to a minimum, staff members sat down with the youth at a time when no other youth were present.



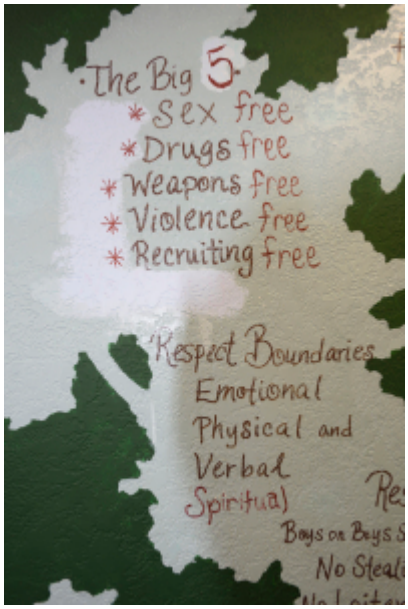
Through the process of becoming trauma-informed, white walls were painted colors chosen by the youth, a curtain was installed to create more privacy, and lighting was dimmed to create a more comfortable atmosphere at the San Diego Youth Services Storefront Shelter.

And so SDYS joined a nascent and emerging nationwide movement of elementary schools, high schools, and juvenile courts that are jettisoning punitive discipline policies and adopting trauma-informed, resilience-building, and restorative approaches to care.

But what exactly does becoming trauma-informed mean? Becoming trauma-informed is an evolutionary learning process, not a quick fix. There are no band aids in a trauma-informed toolbox. According to the Substance Abuse and Mental Health Services Administration (SAHMSA), a *trauma-informed approach* refers to how a program, agency, organization, or community thinks about and responds to those who have experienced or may be at risk for experiencing trauma; it is a change in organizational culture.

In this approach, the whole organization understands the prevalence and impact of trauma, the role trauma plays in people's lives, and the complex and varied paths for healing and recovery. It is designed to avoid re-traumatizing already traumatized people, with a focus on safety first, including emotional safety, and a commitment to do no harm. It requires meaningful involvement of community members and trauma survivors in service and program planning, and close collaborations between public and private sector service systems.

Prior to 2010, SDYS had implemented a few trauma-specific services haphazardly. They needed something that involved everyone. After researching their options, they decided that becoming a trauma-informed organization was the best approach. "We knew we would not just get a certificate in trauma-informed care," says Steven Jella, SDYS associate executive director. "Becoming trauma-informed would have to remain an ongoing issue of agency-wide culture change."



In an effort to reframe messages more positively, SDYS Storefront Shelter staff and youth whited out the "No" in front of sex, drugs, weapons, violence, or recruiting, and replaced it with "sex, drugs, weapons, violence, and recruiting free."

Everything and everybody — maintenance staff, budgets and contracts, board of directors — would need to be included. Becoming trauma-informed is a paradigm shift, says Jella. "It's not about a youth acting out, it's about what triggered them."

For Indie, it meant that when his grandmother died, he was allowed to skip group meetings, put sheets up around his bunk bed for added privacy, and stay up past lights-out to talk with staff about his grief, actions that otherwise would have racked up points, generated consequences, and ultimately run him the risk of getting kicked out of shelter.

As a queer youth in the process of coming out as transgender, Indie also benefited from the increased safety associated with trauma-informed care in a system where one-third of trans youth are turned away from shelters because of their gender identity. He met two other transgender youth while living at Storefront. Staff members referred to them by their requested identities and let them express themselves accordingly. As requested by the youth, bathrooms were made ambiguous, and they were given the opportunity to decide which side of the room they felt most comfortable sleeping on, male or female.

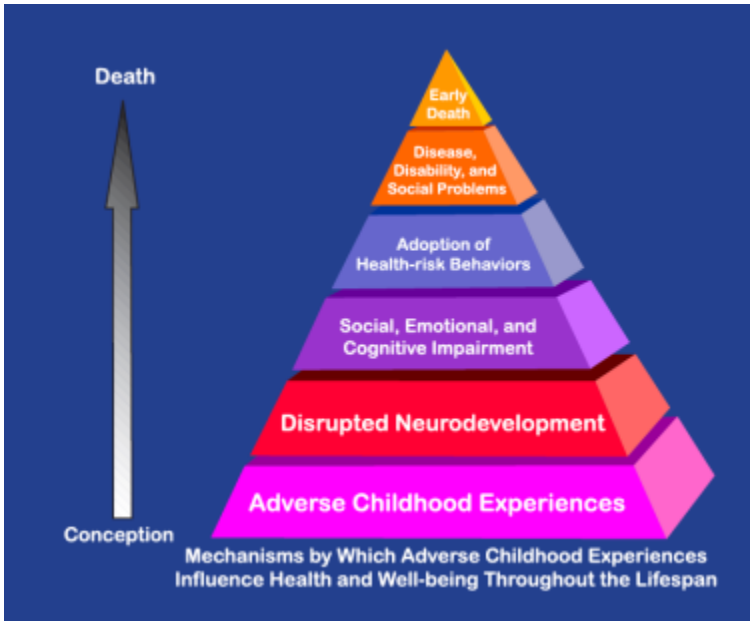
"I got honor role for the first time in my life when I lived at Storefront," says Indie. "It felt like the staff at Storefront actually cared. I still seek support from staff because the connections are so strong."

Left to right: San Diego Youth Services Storefront Shelter staff Sarah Merrill, Jan Stankus, Carly Graber, and Nytasha Thomas, with silhouettes of the youth they work with, and on-site therapy dog, Sunshine.

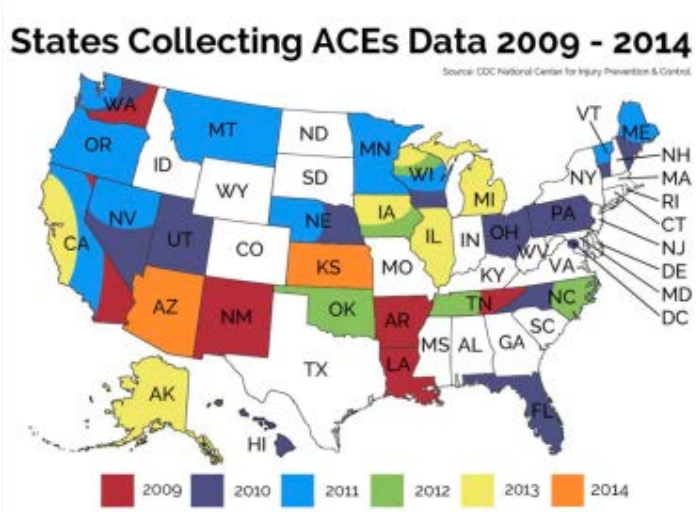
Becoming truly trauma-informed takes time, involves everyone

The process of becoming a trauma-informed agency was no small undertaking. The 220 staff members of SDYS, a non-profit charitable organization founded in 1970, serve about 13,000 youth and families every year through about 25 programs in 14 locations around San Diego County. The agency prevents delinquency and school failure, reduces homelessness, promotes mental health and addiction recovery, and breaks the cycle of child abuse and neglect. Young people – from newborns to 25-year-olds — and their parents or caregivers are referred to SDYS from San Diego County's Child Welfare Services, Probation Department, Police Department, schools, other non-profit agencies, and from the streets.

"Our population has high rates of trauma," says Stephen Carroll, director of the SDYS Homeless/Transition Age Services Division that includes the Storefront youth shelter. "We wanted to make sure this effort impacted the whole agency."



Without intervention, high rates of trauma can result in adult onset of chronic disease, mental illness, violence and being a victim of violence, according to the CDC's Adverse Childhood Experiences Study (ACE Study). The study measured 10 types of childhood trauma: sexual, physical and verbal abuse, and physical and emotional neglect; and five types of family dysfunction – witnessing a mother being abused, a household member who's alcoholic or drug dependent, who's been imprisoned, or diagnosed with mental illness, or loss of a parent through separation, divorce or other reason. Of course there are other types of trauma, such as bullying and community violence, but the ACE Study measured only 10. Each type of trauma was given an ACE score of 1. Think of an ACE score as a cholesterol score for childhood trauma. A person who has been sexually abused and physically neglected, and grew up with an alcoholic mom and an incarcerated dad would have an ACE score of 4. The study found that of the 17,000 mostly white, middle class, college educated, Kaiser-insured adults, two-thirds experienced at least one type of severe childhood trauma. Most had suffered two or more. The study found that a person with four or more adverse childhood experiences is 12 times more likely to attempt suicide, 10 times more likely to use injection drugs, seven times more likely to be an alcoholic, two-and-a-half times more likely to have a stroke, and twice as likely to have cancer. A person with an ACE score of 6 or more has a shorter life expectancy – by 20 years. ACE studies have now been done in 28 states and Washington, D.C., with similar results. And what about youth at risk or experiencing homelessness? Well, if you consider youth behind bars "at risk," a recent study conducted by Florida State's Office of Juvenile Justice and Delinquency Prevention and the University of Florida found that 50 percent of the 64,000 incarcerated youth surveyed experienced 4 or more ACEs, compared to only 13 percent of the original CDC ACE



Study. From May to November 2011, SDYS took three critical steps to become trauma-informed: — The associate executive director sent an email to all agency staff explaining the interest in making a shift to trauma-informed care. Included was a document adapted from the Hollywood Homeless Youth Partnership (10 reasons for Integrating Trauma-Informed Approaches in Programs for Runaway and Homeless Youth).

Left to right: Indie Landrum, SDYS Community Organizer, with Stephen Carroll, SDYS Homeless/Transition Age Services Division Director, at the SDYS TAY Academy.

To encourage the staff to ask, "What does this have to do with what I do?," all staff members were asked to rewrite their job descriptions to include trauma-informed care language. "This brought up questions," says Carroll. "For example, housing and facilities staff asked: 'Why are you asking us to be trauma-informed? We repair broken sinks.' They had to figure out how being trauma-informed impacted them." — They formed their own trauma-informed work group and applied to join a national learning community sponsored by the National Council for Behavioral Health and supported by SAMHSA.

"That was the catalyst for us adopting trauma-informed care as a culture across our entire agency," says Carroll. The SDYS trauma-informed care work group – comprising the associate executive director, three division directors and the program manager for the family/youth support partners program — joined 20 other organizations from across the country that were also becoming trauma-informed. "Some were taking on trauma-informed care for the first time," recalls Carroll. "Some agencies had already gotten the ball rolling. We learned from one another. The other 20 organizations and staff supported us as we mapped out a plan forward, and we supported them."

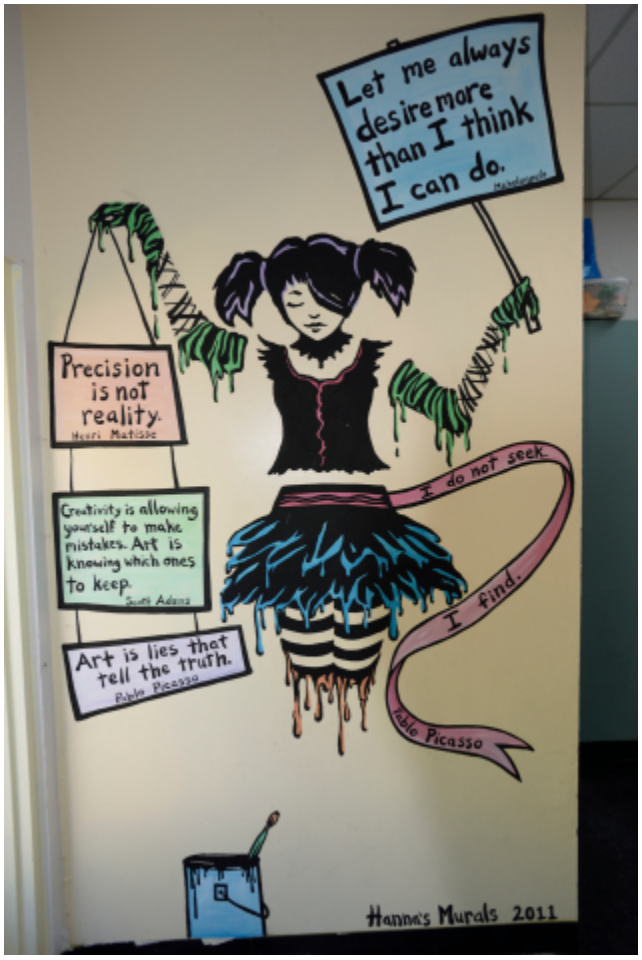
The SDYS work group decided to focus on developing their workforce. "If this was going to be the culture of the agency, we needed to train everybody at all levels," says Carroll.

They developed three trainings: Trauma-Informed 101 Philosophy, Trauma-Informed 201 Care and Practice, and Trauma-Informed Care for Supervisors. To date, 355 people have participated in the Trauma-Informed 101 Philosophy, 98 people in Trauma-Informed 201 Care and Practice, and 50 in Trauma-Informed Care for Supervisors. Training participants have included SDYS staff, volunteers, foster parents, and outside agency staff. Training has been facilitated in partnership with Gabriella Grant of the California Center of Excellence for Trauma-Informed Care. Even the agency's board of directors requested training.

"They were really receptive," says Carroll. "They felt like it would make a difference."

The four-part Trauma-Informed Care for Supervisors training was critical, says Carroll. This makes the organization itself trauma-informed, since the staff interact with each other using trauma-informed approaches. Having this knowledge enables supervisors to respond to staff with care and understanding, instead of using a 100-page rulebook.

"That's the most important part," he says. "A lot of agencies provide trauma-informed training to their staff, and say 'We're trauma-informed'. You can say it, but you won't necessarily provide lasting change within the organization. You can't offer it once and expect an agency to stay on that path."



Expressive arts therapy flourished at the SDYS TAY Academy as a result of the agency becoming trauma-informed.

To provide lasting change, they tackled trauma-informed care sustainability through three approaches:

• Participation in an external online national community of practice, a listserv managed by the National Council for Behavioral Health. Its members ask and answer questions, facilitate webinars, and share links to articles, conferences, speakers, resources, and trainers.
• Participation in a local in-person community of practice, the San Diego -Trauma-Informed Guide Team. The guide team was established in 2008 in response to another workshop led by Grant. Today, more than 160 agencies participate in the team. Members pick each other's brains, assist their agencies in making the shift to trauma-informed practices, and cheerlead each other to keep up the momentum.
• Participation in an internal community of practice — the SDYS trauma-informed work group. During monthly meetings, 20 trauma-informed care champions from across all programs review and advance the agency-wide cultural shift. In-person meetings are complimented by an agency-wide intranet that houses an online resource library for all staff.

- The response from staff?

"The overwhelmingly majority of staff support it," says Carroll. "Instead of relying on black-and-white rules, the staff have to go to where clients are and work with them," he says. "The staff like the fact that it's challenging, and it gets results. They feel better that the care is individualized and they get to be creative. There's still a feeling of uncertainty. When they don't have black-and-white rules and protocols, they question: Are we doing the right thing? Should we have intervened sooner? Later? It's all good — it's part of self-reflection and critical thinking."

Although most of the staff embraced the changes in the agency, a few people left. That's to be expected, says Carroll. Those who left said a trauma-informed approach meant the agency was becoming "too soft" on the youth, allowing them to "get away with murder", to break too many rules.

"Some of the resistance might be that they haven't completed their own healing process," says Carroll.

Last year, in a Trauma-Informed 101 staff training, participants anonymously completed the 10-question ACE survey. In nine of 10 questions, staff members, volunteers, and foster parents who attended the training ranked higher than the original CDC ACE Study participants. The information was incorporated into the supervisors training to build understanding of the "wounded healers" concept. SDYS recognized early on that service providers are triggered the same ways youth are — by their traumatic histories. As a

result, these “wounded healers” also needed ongoing training and supervision with a big focus on staff wellness, health, and prevention.

