Trauma Informed – Why Does it Matter?

by Trauma Matters Delaware (TMD)
August 7, 2018

Presented at the Professional Development Institute for Trauma Informed Practice
Delaware Law School at Widener University
Wilmington, Delaware

Sponsored by SOAR, Inc. and the Beau Biden Foundation
Presenters

• Nancy McGee, Sexual Assault Network of Delaware (SAND) Coordinator

• Sharon Merriman-Nai, Associate Scientist, University of Delaware Center for Drug and Health Studies

• Marilyn Siebold, Adjunct Professor of Psychology, Wilmington University

• Aileen Fink, Director of Behavioral Health, Bureau of Correctional Healthcare Services, Delaware Department of Correction
TMD is a community of people interested in learning more about promoting trauma informed approaches throughout Delaware.
Our Roadmap for Today...

• Cross-Brain Exercise and Overview of Trauma
• Delaware Data on Trauma
• Why Trauma Informed Care (TIC)?
• Building Resiliency
• Breaking down the Barriers to Trauma Informed Approaches
• Taking a Step Towards Trauma Informed Approaches in Your Setting
What is Brain Gym?

- **Brain Gym® International** is committed to the principle that moving with intention leads to optimal learning. The organization was founded in 1987 under the name of the Educational Kinesiology Foundation and in 2000 began doing business as Brain Gym® International.

- Developed by Paul E. Dennison and his wife and colleague, Gail E. Dennison, Brain Gym® movements, exercises, or activities refer to the original 26 Brain Gym movements. These activities recall the movements naturally done during the first years of life when learning to coordinate the eyes, ears, hands, and whole body.

- Clients, teachers, and students have been reporting for over 20 years on the effectiveness of these simple activities. Even though it is not clear yet "why" these movements work so well, they often bring about dramatic improvements in areas such as:
  - Concentration and Focus
  - Memory
  - Academics: reading, writing, math, test taking
  - Physical coordination
  - Relationships
  - Self-responsibility
  - Organization skills
  - Attitude
Cross Brain Exercise

Nancy McGee, Coordinator
Sexual Assault Network of Delaware
nmcgee@contactlifeline.org
Trauma Overview
Delaware Data on Trauma

Sharon Merriman-Nai, Associate Scientist
UD Center for Drug and Health Studies
smnai@udel.edu
TRANSFORMING DATA INTO ACTION

CDHS YOUTH SURVEYS & THE DSAMH SPF-PFS SEOW

DATA COLLECTION

Since 1995, CDHS has collected data on the health and well-being of Delaware students. These surveys are funded by the State’s Division of Public Health, Nemours, and others. Findings support many CDHS projects, including the Strategic Prevention Framework – Partnerships for Success (SPF-PFS) initiative.

SCHOOL BASED SURVEYS

<table>
<thead>
<tr>
<th>DATA SOURCES</th>
<th>SUBJECTS</th>
<th>DATA COLLECTION</th>
<th>GEOGRAPHICAL LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delaware School Survey (CSS)</td>
<td>Substance use, health behaviors, risk and protective factors</td>
<td>Annually (Spring)</td>
<td>State, County</td>
</tr>
<tr>
<td>Youth Risk Behavior Survey (YRBS)</td>
<td>Tobacco, alcohol, substance use, health behaviors, mental health, sexual behaviors, violence, wellbeing, and protective factors</td>
<td>Every 2 Years, Older (Spring)</td>
<td>State, County</td>
</tr>
<tr>
<td>Youth Tobacco Survey (YTS)</td>
<td>Tobacco use and attitudes</td>
<td>Every 2 Years, Older (Spring)</td>
<td>State, County</td>
</tr>
<tr>
<td>College Risk Behavior Survey (CRBS)</td>
<td>Substance use, gambling, personal and social relationships</td>
<td>Every 2 Years, Older (Spring)</td>
<td>State, County</td>
</tr>
<tr>
<td>School Health Profiles</td>
<td>School health policy and professional development addressing a variety of risk and protective factors</td>
<td>Every 2 Years, Older (Spring)</td>
<td>State</td>
</tr>
</tbody>
</table>

COLLABORATION

The Strategic Prevention Framework – Partnerships for Success (SPF-PFS) engages a robust State Epidemiological Outcomes Workgroup (SEOW) to share Delaware data on substance use and related issues. The SEOW is comprised of representatives from a broad spectrum of agencies, organizations, and community groups. It was created through previous State Incentive Grants and continues with support from Delaware Division of Substance Abuse and Mental Health.

SEOW GOALS:

- To build monitoring and surveillance systems to identify, analyze, and proactively data from state and local sources;
- To identify, share, and analyze data;
- To create data guided products that inform prevention planning and policies;
- To train agencies and communities in understanding, using, and presenting data effectively.

