TRAUMA INFORMED CARE

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WELCOME AND INTRODUCTIONS

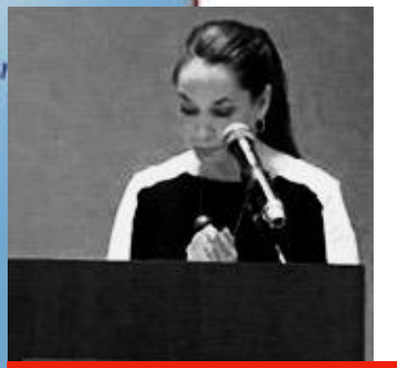
The Merry Misfits of OrgCode

ERIN: Minnesota based youth specialist; SPDAT; coordinated entry

IAIN: Ontario based leader of OrgCode; CEO; do-gooder

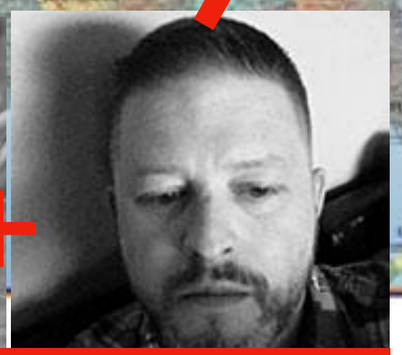
TRACY: Ontario based Associate Director of OrgCode; Master of Everything

KRIS: California based family specialist; shared housing; SPDAT

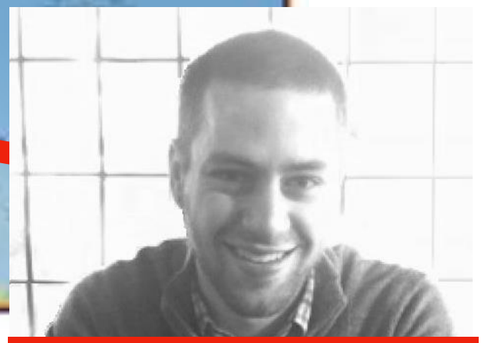


ANN: DC Based Leadership Wonder Woman

MIKE: Arizona based landlord guru



AMANDA & ZACH: West Virginia based rural; HMIS; trainers



DAVID: Florida based data boy wonder; coordinated entry; HMIS

OUR AGENDA

Agenda

MORNING

- Welcome and Introductions
- 5 Tenets of Trauma Informed Care
- Trauma Informed Care vs. Trauma Informed Interventions/Services
- Trauma Specific Interventions/Services (examples)
- Defining Trauma and the Different Types of Trauma
- Trauma on the Brain

AFTERNOON

- How to Identify Trauma in the People We Serve and Strategies to Support the 5 Tenets of Trauma Informed Care
- How to Implement Trauma Informed Policy and Programming
- Guidance for a System-Wide Trauma-Informed Approach

DEFINITIONAL FOUNDATION

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What is Trauma?

- **Event**, series of events, or set of circumstances that is…
- **Experienced** by an individual as physically and/or emotionally harmful or threatening and that has lasting adverse…
- **Effects** on the individual's functioning and/or physical, social, emotional or spiritual well-being

What is Trauma Informed?

A **trauma-informed approach** incorporates:

- **Realizing the prevalence** of trauma
- **Recognizing** how it affects all individuals involved with the program, organization or system, including its own workforce
- **Resisting re-traumatization**
- **Responding** by putting this knowledge into practice

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What Makes an Event Traumatic?

Traumatic events are:

- Sudden, unexpected, and extreme
- Usually involve physical harm or perceived life threat (research shows the perception of “life threats” are powerful predictors of the impact of trauma)
- People experience these events as out of their control
- Certain stages of life makes people vulnerable to the effects of trauma including childhood, teens and early twenties (Tedeschi, 2011)

Sources of Trauma

Sexual Abuse or Assault

The Department of Justice's (DOJ) Office on Violence Against Women defines sexual assault as "any type of sexual contact or behavior that occurs without the explicit consent of the recipient"

Physical Abuse or Assault

Emotional Abuse or Psychological Maltreatment

- Verbal, emotional abuse and excessive demands or expectations may cause an individual to experience conduct, cognitive, affective or other mental disturbances
- Also include acts of omission against a minor such as emotional neglect or intentional social deprivation

Sources of Trauma

Neglect

Victim or Witness to Domestic Violence

> "a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner. Domestic violence can be physical, sexual, emotional, economic or psychological actions or threats of actions that influence another person. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure or wound someone."

