



Standards of Practice for Trauma Informed Care: Definitions and Additional Resources

Definitions and additional guidance for some of the individual [Standards of Practice for Trauma Informed Care](#) appear below. Note that the number (e.g., b. or c.) refers to the specific Standard and that not all of the Standards are represented in this document.

Most of the resources mentioned are attached in the Appendix at the end of this document, however, they have also been hyperlinked so that you can find them on the TIO website. Additional resources that have not been attached in the Appendix can be found on the TIO website on the Additional Resources for the Standards of Practice webpage: <https://traumainformedoregon.org/standards-practice-trauma-informed-care/resources/>

I. Agency Commitment and Endorsement

b. Agency policies

As commitment to trauma informed care (TIC) continues to grow, provider organizations and agencies across multiple systems are beginning to create or adopt policies to shape practice. [Clackamas Behavioral Health Care Trauma-Informed Services Policy](#) is a good example of one such policy.

c. Decision-making roles for individuals with lived experience

*Many of us have “lived experience” of adversity or trauma. What is meant here, however, is that provider systems are beginning to invite and include trauma survivors in leadership roles in their organizations who have **sought or received services from the organization or system** (e.g., mental health or addictions). It is the “lived experience” in the service system that can bring a new and important perspective to assessment, planning, and accountability.*

d. Feedback and suggestions from employees and service recipients.

Many organizations already have client or staff satisfaction surveys in place. These surveys can be modified to include questions directly related to trauma informed care. The [Clackamas County Behavioral Health Clinics Adult Consumer Services Survey](#) is an example of a feedback survey that includes trauma informed care questions. Keep in mind that it is critical, however, to provide information back to clients or staff about the results and what the organization is doing to address key concerns that emerge.

g. Workforce wellness.

Agencies attend to workforce wellness in a variety of ways, from creating a culture where appreciation is a regular part of staff or team meetings, to offering flexible scheduling for employees or the opportunity to work from home, to requiring employees to take earned vacation time, to including self-care plans as a regular part of supervision, to providing on-site wellness opportunities or discounted memberships for health and wellness programs in the community. Find more resources about workforce wellness on the Additional Resources webpage by clicking on the [Workforce Wellness](#) category heading above the resource grid. TIO’s TIP Sheet, [A Trauma Informed Workforce: An Introduction to Workforce Wellness](#), is a good place to start.

II. Environment and Safety

a., b. Physical environment review

Many aspects of the physical environment can affect staff as well as individuals seeking or using services if they have histories of trauma or adversity. Some aspects of the setting may make it difficult or impossible for individuals to enter, engage, or focus their attention. It's often not possible to know exactly what might have a negative effect on an individual without paying attention, noticing discomfort, and asking about it. However, sample scans for potential environmental triggers (or ways to make the environment more welcoming) are included in agency assessment tools found on the Additional Resources webpage by clicking on the [Scanning the Physical Environment](#) category heading above the resource grid.

c. Safe space

When an individual experiences an acute stressor, whether it is personal or the result of a circumstance or an encounter at work, it can be helpful to have a quiet place to go—either to regroup alone, to debrief with a colleague or supervisor, or to release stress hormones through physical activity. Organizations may or may not have the resources to set aside a permanent “safe space” (a breakroom is not private enough) but it may be possible to designate an office that can be made available for this purpose when needed. This requires commitment and creativity on the part of staff—and dissemination of information about what is available and under what circumstances.

d. Physical safety and crisis protocols

It is important when developing crisis protocols or incident response plans that organizations identify not only what to do within the first hours of an incident but what needs to be done days and months later. Plans are more effective if they are developed by staff with different roles in the organization. Plans need to be part of orientation but also practiced and updated regularly. Some considerations for creating a crisis protocol can be found on the TIO TIP Sheet [Considerations for Responding to Crisis](#).

III. Workforce Development

c. Organizational training capacity

Organizations and systems that are committed to TIC will want to think about how to sustain momentum over time—not only to meet the needs of new staff that are coming on board but also to deepen understanding and expertise among the champions. We strongly encourage adapting training materials from TIO or from other sources and creating ongoing training programs that are not dependent on outside resources.

e., g. Hiring and onboarding practices

One of the key areas where organizations can begin to shift the culture to be more responsive to the impact of trauma is through human resources policies and procedures, starting with hiring and onboarding. Specific suggestions and considerations can be found on the TIO TIP Sheet [Human Resources Practices to Support TIC](#). Additional resources can be found on the Additional Resources webpage by clicking on the [Human Resource Practices](#) category heading above the resource grid.

h., i., j., k., m. Supervision and support

One of the key areas where organizations can begin to shift the culture to be more responsive to the impact of trauma is through human resources policies and procedures, including supervision and performance reviews. Specific suggestions and examples of how organizations are incorporating TIC in supervision can be found on the TIO TIP Sheet [Human Resources Practices to Support TIC](#). Additional resources can be found on the Additional Resources webpage by clicking on the [Human Resource Practices](#) category heading above the resource grid.

