Webinar for Baker Act Training
Trauma Series – Workshop 2
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Outline for Trauma-informed Care

- History of trauma-informed care
- Trauma-informed care and organizational culture change
- Principles of trauma-informed care
- Principles of trauma-informed care and recovery
- Principles of trauma-informed care and systems of care
- TIC principles for staff
- Assessing TI Care in organizations
- Curriculum and assessment options
Why are we here?

- Trauma’s effects are pervasive
- Trauma’s effects touch multiple life domains
- Trauma’s effects are deep
- Trauma can be self-perpetuating
- Trauma’s effects are greatest on those who are the most vulnerable
- Trauma effects how people seek help
- Trauma may have occurred by ‘helping’ systems
- Trauma effects staff and consumers, youth and families (Fallot & Harris, 2009)
Trauma-Specific vs. Trauma-Informed?

**Trauma-Specific services** – are designed to treat the long-term effects of past sexual, physical or emotional trauma.

**Trauma-Informed Services** – incorporate knowledge about trauma in all aspects of service delivery; are sensitive to and engage consumers; minimize revictimization; contribute to healing, recovery and empowerment; emphasize collaboration.
A brief history of trauma-informed care

- 1994 – Dare to Vision – SAMHSA sponsors a landmark conference on women’s issues and gender-specific treatment that resulted in a push to address trauma and violence
- 1998 – Women, Co-Occurring Disorders and Violence Study multi-site study to address inadequacy of services for this group (See also [www.nationaltraumaconsortium.org](http://www.nationaltraumaconsortium.org))
- 1998 – National Association of State Mental Health Program Directors issues a *Position Statement on Services and Supports to Trauma Survivors*
A brief history of trauma-informed care

• 1998 – initial findings from the Adverse Childhood Experience Study are published

• 2001 – 2002, states began an informal network to share ideas and support development of trauma-informed systems of care. Results of this network’s activities were published in the appendix to Damaging Consequences of Violence and Trauma: Facts, Discussion Points and Recommendations for Behavioral Health Systems (Jennings, 2004)
A brief history of trauma-informed care

- 2001 – National Child Traumatic Stress Network is created (nctsn.org)
- 2002 – In the wake of 9/11, public and professional awareness is raised about the impact of trauma and appropriate responses
- 2002 NASMHPD launches an initiative to reduce seclusion, restraint and retraumatization through the identification of best practices
A brief history of trauma-informed care

- 2003 – the National Trauma Consortium is organized to increase relationship between research and practice, increase awareness of the impact of trauma through advocacy, public policy and public education, and, offer TA and training to promote leadership, service planning and effective practice in the area of trauma
A brief history of trauma-informed care

- 2004 – *Trauma-informed Service Systems: Blueprint for Action* reflected the work of 31 states’ reports of trauma-related activities
- 2004 – Dare to Act – a second national conference dedicated to understanding and addressing the needs of trauma survivors was held
- 2005 – National Center for Trauma-Informed Care was created to offer TA to create interest and support for implementation of trauma-informed care in public systems
A brief history of trauma-informed care

- 2008 – Dare to Transform – third national conference to share best practices
- 2009 – Florida convenes its first Statewide Interagency Trauma-Informed Care Workgroup
- 2010 – Dependency Summit convenes statewide workgroups on trauma and launches statewide training on trauma and its assessment
As children and their families move through the child welfare and court systems, they often encounter additional stressful, frightening, and emotionally overwhelming experiences through “system generated trauma.”

Research develops on Science of Implementation

- Increasing knowledge base on the relationship between organizational culture and quality of care; implementation research
Core Components of Implementation

Integrated & Compensatory

Program Evaluation
Facilitative Administrative Supports
Selection
Pre-service Training
Consultation & Coaching
Staff Evaluation

Other Assessments of Leadership & Organizational Culture

- Evidence-Based Practice Attitude Scale (EBPAS); Aarons, 2004.
- Multifactor Leadership Questionnaire (MLQ); Bass & Avolio, 1990.
- Dimensions of Organizational Readiness-Revised (DOOR-R); Hoagwood et al., 2003.
- Assessing the Organizational Social Context of Mental Health Services; Glisson et al, 2008
Principles of trauma-informed care

- Safety – ‘ensuring physical and emotional safety’ (Fallot & Harris, 2009)
Principles of trauma-informed care

- Trustworthiness – Maximize trustworthiness, make tasks clear, clarify roles, establish appropriate boundaries, be predictable (Fallot & Harris, 2009)
Principles of trauma-informed care

- Choice – prioritize consumer choice and control (Fallot & Harris, 2009)
Principles of trauma-informed care