SEOW COLLABORATORS:

- Divisions and agencies across state government
- Federal partners
- Academic organizations
- Non-profit organizations
- Community organizations

DATA COMMUNICATION

Once it is collected and analyzed, the data is shared widely to implement strategies to promote healthy life choices. Data is posted on the CDHS website and shared through presentations, reports, maps, and infographics. CDHS staff also provide technical support and information upon request.

WHERE TO FIND THE DATA:

Visit www.cdhs.udel.edu/seow

DATA IS USED TO:

- Promote collaboration
- Assess needs and strengthen funding applications
- Support policy development
- Highlight “success stories” and measure impact
- Identify groups at risk for or experiencing health disparities
2015 Delaware Household Health Survey

Percent

- 44.1% 0 ACEs
- 23.5% 1 ACE
- 18.6% 2-3 ACEs
- 13.8% 4 or more Aces

0 ACEs 1 ACE 2-3 ACEs 4 or more Aces

2015 Delaware Household Health Survey
ACEs in Delaware (Adults)

Percent of Delaware Adults 18 and older who indicated having a dysfunctional household, 2015 (DE Household Health Survey)

- Parental separation/divorce \( (n = 751) \) - 32.6%
- Witnessing maternal/caregiver violence \( (n = 203) \) - 8.7%
- Substance abuse \( (n = 528) \) - 21.1%
- Mental illness \( (n = 274) \) - 12.1%
- Incarceration \( (n = 181) \) - 7.9%

56% of adults had experienced one or more ACES, with nearly 14% experiencing 4 or more.
Adverse Childhood Experiences among children 0-17 years of age in the U.S. and in Delaware, National Survey of Children’s Health, 2016

<table>
<thead>
<tr>
<th>Category</th>
<th>US</th>
<th>Delaware</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unexposed</td>
<td>53.7</td>
<td>51.7</td>
</tr>
<tr>
<td>One adverse childhood experience</td>
<td>24.6</td>
<td>25.7</td>
</tr>
<tr>
<td>Two or more adverse childhood experiences</td>
<td>21.7</td>
<td>22.6</td>
</tr>
</tbody>
</table>
ACEs among Children 0-17 in US and Delaware

- Hard to Cover Basics Like Food or Housing
  - US: 25.5%
  - Delaware: 23.9%

- Child Experienced - Parent or Guardian Divorced
  - US: 25.0%
  - Delaware: 24.9%

- Child Experienced - Parent or Guardian Died
  - US: 3.3%
  - Delaware: 3.4%

- Child Experienced - Parent or Guardian Time in Jail
  - US: 8.2%
  - Delaware: 10.4%

- Child Experienced - Adults Slap, Hit, Kick, Punch Others
  - US: 5.7%
  - Delaware: 6.7%

- Child Experienced - Victim of Violence
  - US: 3.9%
  - Delaware: 5.7%

- Child Experienced - Lived with Mentally Ill
  - US: 7.8%
  - Delaware: 7.4%

- Child Experienced - Lived with Person with Alcohol/Drug Problem
  - US: 9.0%
  - Delaware: 7.9%

- Child Experienced - Treated Unfairly Because of Race
  - US: 3.7%
  - Delaware: 3.4%

Source: National Survey for Children's Health (NSCH), 2016.
*Adverse Childhood Experiences (ACE)
Adverse Childhood Experiences (ACEs) Among Children 0-17 Years of Age in Delaware by Poverty Status, 2016

- Unexposed
- One adverse childhood experience
- Two or more adverse childhood experiences

Source: National Survey of Children's Health (NSCH), 2016
2017 Delaware High School Youth Risk Behavior Survey

- CDC-based survey administered in odd-numbered years on behalf of Division of Public Health
- Sample of 9th, 10th, 11th, 12th classrooms in a census of Delaware public schools
- 2,096 students participated in 2017 YRBS
- Provides an opportunity to see early associations between ACES and early behaviors with potential to impact health and wellbeing
Homelessness:
Where do you typically sleep at night? (%)

Homelessness and past month substance use

<table>
<thead>
<tr>
<th></th>
<th>Past 30 Day Alcohol Use</th>
<th>Past 30 Day Cigarette Use</th>
<th>Past 30 Day Marijuana Use</th>
<th>Past 30 Day Prescription Drug Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless</td>
<td>46</td>
<td>30</td>
<td>54</td>
<td>30</td>
</tr>
<tr>
<td>Not Homeless</td>
<td>28</td>
<td>5</td>
<td>24</td>
<td>5</td>
</tr>
</tbody>
</table>
Homelessness: Where do you typically sleep at night? (%)
Incarceration: In the past year has either your mother or father been incarcerated? (%)