IV. Services and Service Delivery

b. Staff skill in talking about trauma

It can be helpful to acknowledge out loud that individuals seeking or entering services at your agency are likely to have had trauma or adversity in their lives. This can help make a person feel safer in your office and more likely to engage. It is important for all staff to be able to talk about trauma in a way that feels comfortable for them and for the person they are talking with. It is also important that staff help each other reframe challenging behaviors through a trauma lens. Sample trauma education statements can be found in the TIO [Trauma Lens Exercise](#) resource.

d. Intake forms

It's often the case that agency intake forms or documentation requirements were written in the distant past and have never been reviewed or updated. Some questions may be unnecessary and could be triggering for individuals with a trauma history. Often they can be eliminated. In other cases, the wording or timing of questions can be changed to be less intrusive or more respectful. When difficult questions are necessary, staff can sometimes make it easier by providing context or preparing the individual for what is coming.

i. Trauma specific services

Trauma Specific Services (TSS) are programs, interventions, and therapeutic services specifically aimed at treating the symptoms or conditions resulting from a traumatizing event(s). See the tip sheet [Trauma Specific Services: A Resource for Implementation and Use](#) for guidance on how to select appropriate trauma specific services.

V. Systems Change and Progress Monitoring

a. Structure for systems change

See the [Road Map to Trauma Informed Care](#) and the Considerations pages associated with the Gather Information, Prioritize & Create Work Plan, and Implement & Monitor steps.

b. Agency self-assessment

Agency self-assessment can help identify specific areas to focus on. This can occur in a number of different ways. Existing protocols can be helpful in organizing the process and some examples can be found on the Additional Resources webpage by clicking on the [Assessment & Strategic Planning](#) category heading above the resource grid. Some are extremely detailed; others, like the Standards of

Practice, provide an overview of areas of strength and challenge. Self-assessment can also be organized around the principles of TIC or based on specific issues identified by staff or clients.

d. Agency policy review

Organizations that are implementing TIC will need to review existing policies to determine if they are compatible with TIC principles. Organizations may need to modify existing policies or adopt new policies to support a culture that promotes empowerment, safety, transparency, and self-worth. Sample questions to use in the review of existing or new policies can be found in the TIO [Guide to Existing Policies](#) resource.

e. Communication and dissemination

Implementing TIC requires sustained momentum across the entire organization. One way to work on this is by keeping the entire community (staff, leadership, service recipients when possible) informed about and able to give input on priorities and plans. Dissemination of TIC efforts can also be enhanced by ongoing education and concrete ideas about how to apply the principles of TIC. Some organizations have created monthly or quarterly emailed newsletters to sustain interest and momentum. Examples can be found in the [Trauma Informed Care Newsletters](#) compilation compiled by TIO.

APPENDIX

I. Agency Commitment and Endorsement

- b. Clackamas County Behavioral Health Division (CCBHD) Trauma-Informed Services Policy
- d. Clackamas County Behavioral Health Clinics Adult Consumer Services Survey
- g. A Trauma Informed Workforce: An Introduction to Workforce Wellness

II. Environment and Safety

- d. Considerations for Responding to Crisis (needs to be updated on page 8)

III. Workforce Development

- e., g., h., i., j., k., m. Human Resources Practices to Support TIC

IV. Services and Service Delivery

- b. Trauma Lens Exercise
- i. Trauma Specific Services: A resource for implementation and use

V. Systems Change and Progress Monitoring

- a. Gather Information, Prioritize & Create Work Plan, Implement & Monitor steps on the Roadmap to Trauma Informed Care
- d. Guide to Reviewing Existing Policies
- e. Sample TIC Newsletters

Additional resources not included here can be found on the TIO website on the Additional Resources for the Standards of Practice webpage:

<https://traumainformedoregon.org/standards-practice-trauma-informed-care/resources/>



HEALTH CENTERS - BEHAVIORAL HEALTH

TITLE: Clackamas County Behavioral Health Division (CCBHD): Trauma-Informed Services

Version #: 2

Originally Implemented:
10/08/2011
Revised: 07/28/2014

PURPOSE/SCOPE:

The purpose of the Trauma Informed Services Policy is to:

- Promote resiliency, health and wellness for those who have experienced trauma;
- Create a standard of care to address the impact of trauma;
- Establish practices to provide treatment in a trauma informed manner;
- Provide effective and appropriate services for individuals who have experienced trauma;
- Mitigate vicarious traumatization of treatment providers and others working with traumatized individuals

DEFINITIONS:

Trauma: Trauma is the unique individual experience of an event or enduring conditions in which a person's ability to integrate his/her emotional experience is overwhelmed. The person experiences, either objectively or subjectively, a threat to his or her psychological safety, bodily integrity, life or the safety of a caregiver or family member.