“Part of being trauma-informed is acknowledging that the staff have a history of trauma, too. That’s why we have the supervisor training. They can receive the support of their supervisors,” says Carroll.

SDYS staff member Justin Floyd playing pool while on break at the TAY Academy.

Revising, improving, updating…. the process never stops. Over the last year, the SDYS trauma-informed care work group has revised its trauma trainings, updated policies and procedures for youth and family involvement, and are in the process of developing a worksite wellness program based on a survey of 117 staff to be used as a foundation for a combination of in-house and community-based resources.

The agency adopted Seeking Safety as their trauma-specific treatment, in combination with EMDR, Motivational Interviewing, and expressive arts therapies. The shelters have incorporated contributions from youth into their quality improvement procedures through “lots and lots of tools — suggestion boxes, meetings, written, verbal — enough space for everyone to have the input to meet their needs,” says Atkins.

A new project, the Transition Age Youth (TAY) Academy — a partnership between SDYS, the YMCA, South Bay Community Services, Harmonium Inc. and Nash & Associates — was recently designed from the ground up as a trauma-informed, resilience-building program. It operates out of four drop-in resource centers across San Diego County. The program provides resources and support to young adults ages 14-25. Anyone is welcome — not just homeless, foster, or substance-dependent youth. Youth, community, county, and social service providers helped design the program.

The program employs youth who have experienced trauma and who are vital in making connections with other young adults, and connection coaches that work with youth to create vision plans – a road map for their futures. “TAY Academy staff members aren’t called case managers,” says Carroll, “because youth emphasized that they weren’t cases and they don’t want to be managed.”

The program has no formal referral process. TAY have the choice of when to walk in and when to exit. This avoids youth being “passed” from adults at one agency to another.

“From a trauma-informed lens, it avoids re-traumatization,” says Carroll. Over the course of the last year, 1,030 youth made over 12,000 visits to the program, with the average youth making about 12 total visits. The program considers these numbers to be significant outcomes, considering the lack of trust and low utilization rates associated with the TAY population.

San Diego Youth Services Associate Executive Director, Steven Jella

How else does SDYS measure the impact of trauma-informed care? It's tricky. The purpose of trauma-informed care is culture change — to weave and braid it into everything — so it doesn't simply become the next flavor of the month. Unfortunately this can make it expensive and time-consuming to measure, because programs must first ascertain that the changes they're seeing can be attributed to trauma-informed practices, rather than some other outside factors.

"We looked at serious incident reports — police involvement, foster home/group home placements — ultimately the end result of not addressing triggers early on," says Jella. Based on a preliminary look at these indicators, they found significant drops in the overall number of reports from the past three to five years as well as the severity of reports from the past one to two years.

"Something has shifted," says Jella. Prior to adopting trauma-informed care, there was a 40% staff turnover rate at SDYS, not uncommon for nonprofits. After agency wide inclusion of trauma-informed principals and policies it dropped to 33%, a significant decrease.

"Staff typically stay longer in jobs where they get support and training and feel competent by seeing results. If they see results they feel better and they intervene better with the kiddos. That's our rationale, anyway," says Jella.

Indie Landrum, Community Organizer, working at his desk at TAY Academy.

Indie, who is now 21 years old, works as a community organizer on an alcohol and drug prevention program that focuses on reducing LGBTQ youth's access to drugs and alcohol. Indie wants to keep working with youth, get a masters degree in social work, and maybe pursue a doctorate degree. Before living at Storefront, Indie never envisioned living past age 18.

"When I was there it gave me a reason to keep going," says Indie. "I never knew anybody that came from an intense background and was doing good things. Everyone I knew was doing drugs, in jail, or working night shifts at a Wal-Mart. It's really important to see people doing good things. Now I know I can make a difference."

Trauma Informed Approach Concept

SAMHSA, 2014

3 E's	4 R's	6 P's	10 D's
Trauma	Key Assumptions	Guiding Principles	Domains for Implementation
1. Events	1. Realize	1. Safety	1. Governance and Leadership
		2. Trustworthiness and Transparency	2. Policy
2. Experiences	2. Recognize	3. Peer Support	3. Physical Environment
		4. Collaboration and Mutuality	4. Engagement and Involvement
3. Effects	3. Respond	5. Empowerment, Voice and Choice	5. Cross-Sector Collaboration
		6. Cultural, Historical and Gender Issues	6. Screening, Assessment and Treatment Services
	4. Resist Re-traumatization		7. Training and Workforce Development
			8. Progress Monitoring and Quality Assurance
			9. Financing
			10. Evaluation

Trauma

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

Historical and transgenerational trauma are also important aspects.

Trauma Informed Approach

A *program, organization, or system*

that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery;

recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system;

and responds by fully integrating knowledge about trauma into policies, procedures, and practices,

and seeks to actively resist re-traumatization.

Trauma Informed Approach, cont.

A trauma informed approach is distinct from
trauma-specific services.

A trauma informed approach is
inclusive of trauma-specific interventions,
whether assessment, treatment or recovery supports,
yet it also incorporates
key trauma principles into the *organizational culture*.

MODULE 4
What is the Impact of Trauma on the Brain and Body?

Trauma and the Brain

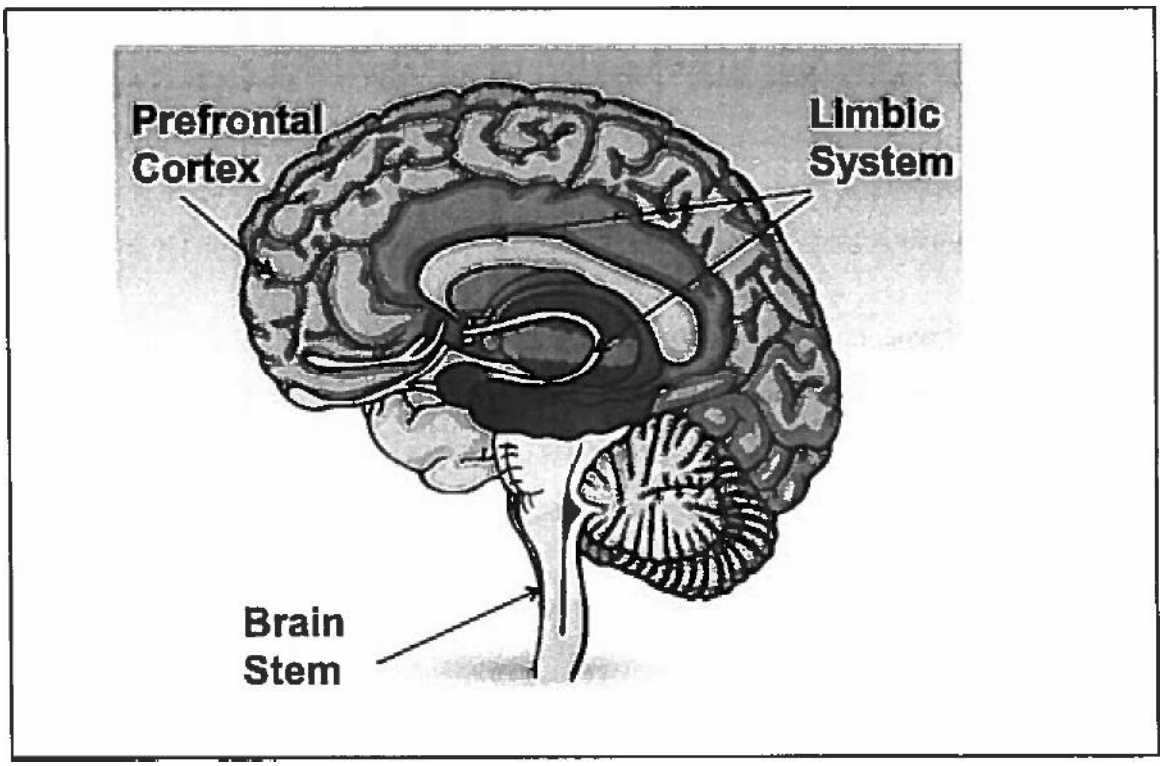
Trauma can have serious consequences for the normal development of children's brains, brain chemistry, and nervous system.

Trauma-induced alterations in biological stress systems can adversely affect brain development, cognitive and academic skills, and language acquisition.

Early trauma may lead to atypical development of the hypothalamic-pituitary-adrenal (HPA) axis stress response, which predisposes to psychiatric vulnerability later in life (van Goozen and Fairchild, 2008).

Trauma-exposed children and adolescents display changes in levels of stress hormones similar to those seen in combat veterans.

These changes may affect the way trauma-exposed children and adolescents respond to future stress in their lives, and may also influence their long-term health.



Plasticity means the brain continues to change in response to repeated stimulation. This plasticity signifies both risk and opportunity, in that trauma can negatively impact the brain, but corrective experiences can repair damage by creating new connections.

(Pynoos, Steinberg, Ornitz, & Goenjian, 1997)

Brain Structure: Three Main Levels

- **Cortex —** abstract thought, logic, factual memory, planning, ability to inhibit action
- **Limbic system —** emotional regulation and memories, value of emotion
- **Brainstem/midbrain** autonomic functions (e.g., breathing, eating, sleeping, feeling pain)

Experience Grows the Brain

- Brain development happens from the bottom up:
  - From primitive (basic survival: brainstem)
  - To more complex (rational thought, planning, abstract thinking: prefrontal cortex)
  - The brain develops by forming connections.
  - Interactions with caregivers are critical to brain development.
  - The more an experience is repeated, the stronger the connections become. (NCTSN: Caring for Children Who Have Experienced Trauma, 2010)

Brain Development

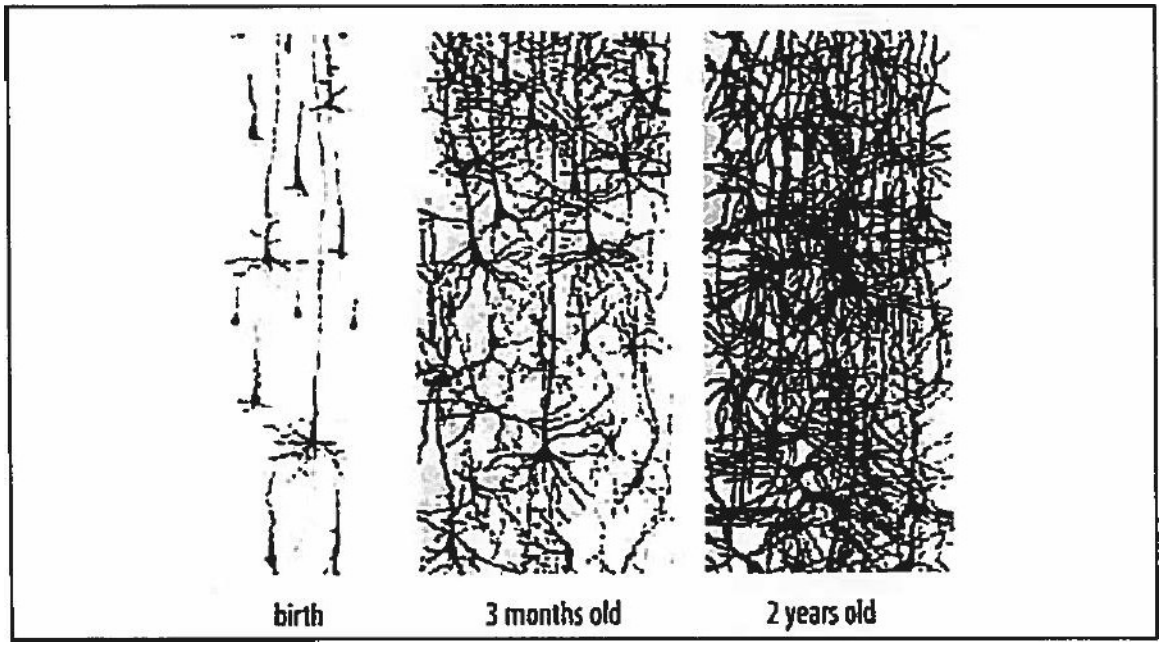
- The prenatal brain has 2-3 times the number of adult nerve cells as the adult brain.
- The maximum number of nerve cells is present at birth.
- Brain growth (size and weight) over the first years of life is due to:
  - Myelination: the process that allows nerve impulses to move more quickly
  - An increase in synaptic connections: how nerve cells communicate with other cells

¦ The growth of the brain is dependent on stimulation and experience.

Brain Development and Experience

- The brain has relatively few synapses present at birth.
- Learning requires forming new synapses as well as strengthening and discarding existing synapses.
- Early synapses are weak and need repeated exposure to strengthen.
- The brain adapts to environment, both positive and negative.

Building Connections: Rapid Growth of Synapses



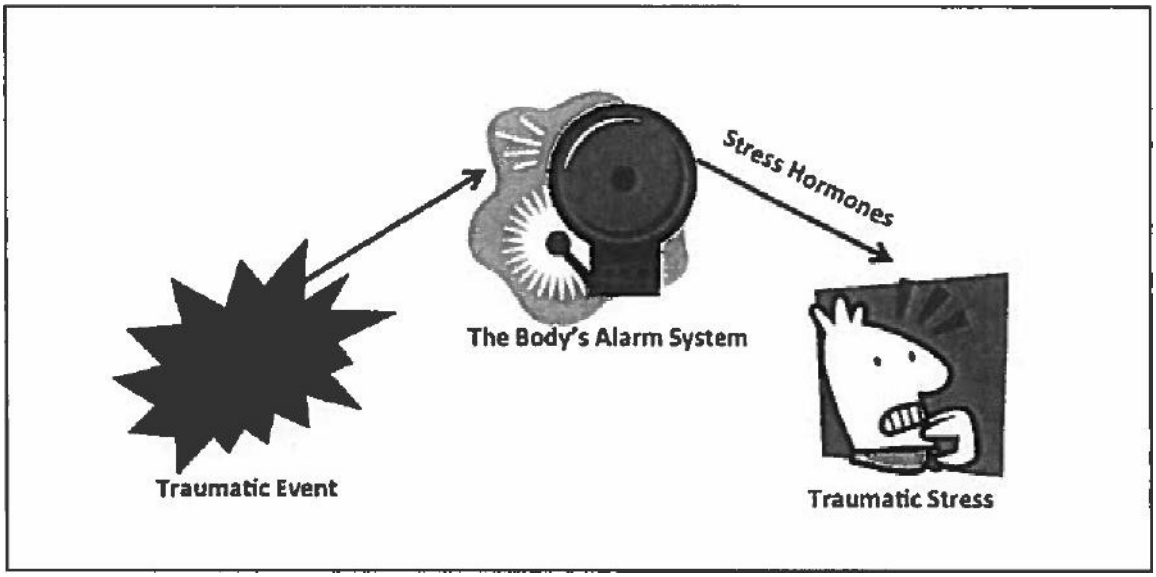
(Carter, 1999)

Trauma Derails Development

- Exposure to trauma causes the brain to develop in a way that will help the child survive in a dangerous world:
  - On constant alert for danger
  - Quick to react to threats (fight, flight, freeze)
- The stress hormones produced during trauma also interfere with the development of higher brain functions.

(reicher, 2002)

Traumatic Stress Response Cycle



(Georgetown University Center for Child & Human Development, n.d.)

- **Past trauma causes the brain to interpret minor events as threatening.**
- **The limbic system has a disproportionate fear/emotional response to the experience and sends signals to the brainstem.**
- **Cortisol and adrenaline are released, increasing heart rate and respiration.**
- **Fight, flight, or freeze response is initiated.**
- **Prefrontal cortex (where reasoning occurs) is skipped - leading to impulsive reactions.**
- **Memories of the event can be foggy and stored erratically.**

(Campbell, J. S. W., n.d.).