- Past 30 Day Alcohol Use
  - Parent incarcerated in the past year: 40%
  - No parent incarcerated: 28%

- Past 30 Day Marijuana Use
  - Parent incarcerated in the past year: 45%
  - No parent incarcerated: 23%

- Past 30 Day Prescription Drug Use
  - Parent incarcerated in the past year: 45%
  - No parent incarcerated: 5%
Incarceration: In the past year has either your mother or father been incarcerated? (%)

- Depressed for Two Weeks
  - Parent incarcerated in the past year: 50%
  - No parent incarcerated: 23%

- Self-Harm
  - Parent incarcerated in the past year: 25%
  - No parent incarcerated: 13%

- Attempt Suicide
  - Parent incarcerated in the past year: 16%
  - No parent incarcerated: 6%

2017 Delaware High School YRBS
Exposure to violence indicators (%)

Fighting and past month substance use

<table>
<thead>
<tr>
<th></th>
<th>Fight past year</th>
<th>Haven't fought past year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past 30 Day Alcohol Use</td>
<td>47</td>
<td>25</td>
</tr>
<tr>
<td>Past 30 Day Cigarette Use</td>
<td>17</td>
<td>4</td>
</tr>
<tr>
<td>Past 30 Day Marijuana Use</td>
<td>48</td>
<td>19</td>
</tr>
<tr>
<td>Past 30 Day Prescription Drug Use</td>
<td>16</td>
<td>3</td>
</tr>
</tbody>
</table>

2017 Delaware High School YRBS
Exposure to violence indicators (%)

Fighting and mental health

Depressed for Two Weeks
- Fight past year: 39%
- Haven't fought past year: 25%

Self-Harm
- Fight past year: 25%
- Haven't fought past year: 12%

Attempt Suicide
- Fight past year: 15%
- Haven't fought past year: 5%

2017 Delaware High School YRBS
Exposure to violence indicators (%)

Threatened at school and past month substance use

- Past 30 Day Alcohol Use
  - Threatened at School: 50%
  - Have NOT threatened: 28%

- Past 30 Day Cigarette Use
  - Threatened at School: 28%
  - Have NOT threatened: 5%

- Past 30 Day Marijuana Use
  - Threatened at School: 47%
  - Have NOT threatened: 23%

- Past 30 Day Prescription Drug Use
  - Threatened at School: 25%
  - Have NOT threatened: 5%

2017 Delaware High School YRBS
Exposure to violence indicators (%)

Threatened at school and mental health

- Depressed for Two Weeks: 51
- Self-Harm: 36
- Attempt Suicide: 28

- Threatened at school: 26, 13, 5
- Have NOT threatened: 28, 13, 5

2017 Delaware High School YRBS
Exposure to violence indicators (%)

Bullying and past month substance use

<table>
<thead>
<tr>
<th>Substance Use</th>
<th>Have been bullied</th>
<th>Have NOT been bullied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past 30 Day Alcohol Use</td>
<td>38</td>
<td>27</td>
</tr>
<tr>
<td>Past 30 Day Cigarette Use</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>Past 30 Day Marijuana Use</td>
<td>30</td>
<td>23</td>
</tr>
<tr>
<td>Past 30 Day Prescription Drug Use</td>
<td>13</td>
<td>5</td>
</tr>
</tbody>
</table>

2017 Delaware High School YRBS
Exposure to violence indicators (%)

Bullying and mental health

- Depressed for Two Weeks: 55%
  - Have been bullied: 23%
  - Have NOT been bullied: 32%
- Self-Harm: 38%
  - Have been bullied: 10%
  - Have NOT been bullied: 28%
- Attempt Suicide: 20%
  - Have been bullied: 4%
  - Have NOT been bullied: 16%

2017 Delaware High School YRBS
Exposure to violence indicators (%)

Emotional teen dating violence and past month substance use

Past 30 Day Alcohol Use: 44% Experience, 26% Do Not Experience
Past 30 Day Cigarette Use: 15% Experience, 5% Do Not Experience
Past 30 Day Marijuana Use: 37% Experience, 22% Do Not Experience
Past 30 Day Prescription Drug Use: 17% Experience, 4% Do Not Experience

Have experienced Emotional DV
Have NOT experienced Emotional DV

2017 Delaware High School YRBS
Exposure to violence indicators (%)

<table>
<thead>
<tr>
<th></th>
<th>Have experienced Emotional DV</th>
<th>Have NOT experienced Emotional DV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressed for Two Weeks</td>
<td>55</td>
<td>22</td>
</tr>
<tr>
<td>Self-Harm</td>
<td>33</td>
<td>11</td>
</tr>
<tr>
<td>Attempt Suicide</td>
<td>20</td>
<td>4</td>
</tr>
</tbody>
</table>
Exposure to violence indicators (%)