Trauma Informed Care: A program, organization, or system that is trauma informed realizes the widespread impact of trauma and understands potential paths for healing; recognizes the signs and symptoms of trauma in staff, clients, and others involved in the system, and responds by fully integrating knowledge about trauma into policies, procedures, practices and settings(SAMHSA, 2014).

Trauma Specific Services: A treatment service intended to reduce trauma symptoms experienced by survivors. Trauma services should be individualized; evidence based, promising or best practices. They services should be provided in a collaborative, person-centered process.

Vicarious Traumatization: Vicarious trauma is a stress reaction that may be experienced by professionals and peer support specialists who are exposed to disclosures of traumatic images and events by those seeking help. The symptoms of vicarious trauma are similar to, but usually not as severe as those of posttraumatic stress disorder, and can affect the lives and careers of even those with considerable training and experience in working with individuals who have experienced trauma.



HEALTH CENTERS - BEHAVIORAL HEALTH

TITLE: Clackamas County Behavioral Health Division (CCBHD): Trauma-Informed Services

POLICY/GUIDING PRINCIPLES:

Trauma sensitivity shall be a governing principle of Clackamas Behavioral Health Centers. Our services will be designed to meet the needs of individuals who have experienced trauma by establishing an environment that creates a safe context, restores power, and values the individual:

1. CHC-BH recognizes that the majority of individuals seeking services and/or currently involved in services have a one point in their lives experienced trauma. Trauma informed care must be applied universally to every individual.
2. CHC-BH will identify and screen for individuals who have experienced trauma at intake. An appropriate assessment of trauma exposure, history and symptoms will be completed and individuals will be connected to trauma specific services that help to address and individual's desired outcome.
3. CHC-BH will provide education and training to all staff members on:
 - a. The potential effects and impact of trauma on individuals, families, groups, organizations, therapeutic relationships, and employee well-being.
 - b. Personal and professional boundaries and on understanding the signs of trauma and behaviors of individuals with a history of trauma.
 - c. The promotion of a clinic environment that is both trauma-informed and trauma sensitive.
4. CHC-BH will provide trauma informed supervision, education, and training for employees to prevent employees from experiencing compassion fatigue and/or vicarious traumatization.
5. CHC-BH will provide clear and specific services to individuals. Individuals receiving services must be informed of their rights, who they will be working with, what goals they wish to achieve, and the expectations of their participation. Boundaries should be made clear and be consistent in order to achieve trustworthiness.
6. CHC-BH will focus on individual choice as a way to maximize autonomy and empowerment. Individuals should have a right to choose the services they receive. Recovery is achieved by giving individuals control in making their own decisions and choosing goals that are relevant to their progress.
7. CHC-BH will increase collaboration and shared power between the individual and the service provider. Individuals will have a role in evaluating the agency's services. Individuals will be present in service planning, goal setting and in all other facets of treatment. Individuals will be seen as the expert on his or her recovery.



HEALTH CENTERS - BEHAVIORAL HEALTH

TITLE: Clackamas County Behavioral Health Division (CCBHD): Trauma-Informed Services

8. CHC-BH will empower individuals and teach skill building as an integral part of the services being provided. There should be an emphasis on individual growth and a focus on individual strength.

RELATED LINKS/RULES:

[OR Dept. of Human Services Addictions & Mental Health Division Trauma Policy](#)

<http://www.samhsa.gov/traumajustice/traumadefinition/approach.aspx>

Approved by: Tracy Garell, Behavioral Health Centers Manager
7/28/14



Clackamas County Behavioral Health Clinics Adult Consumer Services Survey – October 2015

Please help our agency make services better by answering some questions about the services you received OVER THE LAST 6 MONTHS. Your answers are confidential and will not influence the services you receive. Please indicate if you **Strongly Disagree**, **Disagree**, are **Undecided**, **Agree**, or **Strongly Agree** with each of the statements below. Put a cross (X) in the box that best describes your answer. **Your honest answers will not negatively affect your services.** Thank you!

| | Strongly Disagree | Disagree | Undecided | Agree | Strongly Agree | Does Not Apply |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|----------|-----------|-------|----------------|----------------|
| 1. I like the services that I received here. | | | | | | |
| 2. If I had other choices, I would still go to Clackamas County Behavioral Health Clinic. | | | | | | |
| 3. I would recommend this Clinic to a friend or family member. | | | | | | |
| 4. When I come to the Clinic, I feel physically safe. | | | | | | |
| 5. When I work with Clinic staff, I feel emotionally safe. | | | | | | |
| 6. I feel comfortable talking to Clinic staff about personal issues. | | | | | | |
| 7. I trust that Clinic staff will do what they say they are going to do, when they say they are going to do it. | | | | | | |
| 8. The people who work at the Clinic act in a respectful and professional way toward me. | | | | | | |
| 9. The Clinic offers me a lot of choices about the services I receive. | | | | | | |
| 10. I have a great deal of control over the kinds of services I receive, including when, where, and by whom the services are offered. | | | | | | |
| 11. Clinic staff members are willing to work with me (rather than doing things for me or to me). | | | | | | |
| 12. When decisions about my services or recovery plan are made, I feel like I am a partner with the staff, that they really listen to what I want to accomplish. | | | | | | |
| 13. Clinic staff recognize that I have strengths and skills, as well as challenges and difficulties. | | | | | | |
| 14. Clinic staff help me learn new skills that are helpful in reaching my goals. | | | | | | |
| 15. I understand when information about me will be kept private or when it will be shared. | | | | | | |
| 16. The staff are as sensitive as possible when they ask me about difficult or frightening experiences I may have had. | | | | | | |
| 17. I feel safe talking with staff about my experiences with violence, abuse or past traumas. | | | | | | |