Victim or Witness to Community Violence

Sources of Trauma

Historical Trauma

Cumulative emotional and psychological wounding, as a result of group traumatic experiences, that is transmitted across generations within a community

School Violence, Including Bullying

Serious Accident, Illness or Medical Procedure

Natural or Human-made Disasters

Forced Displacement

Sources of Trauma

War, Terrorism or Political Violence
Military Trauma
Victim or Witness to Extreme Personal or Interpersonal Violence
Traumatic Grief or Separation

System-induced Trauma and Re-traumatization

- Child welfare systems
- Mental health systems
- Law enforcement/Incarceration

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Types of Trauma

Acute Trauma

- A one-time traumatic event

Chronic

- Chronic trauma occurs when people experience multiple traumatic events

Complex Trauma

- Describes both people's exposure to multiple traumatic events — often of an invasive, interpersonal nature — and the wide-ranging, long-term impact of this exposure

Prevalence

Homelessness

- 93% of homeless mothers have a lifetime history of interpersonal trauma
(Bassuk et. al., 1997; Bassuk, E. L., Buckner, J. C., Perloff, J. N., & Bassuk, S. S. (1998); Hayes, Zonneville, & Bassuk, 2013; Weinreb, Buckner, Williams, & Nicholson, 2006).
- 83% of homeless children have been exposed to at least one serious violent event by age 12 (Buckner, Beardslee, & Bassuk, 2004).

Mental/Behavioural Health

- 93% of psychiatrically hospitalized adolescents have histories of physical and/or sexual and emotional trauma (Lipschitz, Winegar, Hartnick, Foote, & Southwick, 1999).
- 75% of clients in substance abuse treatment settings report histories of significant trauma (Jennings, 2004)

Veterans

- 81%–93% of women veterans have been exposed to trauma over their lifetimes (Zinzow, H., Grubaugh, A., Monnier, J., Suffoletta-Malerie, S., & Freuh, B. (2007)

Prevalence

Justice

- 96% of female offenders have experienced trauma, often in the form of sexual abuse and intimate partner violence (Jennings, 2008)
- 75%–93% of youth involved with juvenile justice have experienced trauma (Justice Policy Institute, 2010)

Child Welfare

- 50% of children and youth in the child welfare system have experienced trauma (National Center for Children in Poverty, 2007)

Education

- 25% of school-aged children have been exposed to a traumatic event (APA, 2008; National Child Traumatic Stress Network, 2008)

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Population Considerations

- Operationalize policies and procedures that validate the existence of trauma including and in addition to homelessness itself
- Compound/complex trauma
- Specfic population considerations:
    - Families and children
    - LGBTQ2
    - Military
        - PTSD
    - Women
        - DV/sexual assault
        - child abuse
    - Native and African Americans
        - historical trauma/‘soul wounds’
        - slavery and Jim Crow

5 Tenets of Trauma Informed Care

- **Safety** – ensuring physical and emotional safety
- **Trustworthiness** – maintaining appropriate boundaries and making tasks clear
- **Choice** – prioritizing participants' choice and control (people want choices and options; for people who have had control taken away, having small choices makes a big difference)
- **Collaboration** – maximizing collaboration
- **Empowerment** – prioritizing program participants' empowerment and skill-building

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TRAUMA INFORMED CARE VS. TRAUMA SPECIFIC SERVICES

Trauma Specific Services

Trauma-specific services:

The term “trauma-specific services” refers to evidence-based and promising prevention, intervention or treatment services that address traumatic stress, as well as any co-occurring disorders (including substance use and mental disorders) that developed during or after trauma

Trauma Specific Services

INTERVENTION	DESCRIPTION
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (Cohen, Mannarino, & Deblinger, 2006)	TF-CBT is a psychosocial treatment of 8-24 sessions designed to treat PTSD and related emotional and behavioral problems in adults, children and adolescents.
Child-Parent Psychotherapy (CPP) (Liebermann, Ghosh Ippen, & Van Horn, 2006; Lieberman, Van Horn, & Ippen, 2005)	CPP is a relational treatment for parents and their very young children who have experienced at least one traumatic event and, as a result, are experiencing developmental, behavioral, attachment and/or mental health problems, including PTSD.
Seeking Safety (SS) (Najavits, 2004)	SS is a present-focused treatment for clients with a history of trauma and substance misuse. The treatment was designed for flexible use, including group or individual formats. This model creates a balance between exposure to dual treatment issues while avoiding exposure to significant trauma memories.

Trauma Specific Services

INTERVENTION	DESCRIPTION
Cognitive Processing Therapy (CPT) (Monson et al., 2006)	CPT is an adaptation of the evidence-based therapy known as cognitive behavioral therapy (CBT) used by clinicians to help clients explore recovery from PTSD and related conditions. CPT is a manualized, 12-session cognitive behavioral treatment for PTSD that offers an alternative to purely exposure-based interventions.
Eye Movement Desensitization and Reprocessing (EMDR) (Shapiro, 1995)	EMDR therapy facilitates the accessing and processing of trauma by attending to emotionally disturbing material in brief sequential doses while simultaneously focusing on an external stimulus (including therapist directed lateral eye, hand-tapping and audio stimulation). EMDR therapy involves attention to three time periods: past disturbing memories and related events, current situations that cause distress, and to developing the skills and attitudes needed for positive future actions through an eight-phase approach.
Prolonged Exposure (PE) Therapy (Foa, E. B., & Kozak, M. J., 1986)	PE is a cognitive-behavioral treatment program for adults who have experienced single or multiple/continuous traumas and have PTSD.