Impact of Maltreatment on Brain Structure

Structural brain differences can develop in the context of maltreatment. Compared to non-maltreated children, maltreated children present with a smaller corpus callosum, which controls communication between hemispheres related to arousal, emotion, and higher cognitive abilities (De BeHis et al., 1999, 2002; De Bellis & Keshavan, 2003; Teicher et al., 2004).

Adults who were maltreated as children show reduced volume of the hippocampus, which plays a central role in learning and memory (Vythilingam et **al.** 2004; Vermetten et al., 2006; Woon & Hedges, 2008), **and decreased volume of the prefrontal cortex, which controls behavior, cognition, and regulation of emotions** (Tomoda et al., 2009; Miller and Cohen, 2001; Amodio and Frith, 2006).

Trauma and Memory

- Implicit memory — babies can perceive their environment and retain unconscious memories (e.g., recognizing mother's voice)
- Explicit memory — conscious memories created around age two and tied to language development
- Children with early trauma may retain implicit memories of abuse
- Physical or emotional sensations can trigger these memories, causing flashbacks, nightmares, or other distressing reactions

(Applegate & Shapiro, 2005)

Trauma and the Brain

In **early childhood,** trauma can be associated with reduced size of the cortex. The cortex is responsible for many complex functions, including memory, attention, perceptual awareness, thinking, language, and consciousness.

Trauma may affect cross-talk between the brain's hemispheres, including the parts of the brain that govern emotions. These changes may affect IQ and the ability to regulate emotions, and can lead to increased fearfulness and a reduced sense of safety and protection.

In **school-age children,** trauma undermines the development of brain regions that would normally help children:

- Manage fears, anxieties, and aggression
- Sustain attention for learning and problem solving
- Control impulses and manage physical responses to danger, enabling the adolescent to consider and take protective actions

As a result, children may exhibit:

- Sleep disturbances
- New difficulties with learning

a Difficulties in controlling startle reactions

- Behavior that shifts between overly fearful and overly aggressive

In adolescents, trauma can interfere with development of the prefrontal cortex, the region responsible for:

- Consideration of the consequences of behavior
- Realistic appraisal of danger and safety
- Ability to govern behavior and meet longer-term goals As a result,

adolescents who have experienced trauma are at increased risk for:

- Reckless and risk-taking behavior
- Underachievement and school failure
- Poor choices
- Aggressive or delinquent activity

The brain continues to develop in adolescence and young adulthood, providing increased vulnerability, but also a window of opportunity to make new connections based on experiences.

Changes in dopamine levels during adolescence lead to risk-taking behavior (Spear, 2010).

With adult support, adolescents can learn self-regulation, coping skills, and mastery by taking risks.

Study shows that the female brain reaches full maturity at age 21-22, while the male brain is not fully mature until almost 30 (Lenroot et at., 2007).

What can a child welfare worker do?

- Consider the impact of trauma on the child's developing brain based on the age of trauma exposure.
- Recognize that children's "bad" behavior **is sometimes an adaptation to trauma** and may be related to altered physiology.
- Remember that young children can store trauma memories in their bodies, and can be highly impacted by trauma even when they cannot talk about the traumatic event.
- Due to neuroplasticity, the brain can change in response to repeated stimulation. This suggests that early intervention, treatment, and positive caregiving can help repair some of the negative impacts of trauma. Assure that all of these are a part of the child's plan.

Coping with Trauma Reminders

What are trauma reminders?

Many children in the foster care system have been through multiple traumatic events, often at the hands of those they trusted to take care of them. **When faced with people, situations, places, or things that remind them of these events, children may reexperience the intense and disturbing feelings tied to the original trauma.** These "trauma reminders" can lead to behaviors that seem out of place in the current situation, but were appropriate—and perhaps even helpful—at the time of the original traumatic event. For example:

- A seven-year-old boy whose father and older brother fought physically in front of him becomes frantic and tries to separate classmates playfully wrestling in the schoolyard.
- A three-year-old girl who witnessed her father beating her mother clings to her resource mother, crying hysterically when her resource parents have a mild dispute in front of her.
- A nine-year-old girl who was repeatedly abused in the basement of a family friend's house refuses to enter the resource family's basement playroom.
- A toddler who saw her cousin lying in a pool of blood after a drive-by shooting has a tantrum after a bottle of catsup spills on the kitchen floor.
- A teenager who was abused by her stepfather refuses to go to gym class after meeting the new gym teacher, who wears the same aftershave as her stepfather.
- A two-year-old boy who had been molested by a man in a Santa Claus suit runs screaming out of a YMCA Christmas party.

What happens when a child responds to a trauma reminder?

When faced with a trauma reminder, children may feel frightened, jumpy, angry, or shut down. Their hearts may pound or they may freeze in their tracks, just as one might do when confronting an immediate danger. Or they may experience physical symptoms such as nausea or dizziness. They may feel inexplicably guilty or ashamed or experience a sense of dissociation, as if they are in a dream or outside their own bodies.

Sometimes children are aware of their reaction and its connection to the original event. More often, however, they are unaware of the root cause of their feelings and may even feel frightened by the intensity of their reaction.

How can I help?

Children who have experienced trauma may face so many trauma reminders in the course of an ordinary day that the whole world seems dangerous, and no adult seems deserving of trust. Resource parents are in a unique position to help these children recognize safety and begin to trust adults who do indeed deserve their trust.

It's very difficult for children in the midst of a reaction to a trauma reminder to calm themselves, especially if they do not understand why they are experiencing such intense feelings. Despite

reassurance, these children may be convinced that danger is imminent or that the "bad thing" is about to happen again. It is therefore critical to create as safe an environment as possible. **Children who have experienced trauma need repeated reassurances of their safety.** When a child is experiencing a trauma reminder, it is important to state very clearly and specifically the reasons why the child is now safe. Each time a child copes with a trauma reminder and learns once more that he or she is finally safe, the world becomes a little less dangerous, and other people a little more reliable.

Tips for Helping Your Child Identify and Cope with Trauma Reminders

- **Learn as many specifics as you can about what your child experienced so you can identify when your child is reacting to a reminder.** Look for patterns (time of day, month, season, activity, location, sounds, sights, smells) that will help you understand when your child is reacting. Help your child to recognize these trauma reminders. Sometimes, just realizing where a feeling came from can help to minimize its intensity.
- **Do not force your child into situations that seem to cause unbearable distress.** Allow your child to avoid the most intense reminders, at least initially, until he or she feels safe and trusts you.
- When your child is reacting to a reminder, **help the child to discriminate between past experiences and the present one.** Calmly point out all the ways in which the current situation is different from the past. Part of the way children learn to overcome their powerful responses is by distinguishing between the past and the present. They learn, on both an emotional (feeling) and cognitive (thinking and understanding) level, that the new experience is different from the old one.
- **Provide tools to manage emotional and physical reactions.** Deep breathing, meditation, or other techniques may help a child to manage emotional and physical reactions to reminders. If you are unfamiliar with such techniques, ask a counselor to help.
- **Recognize the seriousness of what the child went through, and empathize with his or her feelings.** Don't be surprised or impatient if your child continues to react to reminders weeks, months, or even years after the events. Help your child to recognize that reactions to trauma reminders are normal and not a sign of being out of control, crazy, or weak. Shame about reactions can make the experience worse.
- **Anticipate that anniversaries of events, holidays, and birthdays may serve as reminders.**
- **With your child, identify ways that you can best reassure and comfort during a trauma reminder.** These might be a look of support, a reassurance of safety, words of comfort, a physical gesture, or help in distinguishing between the present and the past.
- **Seek professional help if your child's distress is extreme,** or if avoidance of trauma reminders is seriously limiting your child's life or movement forward.
- **Be self-aware.** A child's reaction to a trauma reminder may serve to remind you of something bad that happened in your own past. Work to separate your own reactions from those of your child.

Lindsey Greene
Self-Care/Secondary Traumatic Stress Trainer

Lindsey Greene is part of Coordinated Care's Community Education team. Coordinated Care is the health plan for children and youth in foster care, adoption support, and alumni of foster care in Washington State. She started her career working in a residential treatment program for youth with behavioral health needs. She has experience working in the child welfare system in two states: Virginia and Washington. Lindsey has worked as a CPS investigator, foster care case manager, adoption worker, and as a supervisor. Lindsey obtained her MSW from the University of Washington in 2014. She joined Coordinated Care's training team in 2015.

Self-Care & Secondary Traumatic Stress

Presented by
Lindsey Greene

Thank You for your participation and partnership!

coordinated care™

Lindsey Greene, MSW

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Self-Care & Secondary Traumatic Stress (STS)

Secondary Traumatic Stress & Self-Care

Compassion ○ Appreciation ○ Resilience ○ Empowerment

Secondary Traumatic Stress & Self-Care

- Balancing your plate
- Defining the terms
- Exposure to other's trauma
- Organizational trauma
- Understanding self care

Balance Your Plate

The Healthy Mind Platter, for Optimal Brain Matter

(Rock & Siegel, 2011)

Compassion ○ Appreciation ○ Resilience ○ Empowerment

Self-Care for Helping Professionals

- Self Care is more than a to-do list of the things you are supposed to do to take care of your mind and body.
- It's also how you manage the stress of the empathetic nature of the work.

Secondary Traumatic Stress & Related Conditions

Secondary Traumatic Stress refers to PTSD related symptoms caused by indirect exposure to traumatic material.

Other terms capture elements of this definition *but are not all* interchangeable.

- The compassion satisfaction/fatigue continuum
- Vicarious trauma
- Burnout

Check-in

- Any clarifying questions so far?
- Any thoughts to share?

Activity- PROQOL

- Complete the PROQOL assessment.
- Answer the poll.
- Break out room discussion.

Breakout Room Discussion

- How did you score in each area?
- Did anything surprise you?
- Do you think your scores are similar to other people in your organization?

Exposure to Other's Trauma

- What someone tells you
- Play, drawings, written stories
- Witnessing trauma responses
- Media coverage
- Case reports

Exposure to Secondary Trauma may cause:

Avoidance/Withdrawal	Hyper arousal	Re-experiencing	Thoughts/Feelings
• Emotional numbing • Feeling disconnected from friends/family	• Nervousness or jumpiness • Difficulty concentrating or taking in information	• Intrusive images • Nightmares/insomnia	• Changes in your worldview • Feelings of hopelessness and/or helplessness • Anger

Compassion ○ Appreciation ○ Resilience ○ Empowerment

When Your Client's Trauma is a Reminder

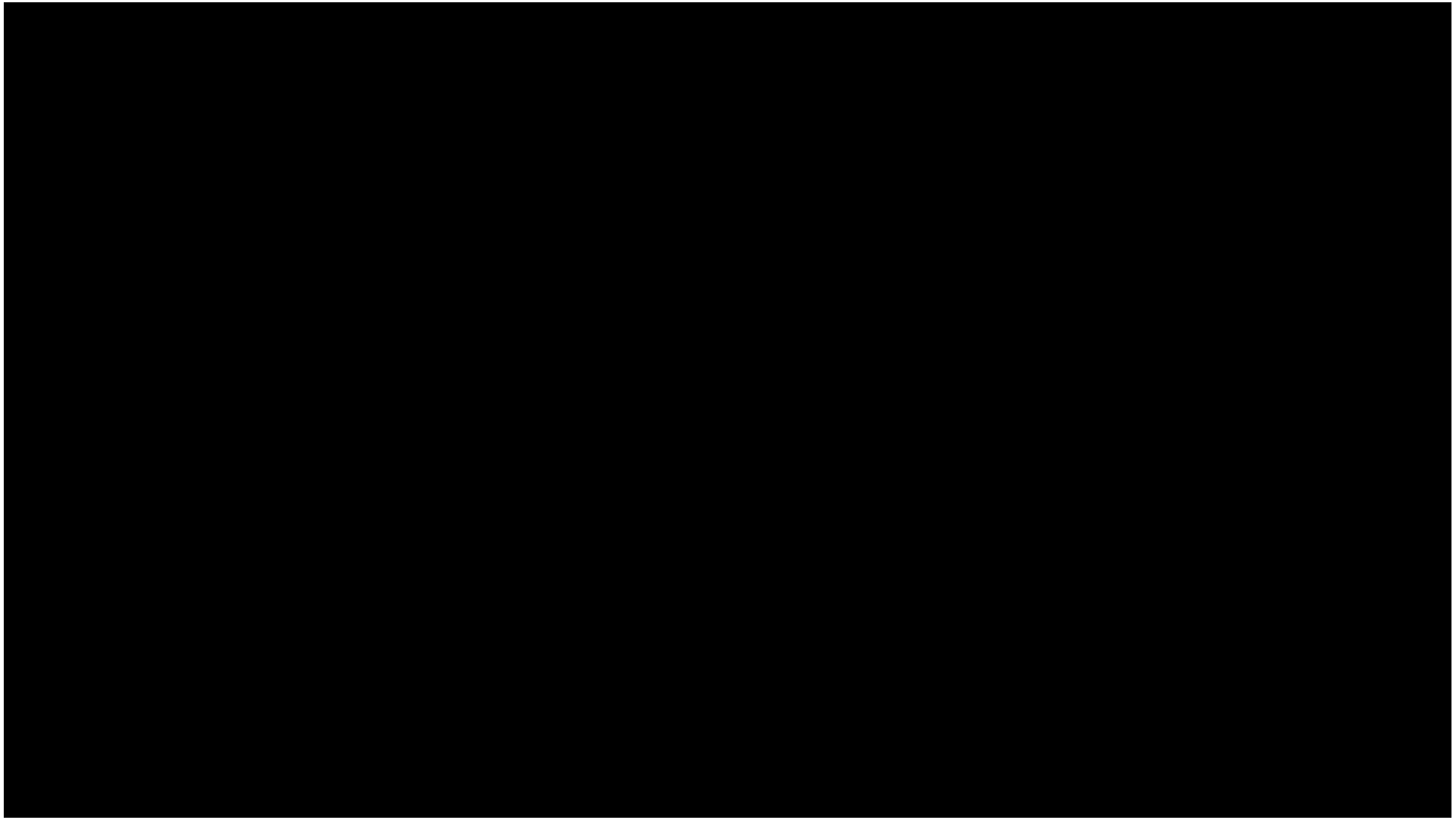
You may:

- React as you would to any trauma reminder
- Have trouble differentiating your experience from your client's
- Expect your client to cope the same way you did
- Respond inappropriately or disproportionately
- Withdraw from your client

Break

Compassion ○ Appreciation ○ Resilience ○ Empowerment

Laura van Dernoot Lipsky: Trauma Stewardship



Compassion ○ Appreciation ○ Resilience ○ Empowerment

Break Out Room Discussion

- What trauma exposure responses do you see in your self and in your organization?

Compassion

Breakout Room Share Back

- Select one person from your breakout room to share back with the larger group just one theme that emerged in your group discussion.