Physical teen dating violence and past month substance use

- Past 30 Day Alcohol Use: 52 (have experienced), 28 (have NOT experienced)
- Past 30 Day Cigarette Use: 24 (have experienced), 5 (have NOT experienced)
- Past 30 Day Marijuana Use: 55 (have experienced), 22 (have NOT experienced)
- Past 30 Day Prescription Drug Use: 30 (have experienced), 4 (have NOT experienced)

2017 Delaware High School YRBS
Exposure to violence indicators (%)

Physical teen dating violence and mental health

- Depressed for Two Weeks: 58% have experienced physical DV, 25% have NOT experienced physical DV
- Self-Harm: 42% have experienced physical DV, 12% have NOT experienced physical DV
- Attempt Suicide: 28% have experienced physical DV, 5% have NOT experienced physical DV

2017 Delaware High School YRBS
Exposure to violence indicators (%)

Sexual teen dating violence and past month substance use

- Past 30 Day Alcohol Use
- Past 30 Day Cigarette Use
- Past 30 Day Marijuana Use
- Past 30 Day Prescription Drug Use

2017 Delaware High School YRBS
Exposure to violence indicators (%)

Sexual teen dating violence and past month substance use

<table>
<thead>
<tr>
<th>Past 30 Day Alcohol Use</th>
<th>Past 30 Day Cigarette Use</th>
<th>Past 30 Day Marijuana Use</th>
<th>Past 30 Day Prescription Drug Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males who experienced sexual DV</td>
<td>Males who have NOT experienced sexual DV</td>
<td>Females who experienced sexual DV</td>
<td>Females who have NOT experienced sexual DV</td>
</tr>
<tr>
<td>53%</td>
<td>47%</td>
<td>43%</td>
<td>59%</td>
</tr>
<tr>
<td>27%</td>
<td>29%</td>
<td>17%</td>
<td>35%</td>
</tr>
<tr>
<td>6%</td>
<td>4%</td>
<td>4%</td>
<td>24%</td>
</tr>
<tr>
<td>5%</td>
<td>4%</td>
<td>3%</td>
<td>5%</td>
</tr>
</tbody>
</table>

2017 Delaware High School YRBS
Exposure to violence indicators (%)

Forced sexual contact (TDV) and past month substance use

Past 30 Day Alcohol Use | Past 30 Day Cigarette Use | Past 30 Day Marijuana Use | Past 30 Day Prescription Drug Use
---|---|---|---
Males who have been forced to have sexual contact | 54 | 40 | 55 | 41
Males who have NOT been forced to have sexual contact | 44 | 19 | 41 | 17
Females who have been forced to have sexual contact | 27 | 6 | 24 | 5
Females who have NOT been forced to have sexual contact | 28 | 4 | 22 | 4
Exposure to violence indicators (%)

Forced sexual contact (TDV) and mental health

- Depressed for Two Weeks
  - Males who have been forced to have sexual contact: 70%
  - Males who have NOT been forced to have sexual contact: 46%
  - Females who have been forced to have sexual contact: 16%
  - Females who have NOT been forced to have sexual contact: 16%

- Self-Harm
  - Males who have been forced to have sexual contact: 50%
  - Males who have NOT been forced to have sexual contact: 43%
  - Females who have been forced to have sexual contact: 7%
  - Females who have NOT been forced to have sexual contact: 7%

- Attempt Suicide
  - Males who have been forced to have sexual contact: 30%
  - Males who have NOT been forced to have sexual contact: 35%
  - Females who have been forced to have sexual contact: 6%
  - Females who have NOT been forced to have sexual contact: 3%

2017 Delaware High School YRBS
## Aggregated Statewide ACEs (%, 2017 Delaware High School YRBS)

<table>
<thead>
<tr>
<th>Location</th>
<th>0 ACE</th>
<th>1 ACE</th>
<th>2 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Statewide</strong></td>
<td>57</td>
<td>23</td>
<td>20</td>
</tr>
<tr>
<td><strong>Males</strong></td>
<td>60</td>
<td>24</td>
<td>16</td>
</tr>
<tr>
<td><strong>Females</strong></td>
<td>54</td>
<td>22</td>
<td>24</td>
</tr>
<tr>
<td><strong>New Castle</strong></td>
<td>57</td>
<td>23</td>
<td>20</td>
</tr>
<tr>
<td><strong>Males</strong></td>
<td>61</td>
<td>24</td>
<td>15</td>
</tr>
<tr>
<td><strong>Females</strong></td>
<td>54</td>
<td>22</td>
<td>24</td>
</tr>
<tr>
<td><strong>Kent</strong></td>
<td>57</td>
<td>23</td>
<td>20</td>
</tr>
<tr>
<td><strong>Males</strong></td>
<td>57</td>
<td>26</td>
<td>17</td>
</tr>
<tr>
<td><strong>Females</strong></td>
<td>56</td>
<td>21</td>
<td>23</td>
</tr>
<tr>
<td><strong>Sussex</strong></td>
<td>55</td>
<td>23</td>
<td>22</td>
</tr>
<tr>
<td><strong>Males</strong></td>
<td>59</td>
<td>22</td>
<td>19</td>
</tr>
<tr>
<td><strong>Females</strong></td>
<td>52</td>
<td>24</td>
<td>25</td>
</tr>
</tbody>
</table>
Aggregated ACES and Substance Use (%)