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Trauma Informed Care

Trauma-informed care:

Trauma-informed care is a strengths-based service delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment"

(Hopper, Bassuk, & Olivet, 2010, p. 82).

It also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals who already have histories of trauma, and it upholds the importance of consumer [sic] participation in the development, delivery, and evaluation of services.

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Trauma Informed

A trauma-informed perspective views trauma related symptoms and behaviors as an individual's best and most resilient attempt to manage, cope with, and rise above his or her experience of trauma.

WHAT'S WRONG WITH YOU → **WHAT HAPPENED TO YOU**

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TRAUMA ON THE BRAIN

Traumatization occurs when both internal and external resources are inadequate to cope with external threat

Van Der Kulk 1989

Impact of trauma is subjective because internal and external resources vary

www.youtube.com/watch?v=4-tcKYx24aA

Impact

Posttraumatic stress disorder (PTSD) is the name given to the broad spectrum of psychological and somatic disorders characteristic of many trauma survivors

Complex PTSD describes the psychological effects of prolonged trauma, which may be particularly severe in individuals subjected to physical/sexual abuse as young children

What's the Point?

When supporting participants, we must be mindful that:

- The brain may still be developing (children, youth and young adults)
- The brain may have been compromised through injury
- The brain may have been compromised organically
- The brain may have been compromised in utero

In other words…

Just because you think someone should be able to do something doesn't mean they can or should

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TRAUMA INFORMED SYSTEMS

Trauma Informed Systems

- Paradigm shift: Moving from a deficit- based system to an asset-based response
  - Participant driven
  - Recovery oriented
  - Cross-sector collaboration

- Not only changes the program and services within the system, but how people are viewed BY the programs and services within the system

Trauma Informed Systems

- Common Understanding about Principles of Trauma Informed Care
- Organizational Commitment
- Staff Training
- Peer Collaboration
- Culturally Competent
- Data Driven and Rigorous Evaluation
- Cross-Sector Participation
  - Schools
  - Law Enforcement
  - Child Welfare
  - Health Care
  - Sexual and Domestic Violence

Trauma Informed Systems

Deficit Based ➲ Asset Based

Relationships Based on Hierarchy ➲ Power Sharing

Behavior/Choices Seen as Bad ➲ Mechanisms for Coping

Policies/Process Triggering ➲ Trauma-Informed Practices

Providing Social Control ➲ Providing Social Services

Rules ➲ Expectations

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Trauma Informed Systems

Wisconsin Trauma Project

- 2012, forty-three counties and three tribes have participated in one or more components of the project

Three components:

- Training for caregivers in Trauma-informed Parenting Workshop
- Training for mental health clinicians in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), a trauma treatment for children ages 3-18
- Training and technical assistance in Trauma-informed County/Tribal Organizational Systems Change

Each component will strengthen local child-serving systems

IDENTIFYING TRAUMA IN THE PEOPLE WE SERVE

Understanding Symptoms & Triggers

Remembering FIGHT, FLIGHT, or FREEZE

Remembering behaviors may be better understood as trauma-based responses used to manage prior overwhelming feelings and situations

All providers understand these responses as adaptive and offer consistent, trauma-sensitive


dangry
dangerous
notready
difficult
lazy
liar
resistant
sabotage
spacey
defiant
dishonest
service
manipulative
disengaged

“We need to hold them accountable”

“I’m not going to work harder than they are”

“People need to meet us half-way”

“They’ve burned too many bridges”

“They’re sabotaging their opportunity”

“We are enabling them”

Others?

Let's Talk About Enable

enable
[en-ey-b*uh* l]

verb (used with object), **enabled, enabling.**

1. to make able; give power, means, competence or ability to; authorize:
   The Millennium Falcon enabled Han Solo's less than 12 parsec Kessel run.

2. to make possible or easy:
   My horse is enabled to do tricks and dances; yours doesn't do anything.

3. to make ready; equip (often used in combination):
   The kookaburra appreciated the talon-enabled shoes that finally fit.

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Recognizing Symptoms

Trauma — physical, sexual and emotional — is both a cause and a consequence of homelessness

Symptoms are not always obvious nor may be associated with trauma by the people we serve

Recognizing Symptoms

Posttraumatic stress disorder (PTSD) is the name given to the broad spectrum of psychological and somatic disorders characteristic of many trauma survivors.

Complex PTSD describes the psychological effects of prolonged trauma, which may be particularly severe in individuals subjected to physical/sexual abuse as young children.

Recognizing Symptoms

The psychological symptoms of PTSD fall within three main categories:

- **Hyperarousal**

  "the persistent expectation of danger:" startles easily, reacts irritably to small provocations, sleeps poorly

- **Intrusion**

  "repetitive reliving of the traumatic experience in thoughts, dreams and actions:" static, sensory flashbacks and nightmares accompanied by terror and rage

- **Constriction**

  "the numbing response of surrender:" detached states of calm or dissociation impeding voluntary action, initiative, critical judgment and perception of reality

PTSD symptoms reflect the brain's normal response to trauma; they are not evidence of psychosis.