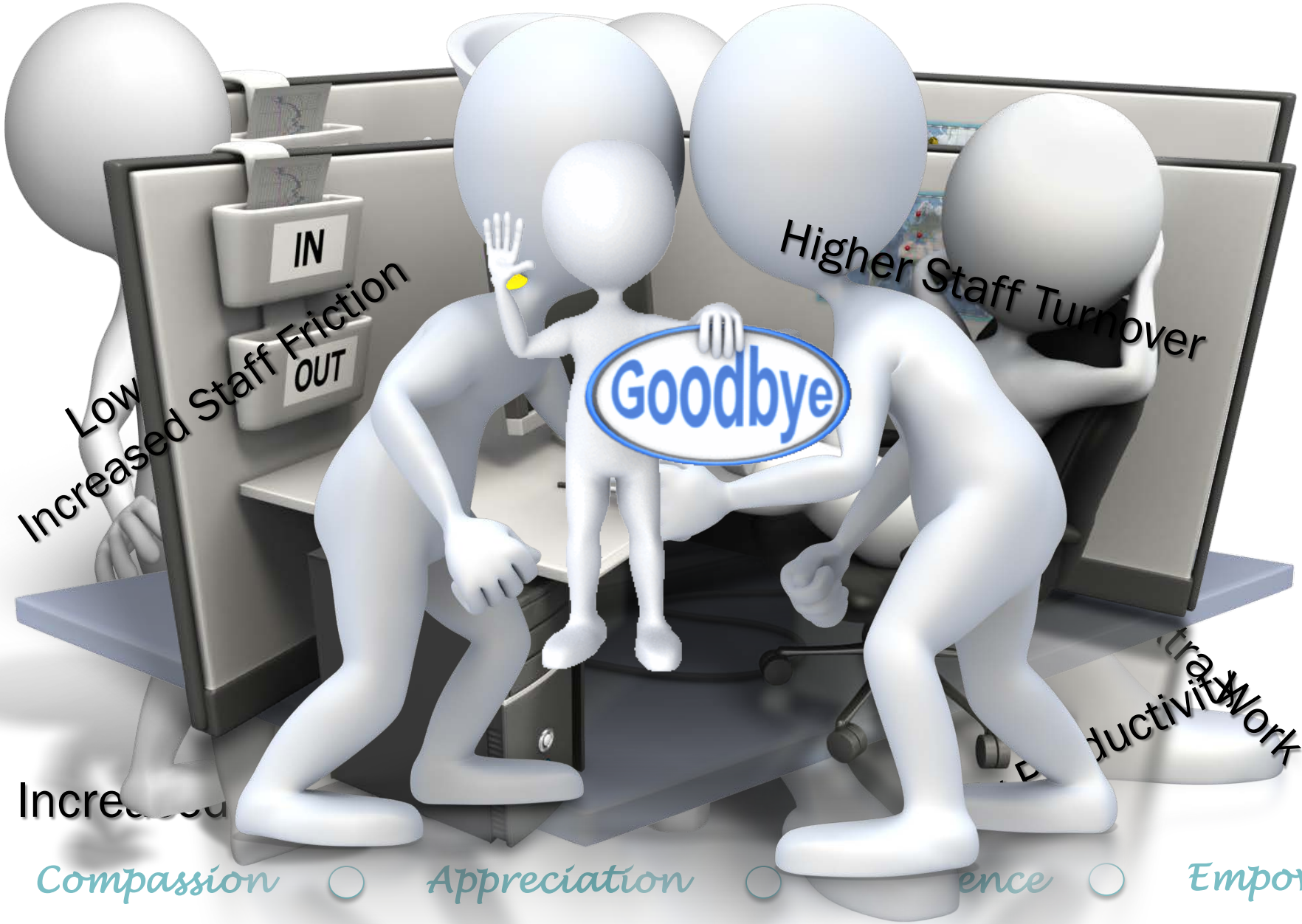
Organizational Stress

- Types of organizational stress (or trauma) include: layoffs, mergers and acquisitions, violence in the workplace, empathetic nature of the work, natural disaster, major reorganizations, the turnover of senior leadership or sudden loss of key talent.

- Direct or indirect, sudden or cumulative, organizational trauma typically has the following qualities:

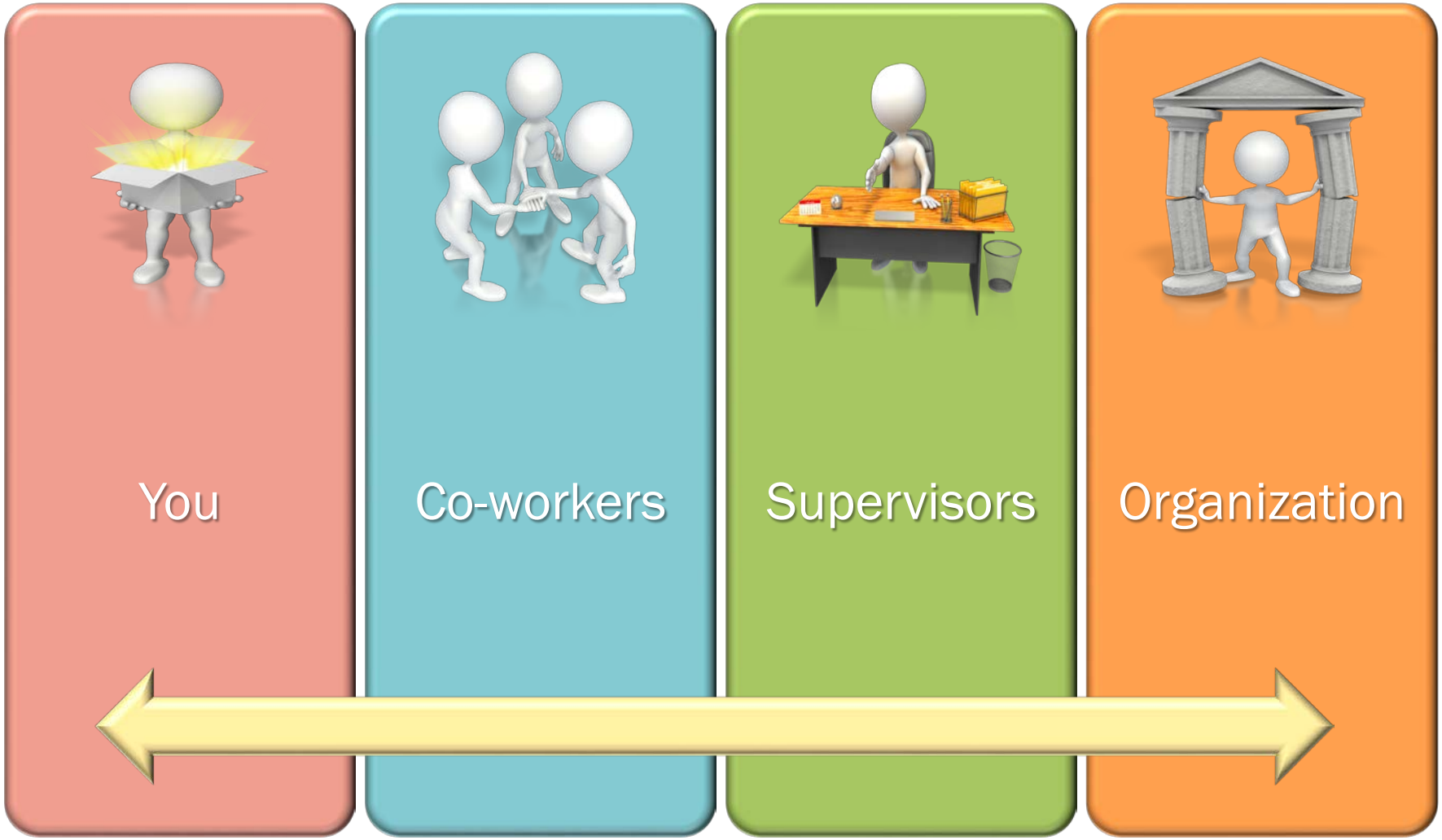
  - A breakdown in communication
  - A breakdown in trust
  - A breakdown in productivity
  - Workers feel powerless
  - A shake up in roles and responsibilities
  - A sense of loss
  - Stress and anxiety contagion

How Staff Stress Impairs Organizational Functioning



Compassion ○ Appreciation ○ ence ○ Empowerment

Who is Responsible for Your Self-Care?



Compassion ○ Appreciation ○ Resilience ○ Empowerment

Getting Past Secondary Traumatic Stress (STS)

- Use Supervision to Address STS
- Increase Self-Awareness of STS
- Maintain Healthy Work-Life Balance
- Implement Plans to Increase Personal Wellness
- Use Employee Assistance Programs
- Utilize Accountability Buddy System or Co-Care
- Practice Self-Care
- Stay Connected
- Counseling Services
- Use Vacation Time

Getting Past Secondary Traumatic Stress - Organizational

- Clinical Supervision
- Trauma Case Load Balance
- Enhance Physical safety of staff
- Incorporate STS Training for Staff
- Partner with STS Intervention Providers
- Ongoing Assessment of Staff Risk and Resiliency
- Reflective Supervision
- Workplace Self-Care Group
- Flextime Scheduling

Break

Compassion ○ Appreciation ○ Resilience ○ Empowerment

Organizational Health

Defining
Organizational Health

An organization's ability to function effectively, to cope adequately, to change appropriately, and to grow from within.

Trauma Informed Care

First and secondhand exposure to Adverse Childhood Experiences and the effects of toxic stress is prevalent in the workplace.

Through Trauma Informed Care, organizational health improvements can be achieved by focusing efforts on building an inclusive and resilient workforce.

Compassion ○ Appreciation ○ Resilience ○ Empowerment

Organizational Benefits of Trauma Informed Care

Organizational Resilience
Staff feel safe & connected to do their best work

Increased Morale & Satisfaction
Staff feel valued

Higher Productivity
Less absenteeism

Higher Retention
Turnover rates decrease

Compassion ○ Appreciation ○ Resilience ○ Empowerment

Organizational Resilience

Co-Care ultimately leads to Resiliency

- Proactive approach to safety and harm-reduction
- Reduces re-traumatization of staff and clients
- Organizational support encourages healing
- Builds resilience against secondary traumatic stress
- Mutual peer support environment

Compassion ○ Appreciation ○ Resilience ○ Empowerment

Self Care Group Activity

Why is self care important in each of these areas?

- Physical
- Psychological
- Emotional
- Spiritual
- Personal
- Professional

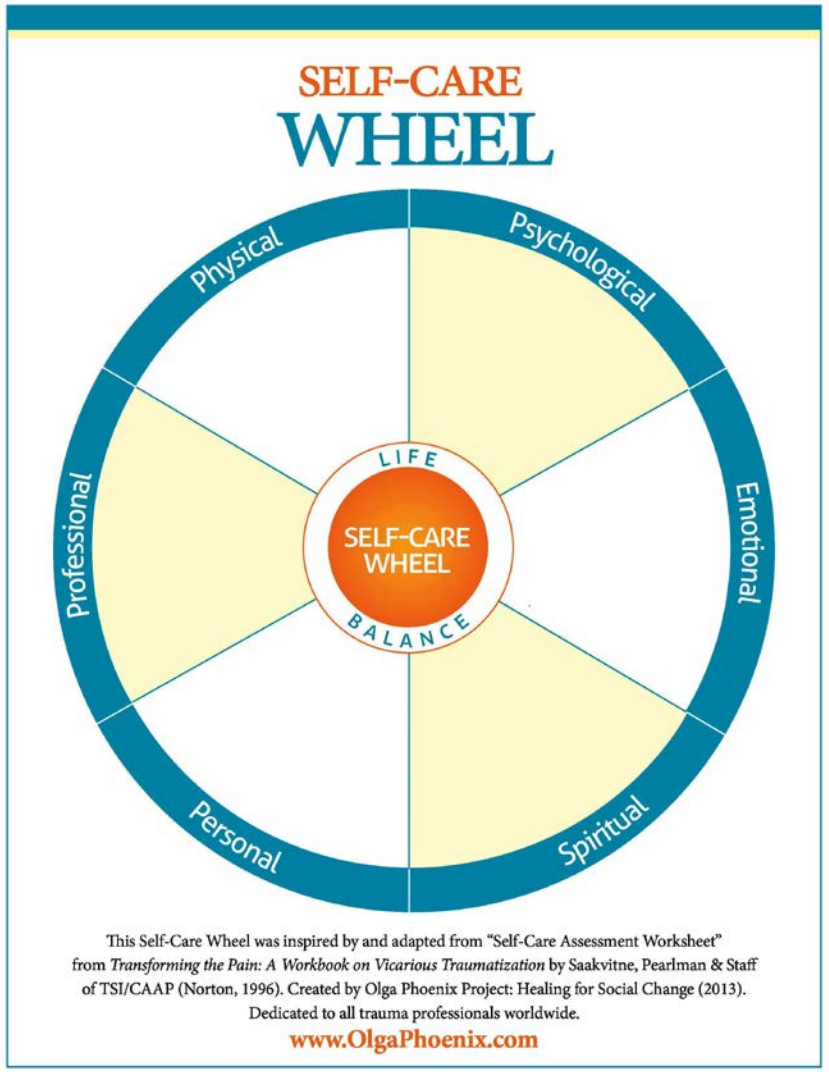
What are you currently doing?
What would you like to try?

Committing to Self-Care

Make a Plan

- Maintain a balance between work and relaxation, self and others.
- Include activities purely for fun.
- Include regular stress management physical activity, meditation, yoga, prayer, etc.
- Notice your strengths and areas for growth on the self assessment.

Make a Plan



Compassion ○ Appreciation ○ Resilience ○ Empowerment

References

National Childhood Traumatic Stress Network
http://www.nctsn.org/resources/topics/secondary-traumatic-stress

Compassion Fatigue Charles R Figley 1995

https://www.drdansiegel.com/resources/healthy_mind_platter/


Reflection &
Journaling

Self-Care & Secondary Traumatic Stress Resources

- Professional Quality of Life Scale (PROQOL)
- Self-Care Wheel (Blank)
- Self-Care Assessment Worksheet
- Self-Care Wheel
- When PTDS Is Contagious - Article

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE (PROQOL) VERSION 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some-questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

_____ 1. I am happy.
_____ 2. I am preoccupied with more than one person I *[help]*.
_____ 3. I get satisfaction from being able to *[help]* people.
_____ 4. I feel connected to others.
_____ 5. I jump or am startled by unexpected sounds.
_____ 6. I feel invigorated after working with those I *[help]*.
_____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
_____ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
_____ 10. I feel trapped by my job as a *[helper]*.
_____ 11. Because of my *[helping]*, I have felt "on edge" about various things.
_____ 12. I like my work as a *[helper]*.
_____ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
_____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
_____ 15. I have beliefs that sustain me.
_____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
_____ 17. I am the person I always wanted to be.
_____ 18. My work makes me feel satisfied.
_____ 19. I feel worn out because of my work as a *[helper]*.
_____ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
_____ 21. I feel overwhelmed because my case [work] load seems endless.
_____ 22. I believe I can make a difference through my work.
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
_____ 24. I am proud of what I can do to *[help]*.
_____ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
_____ 26. I feel "bogged down" by the system.
_____ 27. I have thoughts that I am a "success" as a *[helper]*.
_____ 28. I can't recall important parts of my work with trauma victims.
_____ 29. I am a very caring person.
_____ 30. I am happy that I chose to do this work.

YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCREENING

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental health care professional.

Compassion Satisfaction _____

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 23, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job. (Alpha scale reliability 0.88)

Burnout_____

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

If your score is below 23, this probably reflects positive feelings about your ability to be effective in your work. If you score above 41, you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern. (Alpha scale reliability 0.75)

Secondary Traumatic Stress_____

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

If your score is above 41, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional. (Alpha scale reliability 0.81)

WHAT IS MY SCORE AND WHAT DOES IT MEAN?

In this section, you will score your test so you understand the interpretation for you. To find your score on **each section,** total the questions listed on the left and then find your score in the table on the right of the section.

Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

3. _____
6. _____
12. _____
16. _____
18. _____
20. _____
22. _____
24. _____
27. _____
30. _____

Total: _____

The sum of my Compassion Satisfaction questions is	And my Compassion Satisfaction level is
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about the effects of helping when you are *not* happy so you reverse the score

You Wrote	Change to
	5
2	4
3	3
4	2
5	1

*1. _____ = _____
*4. _____ = _____
8. _____
10. _____
*15. _____ = _____
*17. _____ = _____
19. _____
21. _____
26. _____
*29. _____ = _____

Total: _____

The sum of my Burnout Questions is	And my Burnout level is
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

Secondary Traumatic Stress Scale

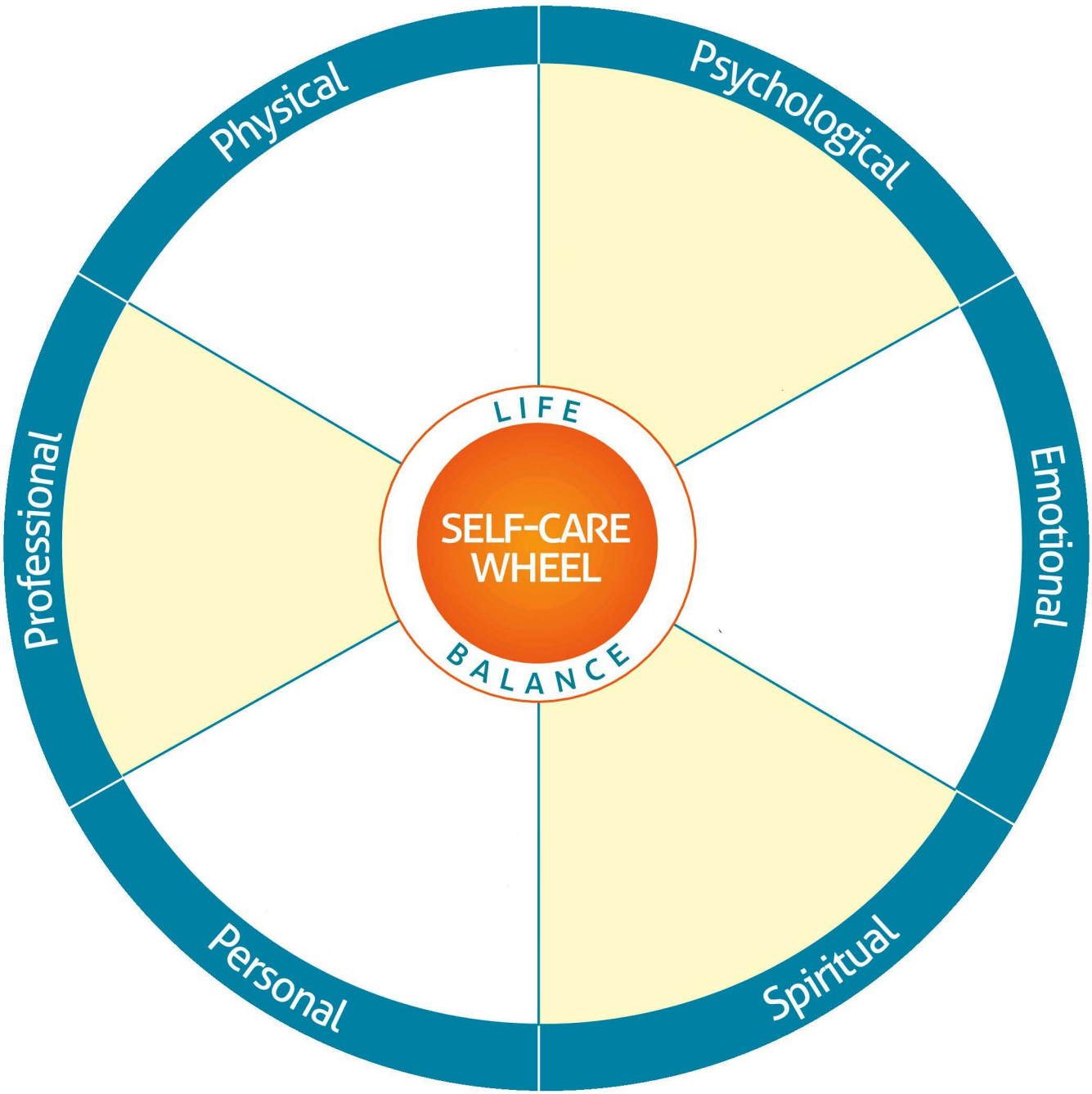
Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

2. _____
5. _____
7. _____
9. _____
11. _____
13. _____
14. _____
23. _____
25. _____
28. _____

Total: _____

The sum of my Secondary Trauma questions is	And my Secondary Traumatic Stress level is
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

SELF-CARE WHEEL



This Self-Care Wheel was inspired by and adapted from "Self-Care Assessment Worksheet" from *Transforming the Pain: A Workbook on Vicarious Traumatization* by Saakvitne, Pearlman & Staff of TSI/CAAP (Norton, 1996). Created by Olga Phoenix Project: Healing for Social Change (2013). Dedicated to all trauma professionals worldwide.

www.OlgaPhoenix.com

Self-Care Assessment Worksheet

This assessment tool provides an overview of effective strategies to maintain self-care. After completing the full assessment, choose one item from each area that you will actively work to improve.

Using the scale below, rate the following areas in terms of frequency:

5 = Frequently
4 = Occasionally
3 = Rarely
2 = Never
1 = It never occurred to me

Physical Self-Care

___ Eat regularly (e.g. breakfast, lunch and dinner)

___ Eat healthy

___ Exercise

___ Get regular medical care for prevention

___ Get medical care when needed

___ Take time off when needed

___ Get massages

___ Dance, swim, walk, run, play sports, sing, or do some other physical activity that is fun

___ Take time to be sexual—with yourself, with a partner

___ Get enough sleep

___ Wear clothes you like

___ Take vacations

___ Take day trips or mini-vacations

___ Make time away from telephones

___ Other:

Psychological Self-Care

___ Make time for self-reflection

___ Have your own personal psychotherapy

___ Write in a journal

___ Read literature that is unrelated to work

___ Do something at which you are not expert or in charge

___ Decrease stress in your life

Source: Transforming the Pain: A Workbook on Vicarious Traumatization. Saakvitne, Pearlman & Staff of TSI/CAAP (Norton, 1996)

___ Let others know different aspects of you

___ Notice your inner experience—listen to your thoughts, judgments, beliefs, attitudes, and feelings

___ Engage your intelligence in a new area, e.g. go to an art museum, history exhibit, sports event, auction, theater performance

___ Practice receiving from others

___ Be curious

___ Say "no" to extra responsibilities sometimes

___ Other:

Emotional Self-Care

___ Spend time with others whose company you enjoy

___ Stay in contact with important people in your life

___ Give yourself affirmations, praise yourself

___ Love yourself

___ Re-read favorite books, re-view favorite movies

___ Identify comforting activities, objects, people, relationships, places and seek them out

___ Allow yourself to cry

___ Find things that make you laugh

___ Express your outrage in social action, letters and donations, marches, protests

___ Play with children

___ Other:

Spiritual Self-Care

___ Make time for reflection

___ Spend time with nature

___ Find a spiritual connection or community

___ Be open to inspiration

___ Cherish your optimism and hope

___ Be aware of nonmaterial aspects of life

___ Try at times not to be in charge or the expert

___ Be open to not knowing

Source: Transforming the Pain: A Workbook on Vicarious Traumatization. Saakvitne, Pearlman & Staff of TSI/CAAP (Norton, 1996)

___ Identify what in meaningful to you and notice its place in your life

___ Meditate

___ Pray

___ Sing

___ Spend time with children

___ Have experiences of awe

___ Contribute to causes in which you believe

___ Read inspirational literature (talks, music, etc.)

___ Other:

Workplace or Professional Self-Care

___ Take a break during the workday (e.g. lunch)

___ Take time to chat with co-workers

___ Make quiet time to complete tasks

___ Identify projects or tasks that are exciting and rewarding

___ Set limits with your clients and colleagues

___ Balance your caseload so that no one day or part of a day is "too much"

___ Arrange your work space so it is comfortable and comforting

___ Get regular supervision or consultation

___ Negotiate for your needs (benefits, pay raise)

___ Have a peer support group

___ Develop a non-trauma area of professional interest

___ Other:

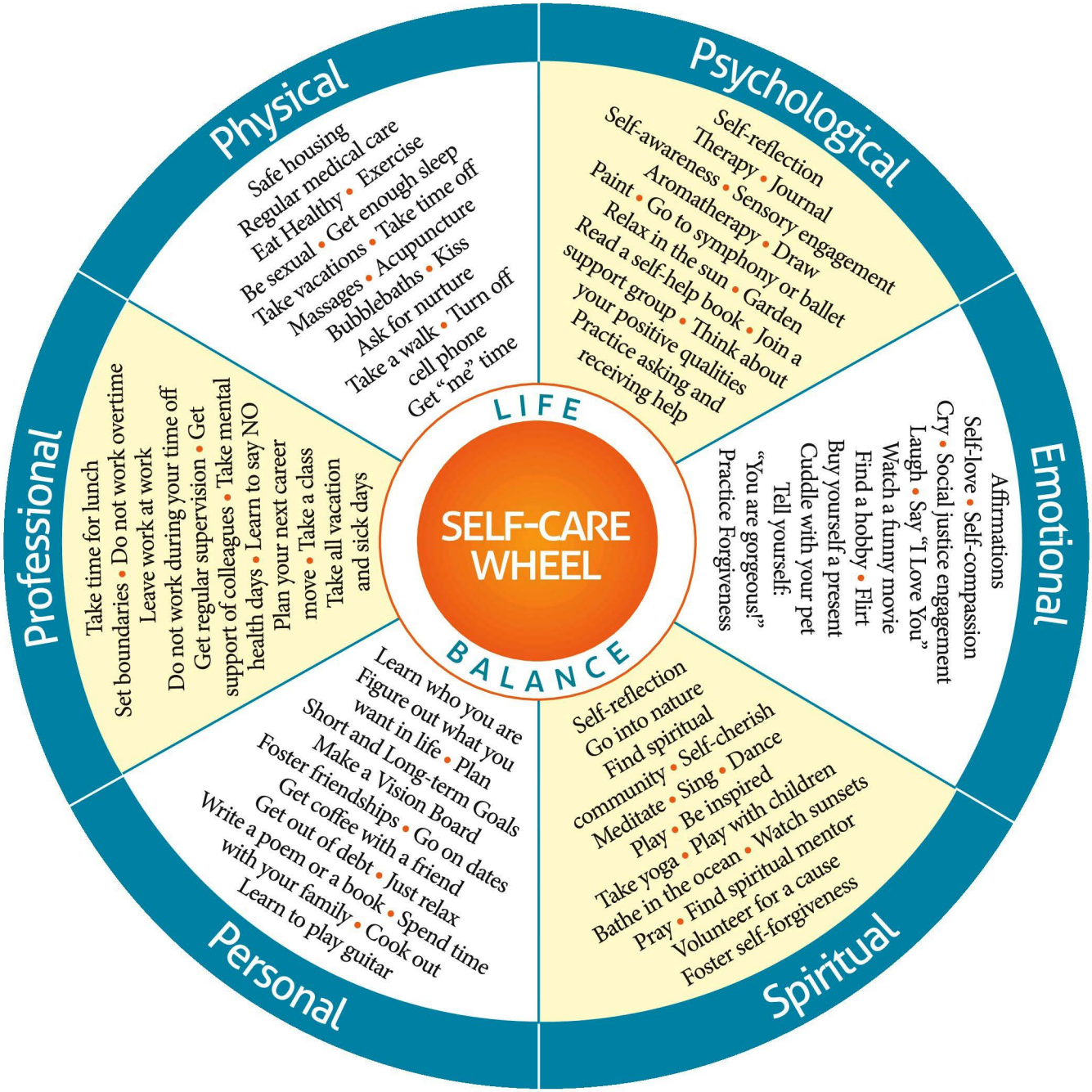
Balance

___ Strive for balance within your work-life and workday

___ Strive for balance among work, family, relationships, play and rest

Source: Transforming the Pain: A Workbook on Vicarious Traumatization. Saakvitne, Pearlman & Staff of TSI/CAAP (Norton, 1996)

SELF-CARE WHEEL



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When PTSD Is Contagious

Therapists and other people who help victims of trauma can become traumatized themselves.

AARON REUBEN
DECEMBER 14, 2015

People stand at the September 11 memorial in New York. ANDREW KELLY / REUTERS

Michael was not in New York on September 11, 2001. But for years afterwards, when an elevator opened at work, he would imagine people on fire rushing out, their screams filling the lobby. When he closed his eyes, he would sometimes see limbs trapped in rubble, unattended by their bodies. He was plagued by moments of violence and destruction that he had not witnessed. On sleepless nights, he would wander the streets of his neighborhood, trying to exorcise other people's demons.

Michael, who asked that his last name be withheld for privacy, is a clinical psychologist who works in lower Manhattan. In the years after the World Trade Center attacks, he treated hundreds of patients with acute and post-traumatic stress disorder. But it took him a while to notice that while the mental health of his patients largely improved with each passing therapy session, his own was deteriorating. By 2004—jittery, depressed, and unable to sleep most nights—he began to suffer panic attacks for the first time in his life. Increasingly, he had to withdraw from social events and public spaces. He asked a colleague to prescribe sleep aids and antidepressants.

Exposed each day to the distress of others, our second-line responders to tragedy—humanitarian workers, therapists, social workers, lawyers, and journalists—can develop traumatic stress disorders that mimic the PTSD of their clients, patients, and sources, down to the images of violence that can haunt a traumatized mind. Thirty to 40 percent of mental-health clients in the U.S. show symptoms of post-traumatic stress. By one estimate, as many as half of the psychotherapists who treat these patients could have symptoms of "secondary" or acquired trauma.

Currently, the best treatments for trauma require sharing the story of what happened. Talk is therapy—but when the things we share are horrifying, our listeners can be altered for the worse. In this way, individual trauma can morph into something collective.

* * *

Michael, who used to be a jazz percussionist, has the slight hunch of a former drummer and the soft white hair of a television physician. He tends to bob his head when he's thinking. No clients attended his first post-9/11 clinic, he told me, because he'd set it up on the New Jersey waterfront in a makeshift hospital on the very day of the attack. Unable to reach patients that day, he could only watch as the familiar Manhattan skyline disintegrated.

The lull would not last. In the days following the attacks, Michael began seeing eight to 10 patients a day for roughly hour-long sessions, five days a week. All had acute stress disorder, the label given to the extreme emotional shock that follows a tragic event. If acute stress disorder goes unabated, it becomes PTSD. Some of his patients had escaped the collapsing buildings, or were first responders who sorted through the rubble after they fell. Many were plagued by images they could not forget, and by survivor's guilt.

Characterized by volatility of emotions, hyperarousal, pervasive fear, and anxiety, trauma is an adaptive response whose aim is simply to keep a person away from similarly dangerous situations in the future. But in the long run, it can leave the victim emotionally distraught, forever alert to new, illusory threats.

The PTSD that follows is a disorder of association. Sounds, smells, images, and thoughts of the traumatic event will elicit a fight-or-flight emotional response long after the trauma has passed, as with the war veteran who jumps when a car backfires.

The best treatments for PTSD target these associations. Traumatized patients are encouraged to confront their associations, often by purposefully reliving the traumatic event in order to experience their full emotional and physical reactions. As patients recount their stories multiple times a session, week after week, the associations of the event can lose their force. Ideally, their reactions will weaken with each telling.

PTSD therapy can be a transformative process for the speaker, but its effect on the listener can be more complicated. “Service providers often must share the emotional burden of the trauma,” writes Brian Bride, a professor of social work at Georgia State University; they “bear witness to damaging and cruel past events, and acknowledge the existence of terrible and traumatic events in the world.” Hearing stories of suffering, in other words, can generate more suffering.

During lectures at psychiatric grand-rounds in medical centers, Michael often asks his audience of physicians and medical students to imagine a lemon. “Hold it in your mind,” he says, “See how yellow it is. Smell the citrus aroma. Now cut a slice off with a knife and take a bite. Taste the strong sour flavor.” When he asks people to raise their hand if they are salivating, nearly all do so. The point of the experiment is simple: What you think and imagine can result in a demonstrable, physical reaction. When a therapist for a patient with PTSD hears a story of violence, empathetic imagining can inadvertently trigger a physiological reaction similar to what the victim may have experienced: a racing heart, shaking hands, nausea, and other elements of the fight-or-flight response.