Past 30 Day Cigarette Use
- 0 ACEs: 3
- 1 ACE: 6
- 2 or more ACEs: 17

Past 30 Day Alcohol Use
- 0 ACEs: 22
- 1 ACE: 33
- 2 or more ACEs: 45

Past 30 Day Marijuana Use
- 0 ACEs: 15
- 1 ACE: 31
- 2 or more ACEs: 43

Past 30 Day Prescription Drug Use
- 0 ACEs: 2
- 1 ACE: 4
- 2 or more ACEs: 17

2017 Delaware High School YRBS
Aggregated ACEs and Mental Health (%)

Aggregated ACEs and mental health

<table>
<thead>
<tr>
<th></th>
<th>0 ACEs</th>
<th>1 ACE</th>
<th>2 or more ACEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressed for Two Weeks</td>
<td>15</td>
<td>6</td>
<td>54</td>
</tr>
<tr>
<td>Self-Harm</td>
<td>33</td>
<td>15</td>
<td>35</td>
</tr>
<tr>
<td>Attempt Suicide</td>
<td>2</td>
<td>6</td>
<td>20</td>
</tr>
</tbody>
</table>

2017 Delaware High School YRBS
### Intergenerational Trauma

#### Maternal Risk Indicators for Substance Exposed Births (n = 450)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division of Family Services (DFS) history as a child</td>
<td>177 (40%)</td>
</tr>
<tr>
<td>Mental health conditions</td>
<td>154 (34%)</td>
</tr>
<tr>
<td>Prior birth of substance-exposed infant</td>
<td>126 (28%)</td>
</tr>
</tbody>
</table>

- Overlaps between all three indicators
  - 38% of mothers with DFS history as a child also have a mental health condition/diagnosis
  - 33% of mothers with a mental health condition/diagnosis also have a previous birth of a substance-exposed infant

Delaware Office of the Child Advocate, 2018

National Survey of Children’s Health (2016) with additional analysis by Kahleel Husseini, CDC, Delaware Division of Public Health, 2017-2018

Delaware Youth Risk Behavior Survey (2017). Centers for Disease Control and Prevention (Administered by the Center for Drug and Health Studies, University of Delaware)

Questions?
WHY TRAUMA INFORMED CARE?

Aileen Fink, Ph.D.
Behavioral Health Director, BCHS
Department of Correction
aileen.fink@state.de.us
WHY BE TRAUMA INFORMED?

• What have you heard so far that would suggest the need for a trauma focus when providing services?
  – Trauma exposure is pervasive
  – Has the potential to impact health and wellbeing across the lifespan

• Why else?
  – Healing occurs within the context of relationships
  – Trauma affects how people approach services designed to help them
  – Services designed to help people can be and often have been inadvertently re-traumatizing

  – *Trauma informed care helps promote healing and recovery*
WHAT IS TRAUMA INFORMED CARE?

• A trauma informed care approach....
  – Is not a service, set of practices or a specific program
  – Is different from trauma specific treatment
  – Involves a shift in knowledge, attitudes and skills
TRAUMA INFORMED CARE

• Trauma informed care approach
  – starts by asking “what has happened to this person” rather than “what is wrong with this person
  – helps systems effectively respond to trauma-exposed consumers and staff
  – provides a framework for developing the skills of staff
TRAUMA INFORMED CARE (TIC)

• The “4 R’s” of a trauma informed approach
  – *Realizes* the widespread prevalence and 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
  – *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices
  – Seeks to actively resist *re-traumatization*
TIC: THE 4 R’s

• **Realizing** the prevalence of trauma
  – All staff have basic understanding of trauma and **realize** the prevalence of trauma in the populations they serve
  – Assumes service recipients have had/are being exposed to events (ACES) and recognize importance of screening children and adults
  – Realizes that staff may have been/are being exposed
TIC: THE 4 R’s

• **Recognizing**
  – how trauma affects individuals, families and communities
    • Staff are able to recognize the signs of trauma in people receiving services as well as for themselves and their coworkers
    • Views behavior as adaptive for survival
  – the impact of organizational and workplace stress
  – triggers
TIC:THE 4 R’s