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Symptoms in Children

Infants (birth to 3 years)

- Eating disturbance
- Sleep disturbances
- Somatic complaints
- Clingy/separation anxiety
- Irritable/difficult to soothe
- Constricted play, exploration, mood
- Repetitive/post-traumatic play
- Developmental regression
- General fearfulness/new fears
- Easily startled
- Language delay
- Aggressive behavior
- Sexualized behavior
- Talking about the traumatic event and reacting to trauma triggers

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Symptoms in Children

Young children (3 to 6)

- Avoidant, anxious
- Helplessness, passive, low frustration
- Restless, impulsive, hyperactive
- Physical symptoms (headache, etc.)
- Difficulty identifying what is bothering them
- Inattention, difficulty problem solving
- Daydreaming or dissociation
- Aggressive behavior
- Sexualized behavior
- Loss of recent developmental achievements
- Sadness/depression
- Poor peer relationships and social problems

Symptoms in Adolescents and TAY

Self Regulation:

- Hard time managing their feelings
- Rely on ineffective, or even dangerous, coping strategies
  - Sleeping on couch, not bed
  - Substance use
  - Hoarding food
  - Bed wetting
  - Poor hygiene
- Deficiencies in identifying, safely expressing and modulating their emotions
- Rapid shifts between withdrawal/isolation to explosive, emotional volatility (crying one minute, screaming the next)

Symptoms in Adolescents and TAY

Attachment and Relationships:

- Push/pull relationships
- Worry about their own and others' safety
- Poor physical, emotional, and sexual boundaries
- Inability to accurately interpret social cues

Behavioural Control:

- Sexually or aggressively provocative
- Prone to emotional and physical outbursts towards peers/adults
- Poor impulse control may manifest as attentional difficulties and impulsive risk-taking behaviors

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Symptoms in Adolescents and TAY

Physical Symptoms:

- Physical aches and pains such as stomachaches or headaches which have no direct biological origin (somatization)
- Physiological challenges (such compromised immune functioning or digestive issues) from stress on body

Dissociation:

- Staring into space, zoning out, or not paying attention
- Difficulty remembering events or a complete loss of consciousness
- Feeling numb or unreal
- May have no awareness of being in that state at all.

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Symptoms in Adolescents and TAY

Self-Concept:

- May be out of touch with their wants and needs and may need others to help articulate them
- Underdeveloped sense of who they are and take on different personalities or identities in different times and situations in an attempt to figure it out
- Youths' emotions and behaviors may not match their chronological age
- Or, they may act older, exhibiting parental, provocative or sexualized behaviors

Cognition:

- Challenges in their ability to anticipate, plan for, and solve problems
- Poor impulse control and use of ineffective coping mechanisms
- Struggle with attention – always on high alert
- Often have deficits in language development, abstract reasoning and executive functioning, and demonstrate distorted thought processes
- Makes it difficult for them to retain and utilize coping skills

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Symptoms in Single Individuals

- Change in personal self-concept, self-blame
- Distrust
- Suicidal thoughts or attempts
- Episodes of feeling detached from one's body or mental processes
- Isolation, guilt, shame, or a feeling of being totally different from other people
- Helplessness and feeling hopeless
- Becoming preoccupied with revenge or, conversely, giving total power to the perpetrator
- Self-harm, self-mutilation
- Alcoholism, substance abuse

Symptoms in Families

- Trauma impacts individual family members, their relationships with each other, and overall family functioning
- Adult member's relationships can support coping, or cause additional stress
- Parent-child relationship is vital to the child's development and recovery
- Sibling relationships are important sources of companionship, comfort, daily support, and family connection
- Extended family and kinship relationships can offer the day-to-day assistance as well as the emotional support

HOW TRAUMA IMPACTS HOMELESSNESS

SHIFT Study Highlights
Trauma's Impact on Homelessness

- Purpose: to examine residential stability of families over time
- Compared families staying in emergency shelter, transitional housing or permanent supportive housing
- Conducted from 2007 to 2010 in Rochester, Syracuse, Buffalo and Albany, New York
- Included 292 families at baseline, at fifteen months (192 families) and thirty months (184 families)
- Most mothers were in their 20s, never married, with two or three children
- Majority of the mothers were African-American; one quarter were Caucasian; and 14 percent were Latina or “other.” More than one-third had no high-school degree or GED

SHIFT Study Highlights
Trauma's Impact on Homelessness

At fifteen months, there were *four* significant predictors for residential instability:

- unemployment
- lower level of education
- poor health
- lower self-esteem

At thirty months, the *only* predictors were:

- severity of trauma symptoms
- lower self-esteem

SHIFT Study Highlights
Trauma's Impact on Homelessness

- 93% of mothers had a history of trauma

- 81% having experienced multiple traumas

- The most common trauma experienced was interpersonal violence (e.g. physical and/or sexual abuse)