One of his patients, Michael recalled, was a construction worker who was tasked with clearing away rubble after the towers fell. One day, “he broke down crying in my office,” Michael said, because he had found a woman’s hand holding a child’s hand. “Just two hands together.” Michael went silent. “You know, right now, I’m feeling a response just telling you the story.”

Hearing stories of atrocity can also cause longer-term changes. Laurie Pearlman, one of the first psychologists to identify the phenomenon of secondary trauma, calls this effect “alterations to the cognitive schema.” Essentially, these stories can change the way the listener views the world, forcing him to recognize that his loved ones may not be as safe as he’d thought, and to face his own helplessness in preventing future tragedies.

This change in thinking can be gradual, and it can be a nearly unconscious process. When Pearlman began counseling victims of abuse in the 1980s, “I found myself affected by the trauma work in ways I didn’t expect or understand,” she told me. She started to view formerly benign settings as possibly threatening, and she found it hard to maintain her normally upbeat attitude. Today, she describes what happened to her as “disrupted world view” and “disrupted spirituality.” These symptoms of exposure to trauma stories, she believes, are the ones that can harm caregivers the most.

Whether an altered world view is ultimately destructive, Pearlman writes, “depends, in large part on the extent to which the therapist is able to engage in a parallel process to that of the victim client: the process of integrating and transforming these experiences of horror or violation.” She recommends that all trauma therapists undergo therapy of their own.

* * *

Trauma after tragedy is nothing new: Evidence of PTSD in soldiers and commanders is present in ancient Greek and Roman texts. The pages of many Greek tragedies, like Sophocles’s *Ajax* and Euripides’s *Heracles,* are rife with veterans maddened by war. In the

Roman army, suicide attempts were, strangely, punishable by death—unless a soldier was found to suffer from shame, sadness, or "weariness of life."

The notion that trauma can be communicable is much newer. Psychoanalysts since Freud have noted that therapy can result in "countertransference," where a patient unearths, and becomes the object of, an analyst's own neuroses, desires, or unresolved conflicts. But it was not until the Vietnam War that a greater danger was observed: that patients could, unknowingly, plant lasting images of violence in the minds of people who hadn't experienced it.

"When the patient reports atrocities, where does the therapist begin?" asked Sarah Haley, a Veterans Administration psychiatrist, in a paper in the *Archives of General Psychiatry* in 1974. In the late years of the Vietnam War, Haley treated veterans with mental illness who described events of extreme violence and brutality, including cases where they were the perpetrators. She records the story of one patient, a Marine who led his squad in the destruction of a pacified village after booby traps were found in the surrounding jungle. "[We] blew them motherfuckers away," he told Haley. The story, and others like it, left her "numb and frightened." How do you treat such patients, Haley asked? "Perhaps," she wrote, "we start by reminding ourselves that atrocities are as old as man."

In 1981 Yael Danieli, a Manhattan-based clinical psychologist and former sergeant in the Israeli Defense Forces, published a review of therapist's emotional reactions to working with Holocaust survivors and their children. The therapists, she wrote, often "found themselves sharing the nightmares of the survivors they were treating." In nine months of treating survivors, one therapist reported having had only two dreams that were not related to his clients' stories.

Another nearly fainted when a patient described seeing "children clinging to their parents' bodies in mass graves." Still another confessed that the first time he saw an identification number tattooed on a client's forearm, he had "to leave in order to throw up."

Danieli found that therapists, fearing their own reactions to traumatic content, dreaded meeting their survivor clients and often avoided discussing the Holocaust with them. Many expressed fears for their sanity. "I dread being drawn into a vortex of such blackness that I may never find clarity and may never recover," a therapist told Danieli. "Once this little black box is open," another said, "it's worse than Pandora's box."

We now know that secondary trauma is a predictable consequence of working with traumatized populations. "Vicarious trauma is inevitable for people doing this kind of work," says Jackie Burke, the clinical director of Rape and Domestic Violence Services Australia, a counseling service for victims of sexual abuse and family violence.

She believes that all members of her counseling staff suffer in some way from the trauma narratives of their clients. "But it will only rise to the level of dysfunction, of PTSD-like symptoms, for a few," she says.

A review of case managers working in community mental-health services in the U.S. found nearly one in five had symptoms of PTSD. Similar rates of distress were found in mental-health workers who treated victims of the 1995 Oklahoma City bombing and survivors of Hurricane Katrina. One review of 100 sexual-abuse therapists found nearly half had secondary traumatic stress.

"What the research points out at this time is there is only one really reliable predictor of whether someone will get vicarious trauma," says Burke. "And that is their level of exposure to trauma." Because caregivers are exposed to traumatic content while on the job, "I conceptualize this first and foremost as a worker health and safety issue." Burke's organization employs two full-time "vicarious trauma" supervisors, who meet with each counselor on staff every week to monitor levels of secondary-trauma symptoms and, when symptoms appear to rise, to develop immediate treatment plans.

One of the most effective interventions, Burke says, is the "leave your work at work," approach. "If you understand that the only thing that predicts traumatization is exposure to traumatic content, then the only way you can reduce risk is by reducing exposure," she says. Organizations can do this by reducing the number of traumatized patients a worker sees, for example, or by enforcing limits on office hours. But she acknowledges that in many cases—including her own workplace—these measures aren't always feasible. "For us it wasn't possible to do that. Our online and telephone counseling services are 24-7."

What they could try to control, though, was the exposure that was happening outside of work. When staffers told her that they kept thinking about their clients' stories even when they were off the clock, Burke and her staff developed a 15-minute decompression exercise to help counselors "drop their worries about clients' well-being with another worker who will be continuing on." Before a counselor leaves her shift, she is required to tell someone still on duty all the disturbing things she heard that day, explain why they were disturbing, and list the things she'll do to try to feel okay about it.

"This helps the counselor do two things," Burke says. "First of all is to recognize that vicarious trauma is there and to think about what to do with that. And secondly, to feel like, 'When I leave work I don't have to think about all that stuff.'"

Burke's team is now trying to retool the "leave it at work" process to work for counselors in more isolated settings, who may not have other staff to talk to after a difficult counseling session. "In that case, who do you leave your worries with?"

The answer for now seems to be: yourself. A new protocol asks counselors to record their feelings related to the work day before they punch out. The goal is immediate reflection to avoid repression of traumatic content and later rumination. So far, says Burke, "this seems to work just as well."

* * *

Michael now admits that he likely had low-level PTSD for several years before his breakdown. “I felt my health eroding, but I could only diagnose it in hindsight,” he says. “I didn’t realize the full extent of what was happening.”

This will be the experience of most caregivers suffering from secondary trauma, unless they and their employers know to take the problem seriously. “You keep stuffing it down,” Michael says, “and try to work harder.”

In the end, Michael had to temporarily shutter his practice while he worked to get his PTSD symptoms under control. He’s back to treating trauma survivors, though, and considers himself a better therapist as a result of his struggle. “No one really understands what you are going through,” he says. “Not unless they’ve experienced it.”

We want to hear what you think about this article. Submit a letter to the editor or write to letters@theatlantic.com.

AARON REUBEN *is a science writer based in Durham, North Carolina.*

Appendix A

Organizational Systems Change

Addressing the Impact of the Work Implementation Objectives

- Provide education and training on the positive and negative impact of the work (e.g., vicarious trauma, vicarious resilience)
- Provide supervision to support the well-being of the workforce
- Create a plan for organization/system structures to promote vicarious resilience and vicarious post-traumatic growth of the workforce
- Ensure an organizational/system culture of collaboration and empowerment

Critical Components of the Implementation Stage

- TILT Teams
- Deliberate trauma informed messaging from administration
- Initial and ongoing trainings for organizations
- Supports for self and co-care and resilience
- Integrate and sustaining deliberate equitable/inclusion practices throughout the organization
- Supportive physical environment
- Deliberate screening and treatment of trauma processes to reduce re-traumatization
- Collaboration and relationships with partners and referrals
- Review of all policies, procedures and forms through a trauma informed lens using the policy audit tool

Leading and Communicating Implementation Objectives

- Have a standing TILT monthly meeting – same place and time
- Elicit feedback and provide follow-up results to all individuals regarding the implementation process
- Integrate a trauma informed approach into organizational/system messaging

Hiring and Orientation Practices Implementation Objectives

- Hire individuals who have an understanding or willing to commit to trauma informed principles
- Use trauma informed interviewing techniques and during the onboarding process
- Utilize the policy audit tool to review employee handbooks, policies, and procedures

    - **SAFETY**
        - Conduct interview and orientation processes in ways that are welcoming, respectful and engaging
        - Include safety training and/or review of safety protocols in new-hire orientation
        - Establish a protocol for how current workers welcome, meet and support new workers
        - Provide an overview of the environment (e.g., emergency exits, location of bathroom, breaks that will occur, etc.)
        - Provide the opportunity to access refreshments (e.g., water, coffee) and the bathroom prior to starting an interview or throughout a new-hire orientation

    - **TRUSTWORTHINESS**
        - Job postings are transparent about tasks, responsibilities and expectations
        - Before and during the interview and orientation process expectations should be clear
        - Front office staff should be trained and prepared for interview days
        - Ask if interviewees need clarification or rewording of questions during the interview process
        - Inform applicants in a timely and respectful manner if they are not selected
        - New-hire orientation should include a review of responsibilities, expectations and the guiding principles of trauma informed care

    - **CHOICE**
        - Provide some choice in timeframes for interviews whenever possible
        - Inform applicants and new staff of their options in the workplace

- **COLLABORATION**
  - Provide opportunities for feedback and elicit opinions during the hiring and orientation process
  - Negotiate hours, salaries and benefits in a way that is collaborative whenever possible

- **EMPOWERMENT**
  - Inquire about strengths and capacities during the interview
  - Provide job training/opportunity for shadowing during the orientation process

Addressing the Impact of the Work Implementation Objectives

- Provide education and training on vicarious trauma, self-care, and resilience
- Provide reflective supervision to support the well-being of the organization
- Commit to an organizational/system culture of collaboration and deep relationship

Establishing a Safe Environment Implementation Objectives

- Provide a trauma informed environmental scan to include scheduled regular walk throughs
- Provide feedback and suggestion systems that include opportunities to give feedback regarding their experience of safety
- Implement changes from the results of the trauma informed environment walk-through and feedback gathered when feasible

Screening, Assessment & Treatment Services

Screening for Trauma Implementation Objectives

- Decide if it is appropriate for your organization to screen for trauma
- Use standard screening tools and protocols as necessary
- Train employees how to use the standard trauma screening tool without re-traumatizing the consumer
- Train employees how to interview with a trauma informed lens to prevent/reduce re-traumatization

Trauma Referrals Implementation Objectives

- Have best practice trauma treatment/interventions
- Have a known resource list of collaborative organizations to appropriately refer

Treating Trauma Implementation Objectives

- Use best practice treatment interventions when treating trauma
- Provide clinical supervision and support to all employees

Cross Sector Collaboration

Collaborating with Others (Partners and Referrals) Implementation Objectives

- Collaborate with partner organizations that are trauma informed
- Promote cross-sector collaboration by identifying partner organizations with common goals
- Model trauma informed principles by collaborating with others, being reciprocal and actively listening

Policy Engagement and Involvement

Reviewing Policies and Procedures Implementation Objectives

- Make a deliberate decision to use the policy audit tool when reviewing sustainable policy changes
- Engage in transparent communication process as allowed
- Invite feedback on policy/procedure review as they change
- Ensure policies/procedures are easily accessible

Progress Monitoring and Quality Assurance Evaluation

Evaluating and Monitoring Progress Sustainability Objectives

- Evaluate trauma informed organizational change regularly using either the Continuum of CARE or the Standards of Practice assessment tools to assess the organizational climate
- Consistently evaluate the impact of trauma informed principles on outcome data and areas of quality improvement
- Incorporate the voice and choice of all individuals in the organization
- Consistently assess and modify organizational priorities/systems through an equity lens

Appendix B

Stages of the Trauma Informed Organizational Model

The first component of the trauma informed organizational model is identifying the stage.

The three stages of the organizational model are:

- Pre-Implementation
- Implementation
- Sustainability

The things to consider, needs and resources for trauma informed organizational change are different, depending on which stage the organization/system is currently in. However, what we know about successful organizational change is that in order for it to work and be sustainable, there needs to be an acceptance that change is a flexible, ongoing and regularly re-evaluated process (Rosenbaum, More & Steane, 2018; Tsoukas & Chia, 2002). Therefore, the three stages are dimensional and flexible.

For example, today you may find your organization/system is in the **Sustainability Stage** in one key development area, only to re-evaluate down the road and find that something new needs to be implemented—bringing that area to the **Implementation Stage** once more. Additionally, your organization/ system may be in different stages, depending on which key development area is being considered (e.g., in **Pre-Implementation** for Leading and Communicating, and **Sustainability** in Treating Trauma).

Appendix C

For Further Resources

Hiring and Orientation Practices Interview Questions

- National Council for Behavioral Health – Trauma Informed Care Interview Questions https://www.nationalcouncildocs.net/wp-content/uploads/2018/07/TIPCI-Interview-Questions.pdf
- Trauma Informed Oregon – Human Resources Practices to Support Trauma Informed Care in Your Organization https://traumainformedoregon.org/resource/human-resources-practices-support-tic/

New Hire Orientation

- Institute on Trauma and Trauma Informed Care – Basics for All Staff: Online Modules http://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-traumainformed-care/online-modules.html
- National Child Traumatic Stress Network (NCTSN) - Learning Center https://learn.nctsn.org/
- Wisconsin Department of Public Instruction – Trauma-Sensitive Schools Learning Modules https://dpi.wi.gov/sspw/mental-health/trauma/modules

Trauma Informed Hiring and Orientation Protocols

- Missouri Department of Mental Health – Policy Guidance for Trauma Informed Human Resources Practices https://dmh.mo.gov/trauma/docs/HRPolicyGuidance32017.pdf
- Trauma Informed Oregon – Human Resources Practices to Support Trauma Informed Care in Your Organization https://traumainformedoregon.org/resource/human-resources-practices-support-tic/

Training the Workforce (Clinical and Non-Clinical)

- Foundational Education • Institute on Trauma and Trauma Informed Care – Basics for All Staff: Online Modules http://socialwork.bufalo.edu/social-research/institutes-centers/institute-on-trauma-and-traumainformed-care/online-modules.html
- National Child Traumatic Stress Network (NCTSN) - Learning Center https://learn.nctsn.org/
- Wisconsin Department of Public Instruction – Trauma-Sensitive Schools Learning Modules https://dpi.wi.gov/sspw/mental-health/trauma/modules

Addressing the Impact of the Work

- Lipsky & Burk - Trauma Stewardship (book) https://www.amazon.com/Trauma-Stewardship-Everyday-Caring-Others/dp/157675944X
- Office for Victims of Crime – The Vicarious Trauma Toolkit https://vtt.ovc.ojp.gov/
- UB School of Social Work – Self-Care Starter Kit https://socialwork.bufalo.edu/resources/self-care-starter-kit.html
- Supervision • Hudnall Stamm - Professional Quality of Life Scale (ProQOL) http://proqol.org/ProQol_Test.html
- National Child Traumatic Stress Network – Using the STS Core Competencies in Trauma Informed Supervision https://www.nctsn.org/sites/default/fles/resources/fact-sheet/using_the_secondary_traumatic_stress_core_competencies_in_trauma informed_supervision.pdf
- Network180 & SAMHSA – Trauma Informed Care Clinical Supervision Scenarios Training Video https://www.youtube.com/watch?v=bJe5fFnwNdA&app=desktop
- Treisman – Trauma Informed Supervision (Therapeutic/frontline context) http://www.safehandsthinkingminds.co.uk/wp-content/uploads/2016/03/trauma informed-supervision.pdf
- Organization/System Supports • Center for Health Care Strategies, Inc. – Strategies for Encouraging Staff Wellness https://www.chcs.org/resource/strategies-encouraging-staf-wellness-trauma informed-organizations/
- Northeastern University -Vicarious Trauma-Organizational Readiness Guide for Victim Services https://vtt.ovc.ojp.gov/ojpasset/Documents/OS_VT-ORG_Victim_Services-508.pdf
- Office for Victims of Crime – The Vicarious Trauma Toolkit https://vtt.ovc.ojp.gov/