- Collaboration – sharing power with consumers, children and families (Fallot & Harris, 2009)
Principles of trauma-informed care

- Empowerment – Prioritize empowerment and skill-building (Fallot & Harris, 2009)
TIC principles for staff - Parallel process

- Safety - Do staff feel safe emotionally? physically
- Trustworthiness - How do we make sure tasks, policies and procedures are clear, predictable & consistent? Is decision making transparent?
- Choice – Do staff have choice and control in daily work life?
- Collaboration – Do staff share power and collaborate?
- Empowerment – Do staff feel empowered? Do they have opportunities to learn new skills (Beyer, Fallot & Harris, 2011)
1. **Self-Direction** – consumers lead, control, exercise choice over and determine their own path recovery

The National Consensus Statement on Mental Health Recovery is available at SAMHSA's National Mental Health Information Center at [http://www.mentalhealth.samhsa.gov](http://www.mentalhealth.samhsa.gov) or 1-800-789-2647.
2. **Individualized and Person-Centered** – There are multiple paths to recovery based on the unique strengths, needs and experiences (including trauma) of an individual.
3. **Empowerment** – consumers have the right to choice and participate in all decisions that affect their lives and should be educated and supported to do so.
4. **Holistic** – recovery encompasses a person's whole life – mind, body, spirit, and community.
5. **Non-Linear** – recovery is a process of continual growth that sometimes includes occasional setbacks and learning from experience.
6. **Strengths-Based** – Recovery relies on building on the strengths, talents, coping abilities and inherent worth of individuals.
7. **Peer Support** – Mutual support, including the sharing of knowledge, experience and skills expedites the path to recovery
8. **Respect** – Community, system, social and self acceptance are vital to inclusion and full participation in all aspects of life
9. **Responsibility** - individuals have responsibility for their own recovery and to identify coping strategies and healing process to promote their own wellness.
**10. Hope** — is essential to overcoming barriers and obstacles and should be fostered by peers, families and providers
Principles of trauma-informed care & recovery-oriented care

- Share core values of consumer empowerment and hope
- Have consumer choice at the center of planning, delivery and evaluation of services
- Are strengths-based and focus on skill building to assist in recovery
- Focus on the need to individualize services based on needs, experiences and goals of consumers
 Principles of trauma-informed care & systems of care - Core values

- Family-driven & youth-guided
- Community-based
- Culturally and linguistically competent
Access to a comprehensive array of services
Services are individualized
Services are integrated across child-serving agencies
Include case management
Ensure smooth transitions to adulthood
Families & youth should be full participants in all aspects of planning & delivery of services
Principles of trauma-informed care & systems of care - Guiding principles

- Early identification & intervention to promote positive outcomes
- The rights of children with emotional and behavioral disorders (EBD) should be protected, and effective advocacy should be promoted
- Children with EBD should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics and services should be sensitive and responsive to cultural differences and special needs
Questions?
Overview of Trauma-Informed Care

- Includes prevention and avoidance of retraumatization
- Supports trauma-specific interventions
- Infuses knowledge and behaviors into all aspects of organizational operation
- Includes identification of agency resources and assets to support the needed organizational cultural shifts to successfully implement trauma-informed care
See trauma as a defining and organizing experience that can shape survivors' sense of self and others.

Integrate an understanding of trauma, substance abuse and mental illness throughout the program.

Review service policies and procedures to ensure prevention of retraumatization.

Involve consumers in designing/evaluating services.

Develop new opportunities for continuous quality improvement & contributions to the emerging science of trauma-informed care.

Trauma-informed organizational change

- TI change is organization-wide, top to bottom, includes all activities
- Involves everyone, from CEO to the direct care staff, includes maximum consumer voice
- It is change in thinking and behavior, not just new information (Beyer, Fallot & Harris, 2011)
Trauma-informed organizational change

- Assessment is a process, not a one time event
- It should examine TI care principles in all organizational activities
- Change is data driven
Stages of trauma-informed organizational change

- **Pre-assessment (readiness)**
  - Is there buy-in from the top?
  - Who is going to oversee the process?
  - Is it inclusive? – all stakeholders need to be included
  - Who are your trauma champions?
  - Are there enough resources related to staff time, technology & expertise to support needed change

- **Assessment**
  - Begin your assessment process
Stages of trauma-informed organizational change
Assessment Domains – Service Level

- **Domain 1 - Review of program procedures**
  - Do they line up with TI Care Principles?
    - Consider each activity a consumer, child, youth or family would engage in at your program
    - Review who the staff are that interact with consumers, children, youth and families
    - Think about where these activities will take place
Stages of trauma-informed organizational change
Assessment Domains – Service Level

- **Domain 1A – Physical and Emotional Safety for consumers, children, youth and families**
  - Review where, when and how services are delivered?
    - E.g.
      - What staff are involved?
      - Are doors locked?
      - Do you feel safe

- **Domain 1F – Physical and Emotional Safety**
  - Do staff feel safe physically? Do they feel safe expressing their concerns?
Stages of trauma-informed organizational change
Assessment Domains – Service Level

- **Domain 1B – Trustworthiness for consumers, children, youth and families**
  - Do consumers, children, youth and families know what to expect from treatment?
  - Are professional boundaries clear?