FOR OFFICE USE ONLY

Location HILLTOP STEWART SANDY WICHITA OFFSITE Unit _____

Please complete other side → → →

As a direct result of services I am receiving:

| | Strongly Disagree | Disagree | Undecided | Agree | Strongly Agree | Does Not Apply |
|-----------------------------------------------------------|-------------------|----------|-----------|-------|----------------|----------------|
| 18. I deal more effectively with daily problems. | | | | | | |
| 19. I am better able to handle things when they go wrong. | | | | | | |
| 20. I am getting along better with my family | | | | | | |
| 21. I do better in social situations. | | | | | | |
| 22. I do better in school and/or work. | | | | | | |

For questions 23-26 please answer for relationships with people other than your provider(s)

| | | | | | | |
|--------------------------------------------------------------------------|--|--|--|--|--|--|
| 23. I am happy with the friendships I have. | | | | | | |
| 24. I have people with whom I can do enjoyable things. | | | | | | |
| 25. I feel I belong in my community. | | | | | | |
| 26. In a crisis, I would have the support I need from family or friends. | | | | | | |

27. What has been the most helpful thing about the services you received over the last 6 months?

28. What would improve services here?

29. How long have you been receiving services here?

- 0-3 months
 3-6 months
 6-12 months
 More than a year

Race/Ethnicity (please select as many as apply):

- Asian
 Black (African American)
 Latino/Hispanic
 Native American
 Native Hawaiian or Other Pacific Islander
 White (Caucasian)
 Other (please describe): _____

Gender: Male Female Transgender Prefer not to answer



A Trauma Informed Workforce:

An introduction to workforce wellness

Purpose. This document provides foundational information about workforce wellness. It is intended for those who are beginning to consider ways to address workforce wellness in their programs and organization by providing background and definitions.

Background. Working with survivors of trauma can be extremely rewarding, but can also be challenging. Without direct attention to the needs of care providers, providing services to trauma survivors can increase the risk for burnout, vicarious trauma, and secondary traumatic stress. External factors and stressors, as well as workers' personal trauma histories can add to the risk.

Whether or not someone has a history of trauma, bearing witness to human suffering and adversity can be deeply impactful. Reactivity related to unresolved trauma among workers and those they serve can make working conditions more difficult and can undermine health and safety. Providing effective and sensitive care to survivors (trauma-informed care), requires an emotionally healthy, competent, and well supported workforce.

Definitions. The terms burnout, secondary traumatic stress, vicarious trauma, and compassion stress or fatigue are often used interchangeably. There are, however, important distinctions to consider when developing resources. It is important when addressing workforce wellness that organizations identify what resources and strategies the organization will provide. Workforce wellness strategies need to not only address the importance of self-care but identify how the organization will work to reduce stress, address vicarious trauma, and support self-care activities. For example, for an employee who is experiencing secondary traumatic stress, the organization would make trauma specific services available (e.g. counseling, EMDR). In addition to providing access to services organizations will likely need to accommodate employees' schedules.

Burnout: The term "burnout" has been applied across helping professions and refers to the cumulative psychological strain of working with many different stressors. It often manifests as a gradual wearing down over time.

Vicarious Trauma: Vicarious traumatization is the cumulative effect of working with survivors of trauma and includes cognitive changes resulting from empathic engagement and a change to your worldview.

Secondary Traumatic Stress: The term "Secondary Traumatic Stress" is used to describe professional workers' subclinical or clinical signs and symptoms of PTSD that mirror those experienced by trauma clients, friends, or family members. While it is not recognized by current psychiatric standards as a clinical disorder, many clinicians note that those who witness traumatic stress in others may develop symptoms similar to or associated with PTSD.

Compassion Stress: Compassion stress characterizes the stress of helping or wanting to help a trauma survivor. Compassion stress is seen as a *natural outcome* of knowing about trauma experienced by a client, friend, or family member, rather than a pathological process.

Protective Factors. There are personal and organization strategies that mitigate the impact of working with survivors of trauma and adversity. Below are a few to consider:

- **Team spirit.** Feeling part of a team (per program, department, entire agency) and having social support on the job can buffer workplace stress.
- **Seeing change as a result of your work.** Having tangible evidence that their work is important and helpful.
- **Training.** Feeling competent to apply a trauma informed approach, as a result of effective training and education.
- **Supervision.** Receiving regular and predictable supervision as a way to prevent, monitor, and respond to stress.
- **Balanced caseload.** Having a diversified caseload based on the topics, intensity, length of service and balance between challenging and successful cases.
- **Stress Inoculation Training.** Practicing response to stressful situations in order to have the skills needed to regulate a stress response.