Establishing a Safe Environment

- Implementing a Program Walk-Through • National Center on Domestic Violence, Trauma & Mental Health – Tips for Creating a Welcoming Environment http://nationalcenterdvtraumamh.org/wp-content/uploads/2012/01/Tipsheet_WelcomingEnvironment_NCDVTMH_Aug2011.pdf
- Trauma Informed Oregon – Agency Environmental Components for Trauma Informed Care http://traumainformedoregon.org/wp-content/uploads/2016/01/Agency-Environmental-Comp
- Screening for Trauma General Screening Considerations • Boyle & Delos Reyes – Trauma Informed Care: Screening & Assessment (PowerPoint Slides) https://www.centerforebp.case.edu/client-fles/events-supportmaterials/2015-0422_TICVideoconference.pdf
- Substance Abuse and Mental Health Services Administration – TIP-57 (Part 1, Chapter 4 p159-171) https://store.samhsa.gov/system/fles/sma14-4816.pdf
- Picking a Tool • ACEs Connection – Different Types of ACE Surveys https://www.acesconnection.com/g/resource-center/blog/resource-list-extended-aces-surveys
- American Psychiatric Association – Online Assessment Measures (Disorder-Specific Severity Measures, Severity of Posttraumatic Stress Symptoms Adult & Child Age 11-17) https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures
- Center for Youth Wellness – ACEQ & User Guide https://centerforyouthwellness.org/cyw-aceq/
- Children F.I.R.S.T. – Child and Adolescent Trauma Measures: A Review https://ncwwi.org/fles/Evidence_Based_and_Trauma informed_Practice/Child-and-AdolescentTrauma-Measures_A-Review-with-Measures.pdf
- National Child Traumatic Stress Network (NCTSN) – Screening and Assessment https://www.nctsn.org/treatments-and-practices/screening-and-assessment
- Treating Trauma Access to Trauma-Specific Interventions • Cognitive Processing Therapy – CPT Provider Roster https://cptforptsd.com/cpt-provider-roster/ • EMDR International Association – Find an EMDR Therapist https://emdria.site-ym.com/general/custom.asp?page=fndatherapistmain

Collaborating with Others (Partners and Referrals) General Screening Considerations Learning from Others and Building Partnerships

- Center for Health Care Strategies – Trauma Informed Care in Action Profiles https://www.chcs.org/resource/trauma informed-care-in-action-profle-series/
- Oral et al. (2016) – Communities Embracing Trauma Informed Care https://www.nature.com/articles/pr2015197#trauma informed-care https://www.nature.com/articles/pr2015197/tables/1
- National Council for Behavioral Health – Domain 6: Building Community Partnerships https://www.nationalcouncildocs.net/trauma informed-care-learning-community/resources/domain6-building-community-partnerships
- National Council for Behavioral Health – Lessons Learned: Adoption of Trauma Informed Care https://www.nationalcouncildocs.net/wp-content/uploads/2014/01/Lessons-Learned-2012-LC-FINAL.pdf
- United Way et al. (2018) – Trauma Informed Philanthropy https://www.unitedforimpact.org/wp-content/uploads/2018/08/FINAL_TraumaGUIDE-single.pdf
- Reviewing Policies and Procedures Tools/Guides for Reviewing • Anna Institute – Re-traumatization With Chart (PowerPoint) http://theannainstitute.org/presentations.html
- Community Connections (Harris & Fallot) – Creating Cultures of Trauma Informed Care https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-andPlanning-Protocol.pdf
- Substance Abuse and Mental Health Services Administration – TIP-57 (p162-163, 166) https://store.samhsa.gov/system/fles/sma14-4816.pdf
- Trauma Informed Oregon – Guide to Reviewing Existing Policies http://traumainformedoregon.org/wp-content/uploads/2016/01/Guide-to-Reviewing-Existing-Policies.pdf

Evaluating and Monitoring Progress

- Coordinated Care Services, Inc. – Trauma Responsive Understanding Self-Assessment Tools https://www.ccsi.org/Pages/TRUST
- National Center on Family Homelessness – Trauma Informed Organizational Self-Assessment (section 1) https://www.air.org/sites/default/fles/downloads/report/Trauma informed_Organizational_Toolkit_0.pdf
- National Council for Behavioral Health – Sustainability Guide https://www.nationalcouncildocs.net/wp-content/uploads/2014/01/TIC-Sustainability-Guide.pdf
- Southwest Michigan Children's Trauma Assessment Center – Trauma Informed Change Instrument https://traumainformedoregon.org/wp-content/uploads/2014/10/Trauma informed-System-ChangeInstrument-Organizational-Change-Self-Evaluation.pdf
- Trauma Informed Care Project – Agency Self-Assessment http://www.traumainformedcareproject.org/resources/Trauam%20Informed%20Organizational%20 Survey_9_13.pdf
- Trauma Informed Oregon – Standards of Practice https://traumainformedoregon.org/resource/standards-practice-trauma informed-care/
- Trauma Informed Oregon – Standards of Practice (Education) https://traumainformedoregon.org/resource/education-standards-practice-trauma informed-care/
- Trauma Informed Oregon – Standards of Practice (Healthcare) https://traumainformedoregon.org/resource/healthcare-standards-practice-trauma informed-care/
- Traumatic Stress Institute – Attitudes Related to Trauma informed Care (ARTIC) Scale http://traumaticstressinstitute.org/artic-scale/

Appendix D

Sample Trauma Informed Interview Questions

The following are sample questions that can be used when interviewing potential candidates for any position. Please note a couple of things:

1. The questions and the language used can be edited and adapted to your organization/system.
    - Words that are italicized and in brackets indicate the interviewer can insert the relevant word based on the interview.

2. This is a collection of sample questions rather than a script the purpose of this list is to provide examples of how an interviewer can inquire about different aspects of a trauma informed approach.

Please talk about what it means to be trauma informed in your work

- Do you have experience working for an organization or system that implemented aspects of a trauma informed approach?
- How will you use a trauma informed approach in your role?
- Give us an example of how you have used the principle in your work.
- Please talk about your understanding of how trauma may interface with the population we work with.
- Please describe your understanding of evidence-based interventions or treatments that are available to the population we work with. How familiar are you with these?
- What strategies do you already use in order to address the potential for vicarious trauma, secondary traumatic stress, burnout and compassion fatigue? What organizational strategies or supports have you found helpful in the past?
- While all the values and principles of a trauma informed approach are important, which one resonates with you the most? Tell us more.
- If you observe an unethical situation between a co-worker and a [client/patient/student/consumer], explain how you would use the principle of trustworthiness in order to address the situation.
- When thinking about a trauma informed approach, what are your thoughts about the role of the [client/ patient/student/consumer] in the work we do here?
- What characteristics or behaviors might be indicators to you that someone has experienced trauma?

- Please explain what self-care or wellness means to you. What strategies do you already use that work?
- What advice would you give to a colleague who is considering working with individuals who may have experienced trauma?
- What aspects of the trauma informed approach would you like to know more about?
- Tell us about a time that you used a trauma informed approach in a difficult interaction with a coworker or [client/patient/student/consumer].
- Do you have experience screening individuals for trauma or adversity? If so, what screening tools did you use?
- Tell us about your understanding of resilience and post-traumatic growth. What thoughts do you have regarding promoting resilience and post-traumatic growth with those we work with? In the workforce?

Appendix E

Assessment Tools

Standards of Practice Assessment:

The following Standards of Practice for Trauma Informed Care organizations in Snohomish County, WA are based on nationally recognized principles of trauma informed care and are in alignment with SAMHSA's Concept of Trauma and Guidance for a Trauma Informed approach. These standards were integrated with Trauma Informed Oregon's Standards of Practice and reviewed and adopted by Snohomish County's Children's Wellness Coalition to include family members, individuals with lived experiences, as well as providers from different fields of practice. These standards are intended to provide benchmarks for planning and monitoring progress and as a means to highlight accomplishments and to challenge each organization.

We recommend your multi-level Trauma Informed Leadership Team (TILT) use this tool. Please keep this in mind when using this Standards of Practice tool:

1. The Standards of Practice are intended to help agencies communicate to their constituencies how and to what extent they are working to build trauma informed care within their programs and/ or systems. We are not attempting to develop metrics or a system of accountability.

2. There is no assumption that this tool will be equally useful across all organizations or systems. Each system will need to determine how the Standards fit within its own culture.

3. Individual Standards will be interpreted differently in different contexts. For this reason, the Standards invite a qualitative (descriptive) response rather than a yes/no answer.

4. It is recommended that this document be reviewed, with a clear internal process, and updated by the Trauma Informed Leadership Team (TILT) at least once a year. How each agency makes their work ongoing and sustainable will be critical.

5. In order to assist organizations to assess strengths and weaknesses and to set goals, we have included a simple set of ratings. The ratings cannot be used to compare one programs or organization to another. Note that although the highest rating is 5 there is always room for improvement, and perspectives may vary on who is making the rating.

Standard of Practice for Trauma Informed Organizations
Self-Assessment Tool

1= We have not 2= We are in the planning 3= We are in the process

4= We have made 5= We are amazing! started stages of implementation significant progress

1.	**Organization Commitment and Endorsement:** Organization leadership acknowledges that an understanding of the impact of trauma is central to effective service delivery and makes operational decisions accordingly.	
a.	Board of Directors and Leadership Team are committed to implementing trauma informed standards in the work of the organization. Notes:	1 2 3 4 5 n/a
b.	Organization develops a TILT (Trauma Informed Leadership Team) and identifies champions within the senior leadership. Notes:	1 2 3 4 5 n/a
c.	Trauma Informed Care appears as a core principle in organization value statements, policies, and written program/services information. Notes:	1 2 3 4 5 n/a

d.	There is a process in place for regular feedback and suggestions from staff and consumers related to trauma informed care (perceived safety, welcoming environment, transparency, shared decision making, supportive /helpful staff). Notes:	1 2 3 4 5 n/a
e.	Individuals with lived experiences in your system have roles in your organization. Notes:	1 2 3 4 5 n/a
f.	Organization budget reflects a commitment of trauma informed care (e.g. training, self-care). Notes:	1 2 3 4 5 n/a
g.	Decisions about changes in policy, practices, procedures, and personnel are made in a way that minimizes negative impact on workforce and on individuals/families receiving services. Notes:	1 2 3 4 5 n/a
h.	The importance of self-care is reflected in organization policies. Notes:	1 2 3 4 5 n/a
i.	The organization made a commitment to diversity and equity within the organization and with the population served. Notes:	1 2 3 4 5 n/a

j.	Leadership looks at best practice for Trauma Informed Care to be embraced throughout the organization. Notes:	1 2 3 4 5 n/a
k.	Leadership identifies barriers to progress and evaluates success. Notes:	1 2 3 4 5 n/a
l.	A high standard of confidentiality is maintained throughout the whole organization Notes:	1 2 3 4 5 n/a
2.	**Environment and Safety:** There is demonstrated commitment to creating a welcoming environment and minimizing and/or responding to perceived challenges to safety.	
a.	Physical space (e.g., external environment, lighting, exits and entrances, waiting room, offices, halls, conference rooms, restrooms) provides actual and perceived safety for staff and individuals receiving services. Notes:	1 2 3 4 5 n/a
b.	Physical environment has been reviewed for cultural responsiveness. Notes:	1 2 3 4 5 n/a
c.	There is a process in place to hear and respond to safety concerns and crisis protocols that arise. These protocols are practiced regularly, and staff know where to access the information when needed. Notes:	1 2 3 4 5 n/a

d.	Individuals who have received services from the organization have helped develop and/or reviewed decisions about physical environment and/or safety protocols. Notes:	1 2 3 4 5 n/a
3.	**Workforce Development:** Human Resources policies and practices reflect a commitment to trauma informed care for staff and the population served.	
a.	Employees, volunteers and board members have received core training in Trauma Informed Care, including:	1 2 3 4 5 n/a
	□ Adverse Childhood Experiences	1 2 3 4 5 n/a
	□ Prevalence and impact of trauma on individuals and staff	1 2 3 4 5 n/a
	□ Principles and Implementation of Trauma Informed Care	1 2 3 4 5 n/a
	□ Self-Care	1 2 3 4 5 n/a
	□ NEAR (Neuroscience, Epigenetics, ACES, Resiliency)	1 2 3 4 5 n/a
	□ Self-Regulation and De-escalation	1 2 3 4 5 n/a
	□ Historical Trauma	1 2 3 4 5 n/a
	□ Equity and Cultural Diversity	1 2 3 4 5 n/a
b.	Handbook and organization manual include TIC language and policies. Notes:	1 2 3 4 5 n/a
c.	Core Trainings are offered to new staff and required for all staff. Notes:	1 2 3 4 5 n/a
d.	Organization is building internal capacity to ensure that ongoing training and education for staff on trauma informed care is available. Notes**:**	1 2 3 4 5 n/a

e.	Ongoing professional development opportunities are available for all staff. To ensure the right trainings are being offered, staff are invited to complete need assessments. Notes:	1 2 3 4 5 n/a
f.	The mission and values of the organization are communicated to all staff. Notes	1 2 3 4 5 n/a
g.	Alternative opportunities for staff to learn about Trauma Informed Care (i.e. webinars, community events, trainings being offered at different times, videos) are offered. Notes:	1 2 3 4 5 n/a
h.	Human Resources or Administration tracks staff trainings. Notes:	1 2 3 4 5 n/a
i.	Peer support is encouraged through mentoring, shadowing opportunities, and case consultation. Notes:	1 2 3 4 5 n/a
j.	Organization supports staff with their own trauma responses. Organization allow staff to take care of themselves if they are triggered. Safety plans are encouraged. Notes:	1 2 3 4 5 n/a