- Approximately 50% met diagnostic criteria for post-traumatic stress disorder (PTSD)

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TRAUMA INFORMED SOLUTIONS

Trauma Informed Solutions

Interaction with staff members or figures of authority:

- Experiences in out of home placement are common, causing or resulting in neglect, separation from parents/family, placed with strangers
- Incarceration or harmful interactions with police
- Healthy development impacted by fear and lack of safety and/or trust
- Safety and trust is paramount -- may test staff to determine if they are reliable, honest, consistent, fair, etc. -- may intentionally challenge and test boundaries

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Trauma Informed Solutions

Solution:

- Reframe ‘defiance’ behaviors as resilience and survival skills
- Reframe ‘consequences’ as results of decisions made
- Slow down and explain every process and step
- Let youth know that they have the right to share only the information that they want to share
- Do not expect immediate rapport and do not assume that immediate rapport means trust has been built
- Boundaries – staff should never attempt to play or replace friends or family

Trauma Informed Solutions

Interaction with their peers

- Experiences of chronic or repeated abuse or neglect by a parent or caregiver; lack of modeling or experiences of healthy relationships;
- May not be able to connect at all - avoid contact with others/isolate
- May over-attach to peers and become preoccupied with others - may be best friends one day and be verbally aggressive the next day.
- Street families
  - Provide sense of support and unconditional love
  - Provide safety or a sense of safety
  - Contributes to victimization
  - Prevent or delay them accessing services
  - May tolerate abusive or exploitation

Trauma Informed Solutions

Solution

- Create opportunities for positive peer interaction and safe space
- Model positive communication, interaction and engagement.
- Create spaces that promote inclusion and diversity
- Refrain from judgement about who program participants claim as kin or family

Trauma Informed Solutions

Ability to participate in programs and follow through with service planning:

- Complex trauma can cause difficulty in regulating emotions, relating to others, planning for the future, and following through with beneficial activities.
- Depression, learned helplessness, learning challenges, and fear of failure can compound these difficulties
- Seem unwilling or uninterested in service planning
- May not return phone calls, make meetings, follow through on goals, etc.
- Appear “defiant” – frequently breaking rules or challenging staff; aren’t a good ‘fit’

Trauma Informed Solutions

Solution:

- Program uses “people-first” language rather than labels (e.g., “people who are experiencing homelessness” rather than “homeless people”)
- Staff uses descriptive language rather than characterizing terms to describe program participants (e.g., describing a person as “having a hard time getting her needs met” rather than “attention-seeking”).

STRATEGIES TO SUPPORT THE 5 TENETS

Trauma Informed Care – Why Strategize?

Trauma can impact how people access services

- Viewing people and services as unsafe
- Having difficulty in trusting people.

A trauma-informed service can work to develop relationships that give the client power and build trust, thus enhancing safety

Trauma Informed Care – Why Strategize?

A recognition that people adapt to trauma in order to keep themselves safe, including:

- Misuse of substances
- Continuing to engage in high-risk situations
- Cutting
- Becoming aggressive, withdrawal or dissociating, 'non-compliant'

Service providers who aren't trauma-informed may see these behaviors as unhealthy, however they should be recognized as coping mechanisms, and service providers can work with clients to develop healthy substitutes and safety planning

Trauma Informed Care – Why Strategize?

- Programs and services for trauma survivors cannot be ‘one size fits all’
- Traditional services might promote interventions that don’t take into account the trauma
- Survivors need personalized services and interventions

We need to find programs for people,
not people for programs

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Safety (Tenet 1 of 5)

Traumatic experiences violate our fundamental belief that the world is a safe place and people can be trusted.

Creating a safe, supportive, welcoming, and respectful environment is essential in any service setting.

To what extent are we ensuring safety?

Trust (Tenet 2 of 5)

Programs, services and staff must maximize trustworthiness through task clarity, consistency, and interpersonal boundaries.

To what extent are we establishing trust?

Let's ask ourselves…

- Do clients clearly know what they can expect from us and our program, and do we follow through?

- Can people trust all program staff to keep their private and personal information confidential?

- Does your agency have written policies for professional conduct for staff (boundaries, interactions, etc.)

Choice (Tenet 3 of 5)

Trauma recovery involves helping people regain a sense of control over their daily lives and build competencies that will strengthen their sense of autonomy

Outlining clear expectations, providing opportunities for people to make daily choices in their life are necessary for a recovery-oriented model

How do we encourage and honour choice?


HONK
HONK
HONK
HONK
HONK

Revisiting Policies

Let's talk about rules…

- Is this policy or rule necessary?
- What purpose does it serve?
- Who does it help?
- Who does it hurt?
- Does it facilitate/hinder inclusion and control?
- Who was included in its development?
- Could this policy or rule re-traumatize someone by limiting control and power, leading to fear or confusion?