Ideas for Workforce Wellness

- Space for self care
- Staff shout outs or thank you cards
- Wellness plans
- Supervision
- Employee Assistance Programs (EAP)
- Workplace wellness rituals (Friday walks, Thursday lunches).

Risk Factors. The following factors are related to workforce stress and vicarious trauma.

- **Personal trauma history.** An employee's past history with adversity can mitigate or create challenges to doing this work. Employees who are aware of their history and have developed helpful coping skills are able to easily relate and support survivors.
- **Type of story.** The type of trauma stories an employee is hearing in their work can make a difference in the impact on the employee.
- **Length of employment.** Employees who are new in the field or new to hearing stories about trauma and adversity without warning or coping strategies are at greater risk for work related stress.
- **Always being empathetic.** Employees who feel like they have to always be empathetic or "always on" because at home they care for elders, children, or other family members or have more than one human service related job.
- **Isolation.** Isolation can be experienced because of the location of the worksite, because you are the only staff doing a particular job (e.g. only psychologist, peer support), or because you are not able to share details about your work with friends and family.

The content in this TIP has been adapted from the following sources:

1. Adams, R.E., Boscarino, J.A., Figley, C.R. (2006). Compassion fatigue and psychological distress among social workers: A validation study. *American Journal of Orthopsychiatry*, 76(1).
2. Berzoff, J., & Kita, E. (2010). Compassion Fatigue and Countertransference: Two Different Concepts. *Clinical Social Work*, 38.
3. Cunningham, M. (2003). Impact of trauma work on social work clinicians: Empirical findings. *Social Work*, 48(4).
4. Cunningham, M. (2004). Teaching social workers about trauma: Reducing the risks of vicarious traumatization in the classroom. *Journal of Social Education*, 40(2).
5. Richardson, J.W. (2001). Guidebook on Vicarious Trauma: Recommended Solutions for Anti-Violence Workers. *National Clearinghouse on Family Violence*

Trauma Informed Oregon is funded through Oregon Health Authority, and is a partnership between Portland State University, Oregon Health Sciences University and Oregon Pediatric Society.

In writing these TIPs, Trauma Informed Oregon will strive for easy to read text, avoiding technical language and spelling out acronyms as needed. For TIPs that include information from other sources this may not always be possible.



WHAT YOU NEED TO KNOW: The following resource was developed to be used by agencies providing housing and shelter services to youth. Feel free to use this document in the development of your own agency crisis response plan. The recommendations in this resource were developed by reviewing the literature about best practices and interviewing providers in agencies about their experiences responding to tragedy. An important focus was to include not only immediate response but how to respond to tragedy that may happen to youth and/or staff days and months following. It is expected that agencies will modify these recommendations to fit their needs and population. (TIO, 2015)

Considerations for Responding to Crisis

Emergency Response Team

In order to effectively develop and implement a plan, we recommend that organizations develop internal Emergency Response Teams. A team or small group response to tragedy is recommended over having one person who is responsible for the response. Emergency Response Teams (ERT) are responsible for creating, updating, implementing, and maintaining a response plan. ERTs can be comprised of administrators, line staff, supervisors, and staff who are able to work effectively under pressure with compassion and empathy. It is recommended that the ERT be between 5-6 people, but more members can be added if determined necessary. This may include people from outside the agency such as mental health professionals. The team should have a designated leader. The purpose of the ERT is to provide a coordinated and consistent response in addressing a traumatic event, including monitoring the wellbeing of staff, communicating with staff, and providing assistance to staff in working with youth. After a death, many actions need to be coordinated in a very short space of time, and also needs to continue for many months.

Here is a brief overview of the ERT responsibilities and its timeline:

Immediate response

- If the incident has happened at [XX]: Ensure the immediate safety of staff and youth (e.g., provide first aid, call ambulance and police).
- If the incident has happened away from [XX]: Find out as many of the facts and circumstances as possible. Do not ignore rumors – investigate them immediately.
- Ensure those affected (youth/staff) are not left alone.
- Inform the relevant [XX] representative
- Convene the Emergency Response Team (ERT) and plan the following steps:
 - Contact the relevant mental health agency.
 - Identify and plan support for staff and youth who are at risk.
 - Set up a youth support room in the organization.
 - Inform staff. Give them a script explaining what has happened, so that all staff are giving youth the same consistent message.
 - Inform youth via a script. Do this in small groups, not at a whole organization meeting.

The first week

- Restore the organization to its regular routine.
- Organize regular staff meetings, to ensure they are provided with up to date information.
- Monitor youth
- Monitor staff wellbeing and provide opportunities for debriefing.
- Collect all the belongings of the deceased youth or staff
- Continue documenting all the organization's actions.