• **Responding** by
  
  – applying trauma informed care principles into the organization at all levels
  
  – Emphasis on building resilience and protective factors
  
  – Being knowledgeable about trauma-specific interventions
TRAUMA INFORMED APPROACH: THE 4 R’s

• Actively avoiding Re-traumatizing service recipients as well as staff
  – We need to guard against exposing individuals to experiences that are traumatic or can re-traumatize them
TRAUMA INFORMED (TIC) PRINCIPLES

• Safety
• Trustworthiness and Transparency
• Peer Support
• Collaboration and Mutuality
• Empowerment, Voice and Choice
• Cultural, Historical, and Gender Issues

– Principles are applicable across service settings, service recipients and the staff providing services
TIC PRINCIPLES

• Safety
  – Staff and service recipients feel physically and emotionally safe
    • The physical setting is safe and inviting
    • Strategies are developed to address aspects of the environment that may be re-traumatizing
  – Interpersonal interactions promote a sense of safety
  – Staff and service recipients are asked about the degree to which they feel safe and how safety can be enhanced
TIC PRINCIPLES

- **Trustworthiness and Transparency**
  - Priority is placed on building and maintaining trust with service recipients, among staff and other partners
  - Operations and decisions are transparent for staff and service recipients
  - Staff keep service recipients fully informed of rules, procedures, etc. while recognizing they may be overwhelmed and have difficulty processing information
  - The potential impact of working with individuals with trauma exposure is acknowledged
TIC PRINCIPLES

• Collaboration and Mutuality
  – Priority on leveling power differences between staff and service recipients and across staff at different levels
  – Service recipients and staff share power in decision making
  – Relationship is valued as an important source of healing
  – Recognizes that everyone in the organization has a role in a trauma informed approach
TIC PRINCIPLES

• Empowerment, Voice and Choice
  – Strengths and experiences of service recipients are recognized and built upon
  – Belief in the ability of people to be resilient
  – Promotes the development of advocacy skills for service recipients
  – Empowers service recipients to have shared decision making
  – Empowers staff to do their work
TIC PRINCIPLES

• Cultural, Historical and Gender Issues
  – Address cultural stereotypes and biases
  – Recognizes the ways that culture influence the experience of trauma and access to supports and resources
  – Ensures that services that are responsive to cultural and gender needs
  – Recognizes and address historical trauma
  – Values traditional cultural connections
TIC PRINCIPLES

• Peer Support
  – Recognizes the value of those with lived experience including family members to promote healing
  – Provides meaningful involvement in planning, policy making and governance for individuals with lived experience
  – Develops peer support services and resources for service recipients
TRAUMA INFORMED CARE IN PRACTICE

https://www.youtube.com/watch?v=wGlG0bZwoL0
NATIONAL EFFORTS

• 2000 Children’s Health Act
  – Established the National Child Traumatic Stress Network

• 2005 SAMHSA
  – Established the National Center for Trauma Informed Care

• 2017 Trauma Informed Care for Children and Families Act
  – Interagency Task Force on Trauma Informed Care, Medicaid demonstration projects to test innovative trauma informed approaches, CDC encourage states to collect and report ACE data
A LOCAL TIC EXAMPLE

https://www.youtube.com/watch?v=11fXsgPPrGo
TRAUMA INFORMED OREGON TIC ROADMAP

ROADMAP TO TRAUMA INFORMED CARE

- Recognition & Awareness
- Foundational Knowledge
- Agency Readiness
- Process & Infrastructure

AGENCY WIDE COMMUNICATION | ONGOING EDUCATION & TRAINING

IMPLEMENTATION PHASE » Repeat

FOUNDATIONAL READINESS PHASE

Gather Information
Prioritize & Create Plan
Implement & Monitor
Adopt Policy & Practice
TRAUMA INFORMED CARE: DELAWARE

• Family Services Cabinet Council ACEs Committee
  – Working to promote TIC state agencies

• Collection, analysis and dissemination of ACE data
  – 2015 Delaware Household Health Survey included 12 ACE items

• Trauma Matters Delaware
  – Community of diverse stakeholders across the state promoting trauma informed approaches

• Universities incorporating ACE curriculum
  – Wilmington University Certificate in Trauma Informed Approaches
TRAUMA INFORMED CARE: DELAWARE

• Efforts to expand screening and trauma specific treatment for children and adults and adopt trauma informed approaches
  – Public Health, Children’s Department, Corrections, Substance Abuse and Mental Health
  – Organizations including DCADV adopting and promoting trauma informed approaches (Sanctuary, Seeking Safety, SAMHSA Guidance, trauma treatment)

• Compassionate Schools Network
  – School districts are working to implement a trauma informed schools approach with support from Casey Family Programs
RESOURCES

• SAMHSA Concept of Trauma and Guidance for a Trauma Informed Approach
  https://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf

• Creating Trauma Informed Systems (National Child Traumatic Stress Network)
  https://www.nctsn.org/trauma-informed-care/creating-trauma-informed-systems

• Trauma Informed Care Project
  http://www.traumainformedcareproject.org/

• University of Buffalo Institute on Trauma and Trauma Informed Care
  https://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/what-is-trauma-informed-care.html
Resilience and Trauma
Why it Matters

Marilyn Siebold, Professor of Psychology, Wilmington University
marilyn.r.siebold@wilmu.edu
What is resilience?