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Moving From Rules to Expectations

RULES by definition mean that authority is exercised over another

EXPECTATIONS by definition mean that there is a belief that someone can achieve what is explained to them

Moving From Rules to Expectations

"Our shelter cultivates desirable shelter resident behaviors by expecting program participants to:

1. *Demonstrate responsibility for themselves, their actions, and their housing plan.*
2. *Store all prescribed and/or over the counter medication in the designated area.*
3. *Abstain from behavior that is disruptive and unacceptable to others. Examples include: verbal, physical, or sexual harassment, threats and/or violent behavior, nudity, possessing weapons, drug dealing, etc.*
4. *Keep bed and common areas clean. Excessive damage to the building may result in termination in the program.*
5. *Smoke only in designated areas.*
6. *Have an active voice in helping us improve.*
7. *Accept responsibility for your own stuff and may not buy, trade and/or sell stuff with others within the shelter."*

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Make It Happen!

People Receiving Services	People Providing Services
Safety = Minimizing loss of control over their lives	**Safety = Minimizing loss of control over the environment**
Safety mean moving toward: • Maximizing choice • Develop authentic relationships • Exploring limits • Defining self • Defining experiences without judgement • Receiving consistent information ahead of time • Being free from force, coercion, threats, punishment and harm • Owning and expressing feelings without fear	Safety means moving away from: • Maximizing routine and predictability • Assigning staff based on availability • Setting limits • Defining client problems/diagnosing • Judging experiences to determine competence and appropriateness of services • Providing information as time allows • Threatening force to de-escalate a situation • Reducing expression of strong emotion

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Let's ask ourselves…

- Are there are a variety of services that people can choose from?
- Is information provided about services that are mandatory, attendance frequency, extent of participation required and the length of time the service is provided?
- In what ways can you or have you created partnerships for those who choose to not work with your program?
- Are expectations clearly written and explained as well as results of not meeting expectations?

LUNCH BREAK!

Collaboration (Tenet 4 of 5)

Recovery and success for trauma survivors is largely based on their ability to regain or develop skills that put them back in control of their lives. Services can facilitate empowerment by giving people a voice in what happens on a daily basis.

To what extent does our work maximize collaboration and sharing of power between staff and participants?

Let's ask ourselves…

- Does the program provide opportunities for people to lead community meetings and program activities?
- Are current participants given opportunities to evaluate the program and offer their suggestions for improvement in anonymous and/or confidential ways?
- Are former participants interested in being involved in providing services?
- Are current or former participants in leadership positions, such as sitting on a board?

Empowerment (Tenet 5 of 5)

Trauma survivors often enter service settings with past experiences that include being mistreated, ignored and silenced

Empowerment is the process of becoming stronger and more confident, especially in controlling one's life and claiming one's rights

To what extent does our work prioritize empowerment and skill building?

Let's Ask Ourselves…

- Is your service plan/program identifying ways for people to exercise strengths and learn new skills?
- Is your service plan/program creating and offering leadership opportunities?
- Is your program providing culturally competent services to support empowerment of minority populations?
- Does your program have celebrations or traditions for success' or milestones?

HARM REDUCTION HELPS

Harm Reduction

Intervention strategies to help people **reduce the negative consequences** of high-risk behaviours by addressing the conditions and situations of risk rather than focusing solely and immediately on cessation of the behaviour

Harm Reduction makes improving the quality of the individual's life, health and wellbeing the primary criteria for success

Harm Reduction

- Affirms choice and self-determination
- Opens door for honest communication about drug use and other risk factors which allows for a stronger service interaction and intervention
- Supports a trauma-informed framework
- Supports a client-centred, strengths-based intervention
- Supports a Housing First model
  - Behaviour doesn't correlate to 'readiness'
  - Promotes a 'low barrier' response

Harm Reduction

- The principle of Harm Reduction can be applied to several areas, not just substance use
  - Relationships (ex: exploitation, violence)
  - Tenancy/good neighbor
  - Young families; child welfare
  - Revisiting trauma – coaching boundaries
- We are interested in the application of Harm Reduction strategies in the context of housing stability

Substance Use

Whether alcohol or other drugs, our focus in applying harm reduction strategies with our participants should focus on:

- Health impacts
- Budgeting and how consumption may impact ability to pay the rent
- Lease violations – drug use on premises, noise complaints, etc.

Let's Ask Ourselves…

- Does your program view substance use from a harm reduction or sobriety perspective?
- When working on budgeting with participants, do you openly and honestly discuss substance use?
- Do you and your participants discuss substance use from a perspective of housing stability?
- Do you find your own values around substance use inform or impact your work?

Compromised Wellness

The decision to engage with or not engage with supports for both physical and mental health concerns rests entirely with the individual. Our focus is on ensuring that a plan is in place to maintain housing:

- Cost of health supports and impact on budget
- Loss of income or benefits due to compromised wellness, and impact on budget
- Potential lease violations due to compromised wellness

Let's Ask Ourselves…

- Do you present multiple options and resources to your participants when talking about physical health issues?
- Do you present multiple options and resources to your participants when talking about mental health issues?
- Do you talk about wellness planning and how it relates to housing stability with your participants?
- Do your own values, beliefs, and experiences impact your work with participants who have compromised wellness?