The first month

- Monitor staff and youth wellbeing.
- Plan for relevant events that will be held by the organization that may be triggering to other youth
- Gather information from staff that is relevant for a critical incident review.
- Conduct a critical incident review.
- Continue documentation of all the organization's actions.

Longer term

- Continue to support and monitor youth and staff.
- Keep staff and youth informed.
- Plan for anniversaries, birthdays and other significant events.
- Implement the recommendations of the critical incident review.
- Include your organization's crisis response plan in its staff induction process.

Pre-Tragedy Considerations

- Contract with a mental health specialist
 - Neutral person
 - Someone who knows the agency
 - Develop relationship before tragedy hits
- Dedicate a section of staff orientation about grief and managing grief
- Staff should be trained on first aid

Immediate Response

Immediate response refers to a timeframe of the moment of the incident to 48 hours later.

Location

- Onsite Incidents
 - Ensure no other participants or staff are in immediate danger
 - Administer first aid when necessary
 - Call 911 for emergency services
 - Alert the Emergency Response Team for assistance
 - Have staff help witnesses move to safe locations
 - Isolate the site of the incident and do everything possible to protect others from viewing the site
- Offsite Incidents
 - Do not ignore rumors

- If true, find out as many of the facts and circumstances as possible
- Reports of death should be confirmed with police or hospital staff

Participants

- Do not leave directly affected participants alone
- Identify safe and secure places where crisis support can be provided
- Informing participants: think about how, when, where, and who
- Make a plan for informing:
 - Start with the friends closest to the participant and other participants identified as vulnerable
 - Speak to them individually or in small groups.
 - Provide them with immediate support and information about where they can receive continuing assistance
 - Inform the rest of the program in small groups, not at a whole agency meeting.
 - Recognize their close association with the participant, their anticipated desire for more information, and their different need for support.
 - Use a script. This is an important way of supporting staff who find the task of informing participants stressful. It also ensures that accurate and consistent information is provided to participants. Use different scripts for participants who were close to the participant and all other participants
 - If it is a suicide, do not describe the method
 - Ask anyone you inform not to spread sensitive information
- Support for participants
 - Set up a participant support room in the agency
 - Should be a safe, supervised location
 - Participants' grief and needs can be expressed, responded to and monitored.
 - An appropriate staff member must supervise the room at all times.
 - The room's door should be left ajar rather than shut.
 - The support room should be quiet and out of the way.
 - Keep a sign-in sheet, so you can monitor which participants are using the room and may be at increased risk.
 - Allow distressed participants access to this room for several days after the incident.

Staff

- Do not leave directly affected staff alone
 - Identify safe and secure places where crisis support can be provided
- Get staff from other programs to fill in for staff directly affected
- The leader of the ERT should brief non-ERT staff about:
 - The facts of the situation. If death is not confirmed as suicide, then refer to it as a participant "death" at this stage
 - The members of the ERT and their roles
 - The response plan for the day, in particular changes to responsibilities or routines
 - How phone inquiries are to be managed
 - Contact being made with staff who were absent at that time or who are on leave. Relevant information about roles and special procedures should also be displayed in a space that is widely used by staff, such as a kitchen or break room.

- Informing staff: think about how, when, where, and who
 - Make a plan for informing staff
 - Think about all staff who could be affected.
 - Visual way for how to prioritize which staff to notify is through concentric circles. Place staff names within the circles. Staff with the most contact with the client would be at the center and should be notified first. Be aware that those who worked the most closely with the client may not necessarily be impacted the most. Grief situations impact everyone differently.
- What to share with staff closest to youth:
 - Situation and the facts as you know them
 - Offer all options for support available, then ask them if there is anything additional they need for support
 - Have options for taking leave
 - Do not have a blanket policy
 - Staff choice of leaving work or staying-keep in mind that in the moment we don't always know what we need, so staff who stay will need to be monitored for signs of increased stress
 - Offer sick time/leave off when possible
 - If the staff person wants to stay, consider temporarily removing them from high stress job responsibilities
 - Give them low-stress, low-risk work, such as office support, cleaning, organizing, etc.
 - Monitor extended absence- stay in touch with staff
 - Encourage use of EAP
 - Review how responsibilities will be covered for the next few days
 - Provide ongoing support. Support/check-ins need to be ongoing over a period of weeks and possibly, months
 - Consider the use of a crisis debriefing team
- All staff should be given:
 - Sources of support they can access for themselves
 - The option of not being involved in informing youth, if they feel this will put their own wellbeing at risk.
 - Preference for if they want to be told over the phone or wait until they come into the office if they are not there at the time of the event
 - When to inform
 - Ideally, staff should meet at the beginning and end of the working day following the incident. This allows for ongoing communication about decisions made by the ERT, while also providing space for staff feedback and support.
 - Staff should be notified in a private setting (away from the youth) when possible.
 - Have water and healthy snacks available
 - Try to limit processed sugar
 - Nutrients that reduce stress (Vitamin C- lowers cortisol and blood pressure in high anxiety situations)
 - Food choices: oranges or strawberries (complex carbohydrates- increases serotonin and stabilizes blood pressure), whole grain pretzels or crackers, fruit (omega-3 fatty acids- reduce surges of stress hormones), almonds, walnuts, pistachios, dark chocolate (helps relieve stress), oatmeal (lowers cortisol and increases serotonin), tea (relieves stress and induces calmness)
 - Have someone contain the space- but open it up for staff to speak or sit in silence
- Staff should be provided with:
 - A script which they should follow to inform participants