- **Domain 1G – Trustworthiness for staff**
  - Do staff know what to expect? Is there consistency across shifts, units, programs, levels, etc? Is there transparency in decision making?
Stages of trauma-informed organizational change
Assessment Domains – Service Level

- Domain 1C – Choice for consumers, children, youth and families
  - Do consumers, children, youth and families have maximal opportunities to choose?
  - What is their level of decision making and involvement in services?

- Domain 1H – Choice for staff
  - So staff have choices in how they perform their jobs?
Stages of trauma-informed organizational change
Assessment Domains – Service Level

- Domain 1D – Collaboration for consumers, children, youth and families
  - How do staff and consumers, children, youth and families have maximum collaboration and share power?
  - Is there a meaningful consumer, child, youth and family presence on the Advisory or other governing boards?
  - What weight is given to consumer, child, youth and family preferences in goal setting?

- Domain 1I – Collaboration for staff
  - Are staff encouraged to be part of decision making? Is it clear that staff opinions are valued?
Domain 1E – Empowerment for consumers, children, youth and families
- What opportunities exist to build skills and take a lead role in their care?

Domain 1J – Empowerment for staff
- Are there opportunities for staff to improve their skills for their current job? E.g., trainings,
- Is there shared accountability across staff, or is it everyone for themselves?
Stages of trauma-informed organizational change

Assessment Domains – Service Level

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- **Domain 2**
  - Formal policy review – do policies reflect TI Care principles and the needs, strengths and experiences of trauma survivors?
    - Do policies minimize retraumatization
    - Are rights and responsibilities of staff and consumers, children, youth and families clearly described?
    - Support the safety of staff and consumers, children, youth and families
Domain 3 – Trauma screening, assessment, service planning and trauma-specific services

- Is there universal trauma screening?
- Does the assessment have potential to retraumatize consumers, children, youth or families?
- How do service plans reflect TI principles?
- Are there trauma-specific services available? appropriate?
Domain 4 - Is there high level buy-in for integrating TI Care into agency programs and practices?

- Do policies reflect this? Is there monitoring of TI Care at the ‘top’?
Domain 5 – Staff Trauma Training and Education

- Is there basic trauma training available?
- Are staff supported to seek specialized trauma training, e.g., in trauma-specific EBPs?
Stages of trauma-informed organizational change
Assessment Domains – Administrative Level

- **Domain 6 – Human Resources**
  - Is experience with trauma a consideration in hiring?
  - Is trauma knowledge and skills assessed in performance evaluation?
  - Is there supervision around vicarious trauma?
Stages of trauma-informed organizational change
Making your plan

- After identifying areas for improvement on TI in each domain, discuss the proposed changes in terms of...
  - Feasibility
  - Needed Resources
  - System support
  - Impact – breadth
  - Impact – quality
  - What are the risks of not making changes?
Stages of trauma-informed organizational change
Making your plan

- Make your plan, identify timelines and responsible staff
Stages of trauma-informed organizational change

- **Educate and celebrate**
  - Plan a kick off that includes as many staff and consumers, youth and families, as possible
    - TI Care Principles
    - The necessity of organizational buy-in
    - Contextualizing trauma in your organization (Co-occurring? Child and families?)
Stages of trauma-informed organizational change

• Interim follow-up
  ○ In the few months after initial assessment, plan additional training opportunities including ‘Trauma 101’ and one on TI Care supports for staff
  ○ Review TI Care plans – what progress is being made? What are the barriers? Unexpected facilitating factors?
  ○ Revise plan if needed
  ○ Celebrate successes!
Stages of trauma-informed organizational change

- Longer term follow-up
  - Review of progress towards meeting TI Care goals
  - How are changes being sustained?
Curriculum and assessment options

- Fallot, R., & Harris, M. (2009). Creating cultures of trauma-informed care available at the annafoundation.org
- **THRIVE - System of Care Trauma-Informed Agency Assessment (TIAA).** http://thriveinitiative.org/trauma-informed/trauma-informed-agency-assessment/
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