What do we know about resiliency?

Why does it matter?

WHAT NOW?
KEEP
CALM
AND
BE
RESILIENT
"He appears to have lost all of his resilience."
The greatest glory in living lies not in never falling, but in rising every time we fall.

- Nelson Mandela
Why does resilience matter?

Resilience reduces our stress levels.
Resilience helps us to maintain social and working relationships with others.
Understanding your own emotional resilience puts you in a stronger position to identify with (empathy) and understand others.
Resilience enables us to tolerate differences, be more curious and to be able to appreciate other’s stand point – all crucial elements in life.
Do you know resilience when you see it?

- Optimism
  - Focus on your strengths

- Ability to problem solve
  - Willing to adapt/be flexible

- Self-belief
  - Confident & have high self-esteem

- Sense of humour
  - Can laugh at life's frustrations

- Emotional Awareness
  - Key to good communication

- Control (of self)
  - Your response to circumstances/organisational ability

- Social support
  - Network of friends or family
Four Patterns of Resilience:

– Dispositional - one having a sense of autonomy, self-worth, good health, etc.

– Relational - one's role in society and in their relationships

– Situational - one's ability to problem solve, make goals, and take action

– Philosophical - one's belief that there is good in all situations and that self-development is important
“In the context of exposure to significant adversity, resilience is both the capacity of individuals to navigate their way to the psychological, social, cultural, and physical resources that sustain their well-being, and their capacity individually and collectively to negotiate for these resources to be provided in culturally meaningful ways.”

Dr. Michael Unger

- Canada Research Chair in Child, Family and Community Resilience and Professor of Social Work at Dalhousie University.
Resilience is more than merely “bouncing back.” Being a resilient person, community or society is more than just being able to bounce back from adversity.

- **Resilience Requires Evolution**
  Resilience thinking can help when confronted with a major disturbance to the system. When adapting to adversity, people, families, businesses and communities can learn coping skills and make creative use of available resources.

- **Resilience is Context Based**
  Resilience depends on point of view. For example, after a deployment the warrior, spouse, children, unit and community all define differently the successful reintroduction into home life.

- **The Environment Matters**
  Resilience is a two-way street: resilience thinking should not fall on our warfighters alone. Society must accommodate those who serve. The same is the case for survivors of natural disasters who need assistance in the face of recovery. It’s essential that the community open its eyes and arms to support those affected.

- **Resilience is Being Prepared**
  Resilience thinking includes learning from prior experiences, anticipating future needs and actively preparing. Specific personal and community systems’ planning can prevent or mitigate some calamity.

- **Resilience Requires Transformation**
  When returning to normal is impossible, we must move forward. People, families, businesses, and communities struggle and grow to adapt in face of adversity and adopt a “new normal.”
What is Resilience?

Is resilience a trait, a skill, or a process?

Does everyone have the capacity for resilience?

Can resilience be learned? If so, what are the learnable skills of resilience?

Can you teach others to be resilient?

• https://video.search.yahoo.com/yhs/search?fr=sgm&hsimp=yhs-sgm_fb&hspart=SGMedia&p=what+is+resilience#id=5&vid=a28c8875155a5f3cf4ff16ff19e86f1&action=view.
The Main Ingredients of Resilience
Dr Karen Reivich
Co-author of The Optimistic Child, with Professor Martin Seligman, and co-author of the Resilience Factor

- **Emotional regulation** – identifying and, if necessary, controlling your feelings.
- **Impulse control** – tolerating ambiguity so you don’t rush to make decisions; thinking before acting.
- **Optimism** – being realistically optimistic in a way that facilitates problem solving.
- **Causal analysis** – thinking about the problems you face, looking at them from other perspectives and considering other associated factors.
- **Empathy** – reading and understanding others’ emotions, which helps to build relationships and garner social support.
- **Self-efficacy** – having confidence in your ability to solve problems, knowing your strengths and weaknesses and relying on your strengths to cope.
- **Reaching out** - being prepared to take appropriate risk, being willing to try new things and thinking of failure as part of life.