- Information on how to offer support, how to manage discussion about death, signs to watch out for youth, and information on grief
- Offer to allow staff to work in pairs for support when informing youth

Notification

- Inform other [XX] supervisors and [XX] rep, as soon as possible
- Have a plan for referring media enquiries

Mental Health Agency Support

- Contact the relevant mental health agency. Their role is to:
 - Provide immediate counseling to the affected participants
 - Identify other vulnerable youth
 - Screen youth at risk
 - Take referrals from staff

The First Week

Participants

- Restore the agency to its regular routine
 - After approximately three days
 - Routine is important to recovery
- Monitor participants and, in collaboration with the relevant mental health agency, begin assessments of participants identified as being at risk.
 - In the first 24 hours the closest friends and associates of the participants and anyone who witnessed the death should be provided with immediate support
 - Develop a plan to support people at risk

Staff

- Restore the agency to its regular routine.
 - After approximately three days
 - Routine is important to recovery
- Organize regular staff meetings, to ensure they are provided with up to date information.
 - Staff should meet regularly during the first week
 - First staff meeting
 - Conducted by the ERT leader or supervisor
 - Held as soon as possible
 - Goals: Introduce ERT members, share accurate information about the death, allow staff an opportunity to express their own reactions and grief, provide staff with scripted statement to tell participants informing them of the death, prepare for youth reactions and questions by discussing the issue with staff
 - At each meeting staff should share any information, concerns or observations which they consider important
 - ERT mental health rep should attend the staff meeting to support staff and stay updated on any at-risk youth
 - Discuss participants of concern and activities of concern

- Continue documenting all the agency's actions.
- Have one team member manage documentation

Memorialization

- Collect all the belongings of the deceased participant
 - Do not allow youth to be present for this
 - An empty space could be a distressing symbol so it is appropriate to forewarn them when this is going to happen
- Determine the agency's involvement in the funeral.
 - Participants and staff may wish to hold a memorial service at the agency
 - Large numbers of participants are not recommended
 - Consider using the support room for reflective activities with small groups
 - Treat all deaths in the same way
 - Meet with closest youth to work out a meaningful and safe way of acknowledging the loss
 - Have a mental health professional on site post-service
 - Spontaneous memorials
 - Set some limits around the material, the content, the location and the length of time
 - For example, set up poster paper for youth to write messages but set posters up in an area that may be avoided by those who do not wish to participate. Monitor for messages that are inappropriate. After a few days (2-5) remove posters and give to staff or close youth
 - Consider adopting a ritual as a standard part of practice when a participant dies.

The First Month

- Monitor staff and participant wellbeing.
 - Look for staff and participant distress
- Plan for the impact this incident could have on all relevant events that will be held by the agency
- Gather information from staff that is relevant for a critical incident review.
- Conduct a critical incident review.
 - Allow staff to contribute their views on how the agency has managed the crisis
 - Anonymous, written survey
 - Collate responses and incorporate them into policy and planning
 - Important to also highlight what was done well
- Consider offering staff information sessions with a mental health agency.
 - General training on signs of suicide risk
 - Current research on building resilience
 - Understanding grief and loss
- Continue documentation of all the agency's actions and decisions
 - 12 months
- Check in with staff at staff meetings and supervision
- Staff get together time- e.g. "Monthly Breakfast" or "Self-Care group"
- Begin implementing critical incident review

Longer Term

- Continue to support and monitor participants and staff.
 - Participants
 - Reminders about there is no right way to remember or grieve the loss of a friend and that they must be kind to each other and respect their differences
 - Staff
 - Consider additional personnel support
- Keep staff and participants informed.
 - Regular and relevant communication
- Plan for anniversaries, birthdays and other significant events.
 - Be aware that anniversaries can bring people back to the early stages of grief
 - Discourage large group memorials
 - Let youth and staff know it's normal to re-experience grief and sadness at significant times, and tell them things will get easier over time
 - Suggest activities which make the youth feel good and which remind them of the good times they shared with the person they have lost
 - Encourage them to contact sources of support rather than spending their days alone
 - Remind them that there is no 'right' way to mark an anniversary, and help them find a way of coping which they feel comfortable with
 - Help them connect with counselors or other support services if they are feeling overwhelmed or unable to cope in the lead-up to the event.
- Complete the recommendations of the critical incident review.
- Include your agency's tragedy plan in its staff induction process.