High Risk Behaviours

- People engage in risky behaviours for many reasons, and while it is important to try to understand the reasons, it is equally important to ensure stable housing:
  - Illegal income sources – sex work, drug sales, theft, etc.
  - High risk sexual behaviours and their potential impact on health

Let's Ask Ourselves…

- Do you feel comfortable and confident discussing high risk behaviours with your participants or do you avoid these topics?
- Does your service planning include safety planning for high risk behaviours?
- Do you discuss strategies for reducing risks rather than stopping high risk behaviours?

Breakout Discussion: Beyond ‘Buzzwords’

20 minutes then regroup

2 ways my agency has trained staff to understand the impacts of trauma and what we still need to know

2 ways we involve people in decision making + 1 way we/others don’t

2 ways my program/team process and review case plans and crises that occur through a trauma informed lens + 1 way we/others don’t

2 ways my program/team ensures a safe environment and + 1 way we/others don’t (how do we know guests feel safe?)

2 ways my team shows support to a person in crisis + 1 way doesn’t

IMPLEMENTING TRAUMA INFORMED POLICIES

**Content primarily referenced from Trauma-Informed Organizational Toolkit* from SAMHSA

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Supporting Staff Development

- Staff members are required to complete a certain amount of staff development time (e.g., trainings, conferences, etc.) per year
- Coverage is in place to support training and Financial assistance/paid time-off is available for staff to attend trainings
- The program educates staff members about:
  - Confidentiality
  - Informed consent
  - Roles and responsibilities
  - Professional boundaries

Supporting Staff Development

Mechanisms for encouraging self-care:

- Addressing topics related to self-care in team meetings
- Encouraging staff members to understand their own stress reactions and develop their own self-care plans
- Devoting part of supervision to talking with staff members about the impact of working with trauma survivors
- Providing trainings about compassion fatigue and self-care strategies

Creating a Safe, Supportive Environment

Establishing a safe physical environment:

- The building is well maintained and clean
- Things are fixed when they are broken
- The building is swept/dusted/mopped, sprayed for bugs, etc.
- The building is locked when vacated
- The building is accessible for people with hearing, visual and mobility impairments

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Creating a Safe, Supportive Environment

Establishing a supportive environment:

- Information sharing
- Cultural competence
- Privacy and confidentiality
- Safety and Crisis prevention planning
- Open and respectful communication
- Consistency and predictability

Let's ask ourselves…

- Are first contacts welcoming, respectful, engaging?
- Are individuals who have broken a rule or been 'disrespectful, treated differently?
- Is personal/private space respected?
- Is the information shared with us kept safe?
- Do staff know how to redirect or de-escalate?
- Do people have crisis and safety plans?
- Are spaces clean, organized and population specific?
  - 'safe space' for LGBTQ2 youth
  - resources for DV, etc.

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Assessing and Planning Services

- Conducting intake
- Developing goals and plans
- Offering services and trauma-specific interventions

Better Including the People We Serve

- Giving participants a voice
- Giving them choice in how and where they receive services
- Enabling trained peers
- Providing opportunities for developing and evaluating program activities
- Former participants can have staff and leadership positions
- Client grievance policy

Adapting Policies

Establish and review written policies:

- The program mission statement and policies are written in clear, simple language for staff and program participants
- The program mission statement and policies are written in all of the primary and preferred languages of the people who are served by the agency
- Written policies are in place to outline emergency responses to situations such as fire or natural disasters