*Look at the list above and think - which is your strongest skill, and which could use some improvement?*
Resilience begins with beliefs.
Resilience is a process, not a trait.
Everyone, regardless of age or circumstances, has the capacity for resilience.
The three major protective factors that help us mitigate adversity and nourish personal strength are caring relationships, high expectations, and opportunities to participate and contribute.
Resilience isn’t just for people from high-risk environments.
Most people make it despite exposure to severe risk. Close to 70 percent of youth from high-risk environments overcome adversity and achieve good outcomes.
Resilience isn’t a program or curriculum.
Resilient people identify themselves as survivors rather than victims.
Resilience is not just for remediation or intervention.
One person’s support can be crucial in developing another’s resilience.
Challenging life experiences can be opportunities for growth and change.
Resilience is not just for remediation or intervention. It incorporates a shift from a problem based deficit model to a strengths based one. This model of resilience is positive, protective, and preventive.
Research has identified a set of protective and risk **factors** that help children achieve positive outcomes in the face of significant adversity.

https://developingchild.harvard.edu/science/key-concepts/resilience/

Protective Factors include:
• providing supportive adult-child relationships;
• scaffolding learning so the child builds a sense of self-efficacy and control;
• helping strengthen adaptive skills and self-regulatory capacities;
• using faith and cultural traditions as a foundation for hope and stability.
The Science of Resilience

- One way to understand the development of resilience is to picture a balance scale or seesaw. Protective experiences and adaptive skills on one side counterbalance significant adversity on the other.

- [https://developingchild.harvard.edu/resources/inbrief-resilience-series/](https://developingchild.harvard.edu/resources/inbrief-resilience-series/)
Resilience in the Community

- https://video.search.yahoo.com/yhs/search?fr=sgm&hsimp=yhs-sgm_fb&hspart=SGMedia&p=what+is+resilience#id=1&vid=83f3621449fcad1dd5f5ac8f6185e2f9&action.
- https://developingchild.harvard.edu/resources/resilience-game/
- https://youtu.be/tMaBi-SVPjo
The Resiliency Wheel

- Set and Communicate High Expectations
- Provide Opportunities for Meaningful Participation
- Set Clear, Consistent Boundaries
- Increase Prosocial Bonding
- Teach "Life Skills"
- Provide Caring & Support
Research has identified a common set of factors that predispose children to positive outcomes in the face of significant adversity.

These counterbalancing factors include:

• facilitating supportive adult-child relationships;
• building a sense of self-efficacy and perceived control;
• providing opportunities to strengthen adaptive skills and self-regulatory capacities; and
• mobilizing sources of faith, hope, and cultural traditions.
1. Resilience requires supportive relationships and opportunities for skill building.

2. Resilience results from a dynamic interaction between internal predispositions and external experiences.

3. Learning to cope with manageable threats to our physical and social well-being is critical for the development of resilience.

4. Some children respond in more extreme ways to both negative and positive experiences.

5. Individuals never completely lose their ability to improve their coping skills, and they often learn how to adapt to new challenges.

https://developingchild.harvard.edu/.
NOW WHAT?

From Resiliency In Action: Practical Ideas for Overcoming Risks and Building Strengths in Youth, Families, and Communities, published by Resiliency In Action. Copyright 2007 Resiliency In Action, Inc., all rights reserved.)

Nan Henderson, M.S.W.

Four basic characteristics of resiliency building that add the power of “protective factors” to people’s lives.

2. Adopt a “Strengths Perspective.”
3. Surround Each Person—as well as Families and Organizations—with all elements of “The Resiliency Wheel.”
4. Give It Time.
When asked ‘Why Resilience was important to them’:

- 85% stated it enabled them to cope with difficulties.
- 61% said it enhanced their performance.
- 56% felt it encouraged good leadership.
- 31% said it helped them remain competitive with others.
- 21% stating it had a good impact on profitability.

Karen Griffin
Space2BE
T: 0207 6663 070
E: karen@space2be.co

Julie Hurst
Work Life Balance Centre
T: 01530 273056
E: jhurst@worklifebalancecentre.org
WHY DOES RESILIENCE MATTER AT WORK?

• Resilience reduces our stress levels.
• Resilience helps us to maintain social and working relationships with others.
• Understanding your own emotional resilience puts you in a stronger position to identify with (empathy) and understand the families that you work with.
• Resilience enables us to tolerate difference, be more curious and to be able to appreciate other’s stand point – all crucial elements in social work.
• More resilient workers have improved relationships with service users, thus enhancing their professional practice and ultimately, improving outcomes.
Your Turn...

Breaking Down the Barriers to Trauma Informed Approaches
Moving Forward...

Brainstorming:
Taking a Step Towards Trauma Informed Approaches in Your Setting
Questions?
Thank You!