4.	**Hiring and Onboarding Practices:**	
a.	Job descriptions and hiring questions include trauma informed language**.** Screening and interviewing protocols includes applicant's understanding and prior experience/training regarding the prevalence and impact of trauma and the nature of trauma informed care. Notes:	1 2 3 4 5 n/a
b.	The organization provides an avenue for individuals with lived experiences of our services to participate in or inform the hiring process. Notes:	1 2 3 4 5 n/a
5.	**Supervision and Support:**	
a.	Staff receive regularly scheduled supervision that is supportive and where strengths are incorporated and encouraged. Notes:	1 2 3 4 5 n/a
b.	There is a clear process for peer support and guidance. Notes:	1 2 3 4 5 n/a
c.	Supervision includes discussion of self-care and wellness. Notes:	1 2 3 4 5 n/a
d.	Supervision includes learning and application of knowledge about trauma and Trauma Informed Care to include strength-based approaches and reflective supervision, if possible. Notes:	1 2 3 4 5 n/a

e.	Supervisors have had training /consultation on supervising for Trauma Informed Care. Notes:	1 2 3 4 5 n/a
f.	Performance reviews expect increased awareness, understanding and practice of skills related to trauma informed care. Notes:	1 2 3 4 5 n/a
g.	Supervisors and staff can explain personnel policies; disciplinary actions reflect principles of transparency, predictability, and inclusiveness. Notes:	1 2 3 4 5 n/a
6.	**Services and Service Delivery:** Service delivery reflects a commitment to trauma informed practice related to screening, assessment, treatment services, aspects of engagement and cross-sector involvement, a collaboration.	
a.	The first point of contact is welcoming and engaging for individuals seeking support or services. Physical environment provides a welcoming environment (color, furniture, wall decorations, greeting by name, access to water). Notes:	1 2 3 4 5 n/a
b.	Direct staff understand the signs, symptoms and risks of suicide and are able to respond and get appropriate help. Notes:	1 2 3 4 5 n/a

c.	Intake forms and processes have been reviewed and modified to reduce unnecessary detail that might be triggering to individuals or staff who are seeking or entering services. Notes:	1 2 3 4 5 n/a
d.	Organization has easy-to-read paperwork for staff and consumers that explains core services, key rules and policies, and process for concerns/complaints. All paperwork reflects trauma informed care principles and they are embedded in the operating policies. Notes:	1 2 3 4 5 n/a
e.	Policies related to treatment services (cancellations, no-shows and other rules) have been reviewed and modified as needed to reflect an understanding of trauma and its impact. Notes:	1 2 3 4 5 n/a
f.	Wearing a trauma lens at all times, language is framed to ask, “What has happened?” instead of “What is wrong?” Notes:	1 2 3 4 5 n/a
g.	The TILT (Trauma Informed Leadership Team) meets regularly and all departments are represented. The team has a clearly articulated succession plan. Notes:	1 2 3 4 5 n/a
h.	There is a way to support those your organization serves as they succeed Notes:	1 2 3 4 5 n/a

i.	The organization has cultural representation to reflect the community served. Notes:	1 2 3 4 5 n/a
j.	Individuals receiving services have the opportunity to provide input/feedback and/or to grieve policies that affect them. Notes:	1 2 3 4 5 n/a
k.	In organizations providing direct service, the importance of the primary relationship is recognized and supported though policy and practice. Notes:	1 2 3 4 5 n/a
l.	In organizations providing direct service, trauma specific services are offered, preferably reflecting promising or best practices. Notes:	1 2 3 4 5 n/a
m.	In organizations not providing direct services, staff have up-to-date information about trauma specific services available for referrals. Notes:	1 2 3 4 5 n/a
n.	Peer support is available and routinely offered to individuals receiving services. Notes:	1 2 3 4 5 n/a

o.	Individuals receiving services are not terminated from services without notice and direct contact (unless precluded by circumstances). Notes:	1 2 3 4 5 n/a
7.	**Cross-Sector Collaboration:**	
a.	Organization is working with community partners and /or systems to develop common trauma informed language, protocols, and procedures. Notes:	1 2 3 4 5 n/a
b.	The organization provides warm hand offs (e.g. introductions when making referrals). Notes:	1 2 3 4 5 n/a
c.	The organization is committed to developing a robust network of culturally responsive connections across all sectors to build capacity. Notes:	1 2 3 4 5 n/a
8.	**Diversity and Equity:**	
a.	The staff and board members represent the individuals served. Notes:	1 2 3 4 5 n/a
b.	The organization's TILT represents the community. Notes:	1 2 3 4 5 n/a

c.	Your organization honors cultural diversity and equity. Services are tailored to be relevant for those you serve. Notes:	1 2 3 4 5 n/a
d.	The organization's materials and services are offered in languages other than English. Notes:	1 2 3 4 5 n/a
9.	**Systems Change & Progress Monitoring:** There is a demonstrated commitment to planning, implementation and continuous improvement. To include progress monitoring, quality assurance and evaluation.	
a.	Organization initiates regular feedback from the individuals they serve. Notes:	1 2 3 4 5 n/a
b.	Organization completes a regular self-assessment. Notes:	1 2 3 4 5 n/a
c.	Senior Management and/or Trauma Informed Care Leadership Team (TILT) receives regular updates on progress and priorities for systems change to ensure trauma informed care. Notes:	1 2 3 4 5 n/a
d.	There is a regular mechanism for communicating to all staff and stakeholders about emerging trauma informed practices and the organization's efforts to promote and sustain this framework. Notes:	1 2 3 4 5 n/a

e.	The organization is using data to help establish priorities and measure impact (i.e. staff retention, absenteeism, engagement and retention of service recipients, etc.) Notes:	1 2 3 4 5 n/a
f.	The self-assessment or quality assurance process for Trauma Informed Care is ongoing. Notes:	1 2 3 4 5 n/a
g.	New employee orientation includes principles of Trauma Informed Care. Notes:	1 2 3 4 5 n/a
h.	Organizations culture priority is strength based. Notes:	1 2 3 4 5 n/a

CARE Continuum Assessment Tool

CARE Continuum Assessment General Guide This guide provides a brief overview and general guide for the CARE Continuum Assessment. Overview the CARE Continuum Assessment is a tool to evaluate supports for trauma informed care. It is for use by those who are guiding and implementing trauma informed principles and practices for their organization, such as the Trauma informed Leadership Team (TILT). Results highlight supports and areas that need attention to promote successful implementation of trauma informed practices.

The assessment uses an R=MC2 framework that measures factors related to the successful implementation and spread of an intervention, practice or program. 1 Measures include motivation, intervention-specific capacity, and general capacity as they contribute to the willingness and ability of an organization to implement a practice or program (Table 1).

Continuum CARE Assessment Survey Monkey Link:
https://www.surveymonkey.com/r/RVVFXN5

Table1. Components of the R=MC^2 framework		
Component	Subcomponent	Definition
Motivation The desire or act to move toward a goal	Relative Advantage	The degree to which an intervention is seen as better than the current state or alternatives
	Compatibility	The degree to which an intervention is seen as a good fit with the services and mission of the organization and the needs of those it serves
	Complexity	How easy it is for an intervention to be understood and applied by the intended audience
	Priority	The degree to which an intervention is perceived as a priority for the organization, leadership, and staff
	Ability to try	The availability and/or knowledge of opportunities to learn and test out an intervention
	Visibility of outcomes	The degree to which the outcomes of an intervention are seen by others
	Joy	The emotional response to an intervention
Intervention-Specific Capacity The knowledge, skills, support, and resources needed to implement a specific practice or program	Innovation specific knowledge, skills, and/or abilities	The knowledge and skills needed to use an intervention
	Program Champion	The presence of an influential person or people who support an intervention through communication and actions
	Specific Implementation climate supports	The extent to which an intervention is seen as supported by leadership, manager, and supervisors
	Inter-organizational relationships	The existence of collaborative relationships with partner agencies, technical assistance providers, or other systems that can provide training and support for implementation

Table 1 Components of the R=MC^2 Framework[1]

[1] *1 Scaccia J. et al. "A practical implementation science heuristic for organizational readiness: R=MC2". J Community Psychol. 2015 April; 43(4): 484-501*

Below is a list of terms and definitions that are used in survey questions.

- “Trauma Informed designated CARE site” refers to the recognition given by The Snohomish County Children’s Wellness Coalition, partner agencies and Snohomish County Human Services to organizations that have committed to staff professional development, participation in ongoing learning communities and operational change that focuses on compassion, appreciation, resilience and empowerment.

- “Trauma Informed CARE movement” refers to the range of activities being used to create and support trauma informed organizations and communities. This includes training, staff development, resource building, learning communities, and trauma informed practice and policy change.

- “Trauma Informed Care practices” refers to the specific practices used within an organization to recognize and respond to the impact of trauma, aid in recovery, and/or avoid re-traumatization. Examples of trauma informed practices include providing information about the impact of adverse childhood events and trauma; changing the physical environment to be more welcoming and culturally reflective of the community served; using the approach of “what happened” as opposed to “what is wrong”; using active and compassionate listening when in communication with others; or promoting mindfulness for both staff and individuals served.

- “Co-Care” refers to co-regulation, which is having trusted partnerships (such as with friends and/or coworkers) and/or community environments where you can support one another in emotional regulation and well-being.

Motivation

Please rate each question using the following scale: 1=Strongly Disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree	Score (1-5)
1. We can do a better job of supporting those we serve by being a trauma informed designated Compassion, Appreciation, Resilience and Empowerment (CARE) site	
2. Being a trauma informed designated CARE site advances the goals and mission of our organization	
3. Being a trauma informed designated CARE site provides an opportunity to improve our current practices	
4. It is worthwhile to invest in learning about the impact of adverse childhood experiences (ACEs) and trauma on the brain	
5. It is worthwhile to invest in learning about the impact of adverse childhood experiences (ACEs) and trauma on behavior	
6. It is worthwhile to invest in learning about resilience and factors that strengthen resilience	
7. The benefits of implementing trauma informed care practices outweigh the costs to the organization (e.g. financial resources, staff time to learn and implement trauma informed practices, etc.)	
8. It makes sense for our organization to provide trauma informed care	
9. Trauma informed care practices fit well with other practices in our organization	
10. Trauma informed care supports the needs of those we serve	
11. Understanding the effects of trauma on the brain is important for supporting the needs of those I serve	
12. Understanding the effects of trauma on behavior is important for supporting the needs of those I serve	
13. The components of the trauma informed CARE movement are easy to understand	
14. It is easy for me to review practices using a trauma informed lens and change them to be more trauma informed (if needed)	
15. It is easy for me to understand how to use trauma informed care practices in my work	
16. I find it easy to practice self-care, empowerment and “co-care”	

17. I am aware of the opportunities available at my organization to learn about trauma informed care practices	
18. I am aware of opportunities available at my organization to practice using trauma informed care practices in my work	
19. I am aware of opportunities available at my organization to practice self-care, empowerment, and “co-care”	
20. I have seen the benefits of using trauma informed care practices for those we serve	
21. I am aware of the ways our organization is measuring progress of the trauma informed CARE movement at our organization	
22. I have seen the positive impact of the trauma informed CARE movement at my organization	
23. The trauma informed CARE movement is a priority for staff	
24. The trauma informed CARE movement is a top priority for our leadership	
25. Our organization emphasizes that using trauma informed care practices is very important for improving the quality of our services	
26. There are other initiatives or practice changes occurring in our organization that make it difficult to prioritize trauma informed care practices	
27. My experience with the trauma informed CARE movement has been positive	
Total (sum questions 1-27):	
For a motivation average, divide the total sum by **27:**	

Intervention Specific Capacity

Please rate each question using the following scale: 1=Strongly Disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree	**Score (1-5)**
28. Staff have the skills needed to implement trauma informed care practices in the workplace	
29. Managers and supervisors have the knowledge needed to support staff in implementing trauma informed care practices	
30. We have the tools and resources we need to implement trauma informed care practices	

31. We have an influential member or members of our staff who promote the trauma informed CARE movement	
32. There is at least one person in our organization who provides updates on the trauma informed CARE movement	
33. We have the right people involved in the trauma informed CARE movement	
34. Managers and supervisors show active and visible support of the trauma informed CARE movement	
35. Leadership shows active and visible support for the trauma informed CARE movement	
36. Leadership meets with people in our organization to work on the trauma informed CARE movement	
37. Our organization dedicates the necessary resources (e.g. staff time, money, supplies) to trauma informed CARE movement activities to support their success	
38. We have collaborative relationships with local organizations who are also participating in the trauma informed CARE movement	
39. We use assistance from other organizations and resources to help us with the trauma informed CARE movement	
Total (sum questions 28-39):	
Intervention Specific capacity, divide the total sum by **12:**	

General Organization Capacity

Please rate each question using the following scale: 1=Strongly Disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree	**Score (1-5)**
40. Staff within our organization have the necessary skills and training to do their jobs effectively	
41. Staff within our organization have experience using trauma informed care practices	
42. It's hard for staff to take on new projects or practices due to heavy workloads	
43. Managers and supervisors provide regular updates on ongoing projects	
44. Managers and supervisors promote change in our organization by behaving in a manner consistent with the proposed change	

45. Leadership provides regular updates on ongoing projects	
46. Leadership promotes changes in our organization by behaving in a manner consistent with the proposed change	
47. For the most part, enough resources (e.g. money, supplies) are dedicated to projects to make sure they are successful	
48. Our organization has the necessary support for practice innovations in terms of facilities and equipment	
49. There is a clear method for sharing information in our organization	
50. There is a person or department responsible for monitoring and evaluating how well projects are doing in our organization	
51. Staff are receptive and open to change	
52. Staff are encouraged and take action to do things differently to improve their work	
53. Ideas and suggestions from staff get fair consideration by leadership	
54. In general, our organization is good at implementing changes	
55. When we encounter a problem in services, we make a serious effort to figure out why it is happening	
56. Our organization is adequately staffed	
57. Staff turnover is not a problem in our organization	
58. In general, staff feel supported by leadership and management	
59. Our organization has a positive work environment	
60. In general, there is flexibility to deal with change and learn new practices	
61. Staff have a sense of personal responsibility for improving services and outcomes for those we serve	
Total (sum questions 40-61):	
General organizational capacity, divide the total sum by **21:**	

Appendix F

Technical Assistance with Trainings

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Appendix G

Definitions

Trauma Informed Care

Trauma Informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma that emphasizes relationships, being curious, non-judgmental, holds accountability, and creates space for physical, psychological, and emotional safety for all. This paradigm shift builds and allows for opportunities to rebuild and keep a sense of empowerment and resiliency.

Restorative Practices

A way of thinking and being focused on creating safe spaces for real conversations that deepen relationships and build stronger more connected communities.
~Mark Vander Vennen

An emerging social science that studies how to strengthen relationships between individuals as well as social connections within communities.
~International Institute of Restorative Practice

Adverse Childhood Experiences (ACE) Study

A late 1990's groundbreaking Kaiser Permanente weight loss research study conducted by Dr. Vincent Felitti, Dr. Rob Anda and colleagues that showed the high prevalence of adversity in childhood (ACEs), and a relationship between ACEs and negative health outcomes throughout the lifespan.

Burnout

A gradual process of experiencing feelings of hopelessness, fatigue and being overwhelmed as a result of a lack of support, excessive workloads and expectations.

Champion

An individual or individuals who are trained specifically to take on roles such as educator, trainer, mentor, coach and/or advocate for a trauma informed approach to ensure sustainability.

Compassion Fatigue
A combination of secondary traumatic stress, vicarious trauma and/or burnout that manifests. One loses empathy, this fatigue is extremely common. It is critical to get support when this happens to prevent harm.

Guiding Values and Principles
A framework for individuals, organizations, and systems to consider their day-to-day activities in a way that prevents re-traumatization. This includes safety, trustworthiness, choice, collaboration, inclusion, and empowerment.

Re-Traumatization
When a policy, procedure, interaction, or the physical environment replicates someone's original trauma literally or symbolically-triggering the emotions and thoughts associated with the original experience.

Secondary Trauma
The onset of trauma-related symptoms in a worker as a result of witnessing the trauma/adversity of another.

Trauma Informed Care Stages
The first component of the trauma informed organizational model that defines the things to consider, needs and resources for trauma informed organizational change. Includes Pre-Implementation, Implementation and Sustainability.

Resiliency
The ability to bounce back from adverse situations. Resiliency can trump Adverse Childhood Experiences.

Appendix H

Domains of Consideration (SAMHSA, 2014a)

1. **Governance and Leadership** – Leadership supports and invests in implementing and sustaining a trauma informed approach.

2. **Policy** – Written policies establish the trauma informed approach as a key part of the organizational mission.

3. **Physical Environment** – Everyone experiences the setting as inviting, collaborative and physically/emotionally safe.

4. **Engagement and Involvement** – All stakeholders in the organization have significant involvement and voice in all areas of organizational functioning.

5. **Cross Sector Collaboration** – Collaboration with others is built on mutual understanding of trauma and the guiding values and principles of a trauma informed approach.

6. **Screening, Assessment, Treatment Services** – All practices/services of the organization reflect the values and principles of a trauma informed approach.

7. **Training and Workforce Development** – Organization believes that ongoing training on trauma, a trauma informed approach and self-care is essential.

8. **Progress Monitoring and Quality Assurance** – Organization has ongoing assessment, tracking and monitoring of the guiding values and principles of a trauma informed approach.

9. **Financing** – Financial structures are in place to support resources needed for implementation and sustainability of a trauma informed approach.

10. **Evaluation** – Evaluations of implementation and service provision reflect an understanding of trauma and a trauma informed approach.