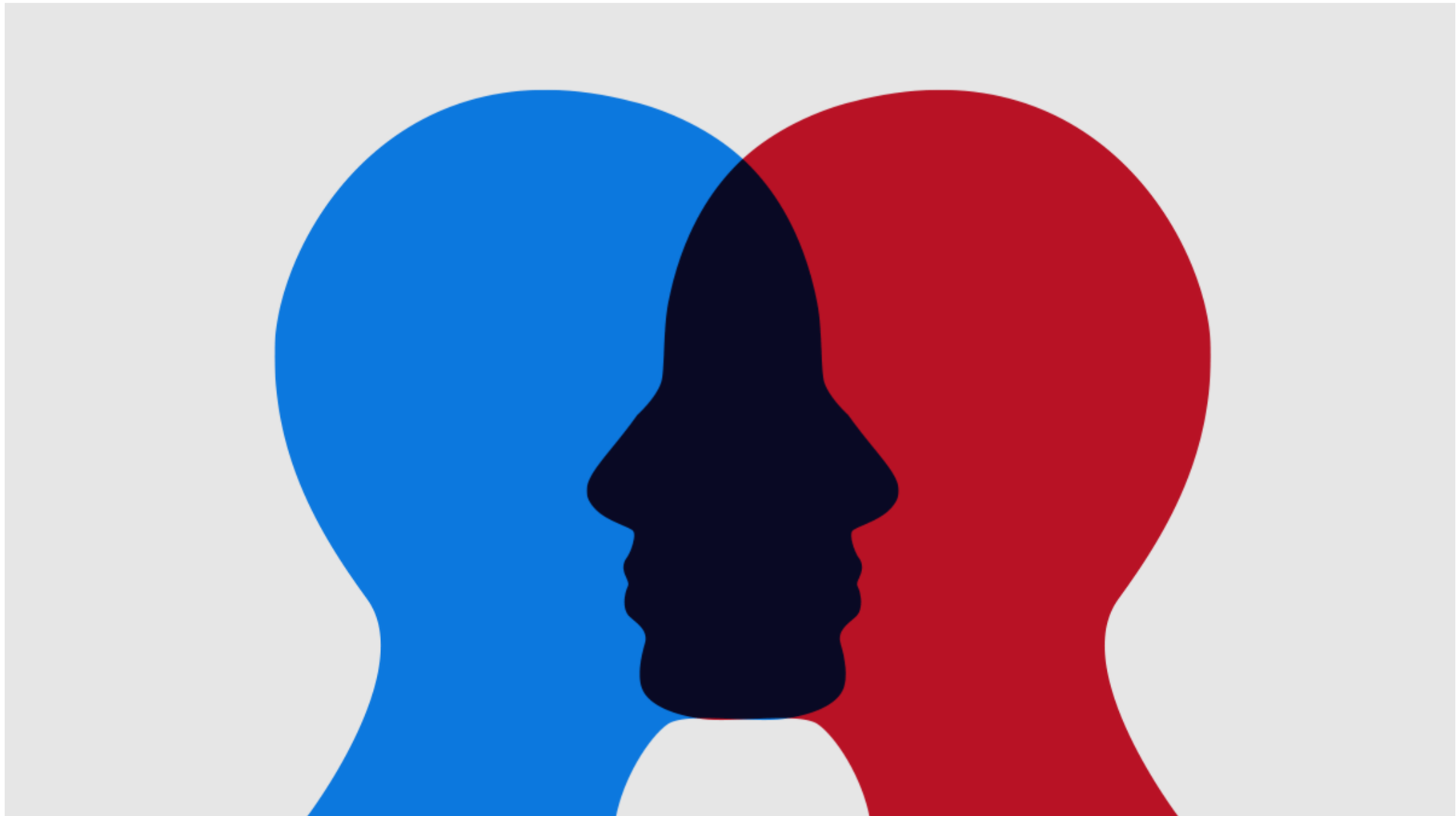
Adapting Policies

Establish and review written policies:

- Written policies are in place to obtain the informed consent of program participants
- Written policies are in place to protect the confidentiality/privacy of people served
- The program has a formal grievance process
- Written policies are in place to outline professional conduct for staff (e.g. boundaries, responses to clients, etc.)

SECONDARY TRAUMA & COMPASSON FATIGUE

"As we listen empathically to the stories of our clients, it becomes impossible not to enter their world and experience their pain." (Shallcross, 2013)



“Compassion hurts. When you feel connected to everything, you also feel responsible for everything.

You cannot turn away. Your destiny is bound to the destinies of others. You must either learn to carry the universe or be crushed by it.

You must grow strong enough to love the world, yet empty enough to sit down at the same table with its worst horrors.”

- Andrew Boyd

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What Is It?

Secondary traumatic stress is the emotional duress that results when an individual hears about the firsthand trauma experiences of another:

- Between 40% and 85% of "helping professionals" develop vicarious trauma, compassion fatigue, and/or high rates of traumatic symptoms.[1]
- 70% of Masters level Social Workers and Sexual Assault therapists experience secondary traumatic stress.[2]
- 50% of Child Protective Service Workers suffer high to very high levels of compassion fatigue.[3]

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What are Symptoms?

- Lingering feelings of rage/anger about clients
- Becoming overly involved emotionally
- Experiencing bystander guilt, shame self-doubt
- Preoccupied with thoughts of clients outside work
- Over-identification with clients
- Loss of hope, pessimism, cynicism
- Distancing, numbing, detachment
- Difficulty in maintaining professional boundaries with the client, overextending

Risk and Resiliency Factors

Risk and Resiliency Factors

Organizational Strategies

- Provide adequate clinical supervision, including reflective supervision
- Maintain caseload balance
- Support workplace self-care groups
- Enhance the physical safety of staff
- Offer flextime scheduling
- Train organizational leaders and non-clinical staff organizational leaders on organizational implementation and assessment
- Provide ongoing assessment of staff risk and resiliency

Individual Strategies

- Use supervision to address symptoms
- Increase self-awareness
- Maintain healthy work-life balance
- Exercise and good nutrition
- Practice self-care
- Develop and implement plans to increase personal wellness and resilience
- Continue individual training on risk reduction and self-care
- Use Employee Assistance Programs or counseling services as needed

NOW WHAT?

What can you do today?

What can you do next week?

What can you do in one year?

Please take a few moments to complete the "Continuing Education Course Evaluation" form

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