Citations

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Appendix IVb



WHAT YOU NEED TO KNOW: This table provides examples of how you can reframe challenging behaviors through a trauma lens. The examples in the table are some of the most frequently reported in TIO trainings and include challenging behaviors from service recipients and staff. It also includes challenging environmental features. This table was compiled by TIO social work interns and can be used as a guide to creating your own table based on common experiences in your work. (TIO, 2016)

TRAUMA LENS EXERCISE

| Challenging event SERVICE RECIPIENT | Non-trauma informed response | Trauma-related explanation / Trauma Education Statement | Strategies |
|-----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Service users not showing up for appointments, not returning calls, arriving late | Service user is avoidant, lazy, irresponsible, doesn't care about their treatment, is disrespectful | <p>What we know about trauma is that survivors frequently experience sleep disturbances and hyperarousal - this can mean that keeping track of appointments or attending early morning appointments may be difficult.</p> <p>What we know about trauma is that many survivors use avoidant coping mechanisms such as numbing, sleeping, or not showing up to reduce the impact of re-traumatization, particularly when they've experienced trauma from our service system.</p> | <p>Provide as much choice as possible about when, where, how often, and how long meetings or appointments take place.</p> <p>Ask what would be helpful in terms of meeting reminders (examples: providing a calendar/notebook, calling or sending a reminder text or email).</p> <p>Ask if the time of the appointment or past negative experiences are impacting meeting attendance. If so, problem solve together around possible options.</p> |
| Service user showing aggressive behavior, yelling, displaying anger | Service user is dangerous, violent, aggressive, has anger management issues, defiant, difficult, unwilling to follow program rules/policies | <p>What we know about trauma is often times regulating emotions may be compromised once a survivor has been triggered.</p> <p>Being activated can affect a person's cognitive ability to take in information which can lead to experiences of feeling helpless, unsafe, or out of control.</p> <p>Engaging in aggressive behavior may have been an effective way to protect themselves from painful experiences in the past.</p> | <p>Ask if they'd like to move to a more private or quiet space.</p> <p>Conduct an environmental assessment of your organization- look for sounds, smells, space, seating, signage, rules, policies, etc. that might be triggering. Ask service users to do the same with you, and use their feedback to make changes.</p> <p>Review intake or early engagement procedures to see what may cause triggers, and solicit feedback from service users during the process.</p> <p>Be explicit, clear, and transparent about the conditions you and the service user are experiencing; offer alternative options.</p> |

| | | | |
|-------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Service user repeating requests, asking multiple staff members for the same services/resources</p> | <p>Service user is lying, manipulative, splitting staff, triangulating, acting entitled, working the system</p> | <p>What we know about trauma is that ambiguity can often heighten feelings of anxiety, mistrust, and confusion for survivors - people may keep asking for what they need until they get a direct answer or get their needs met in that moment.</p> <p>What we know about trauma is that survivors have often had to work very hard to get their needs met or to have their voices heard in the past.</p> <p>What we know about trauma is that historical and collective experiences with systems impact current engagement practices.</p> | <p>Be transparent and consistent about what the agency does/does not offer in terms of client resources.</p> <p>Provide clear information and adequate training to staff regarding agency policies and procedures to reduce miscommunications.</p> <p>Provide accurate information about other community resources so both staff and service users know alternate options.</p> <p>Use a trauma lens to remind yourself and co-workers why someone may be in a situation where they may need to exhibit these behaviors.</p> <p>Ask service users about their experiences with your organization - find out what they need to know about the system, and connect them to resources as needed.</p> |
| <p>Challenging behavior/event SERVICE PROVIDER</p> | <p>Non-trauma informed response</p> | <p>Trauma-related explanation / Trauma Education Statement</p> | <p>Strategies - workplace and workforce</p> |
| <p>Service provider displaying mood swings, defensiveness, outbursts, blaming others</p> | <p>Not a team player, unprofessional, snappy, needs medication, difficult to work with, bossy, control freak</p> | <p>Often time's service providers are trauma survivors themselves or have experienced vicarious trauma due to the nature of their work - this can impact their ability to regulate emotions, process difficult situations, or cope with stress.</p> <p>Organizations can sometimes create conditions/dynamics similar to those which service users have experienced. This can lead to experiences of burn out, vicarious trauma, and stress.</p> | <p>Provide ongoing trainings on vicarious trauma, secondary traumatic stress, and compassion fatigue.</p> <p>Provide opportunities for regular and predictable peer support and supervision.</p> <p>Be creative and flexible about staffs' ability to vary their work or caseloads.</p> <p>Be aware of where parallel process might be happening - are there dynamics among co-workers and leadership that mirror the issue you're trying to work to help?</p> <p>Take workforce wellness seriously - ask staff what they need to feel safe both in and outside of work and conduct an organizational assessment to learn how this can be accomplished.</p> |

| Challenging environmental features | Non-trauma informed response | Trauma-related explanation / Trauma Education Statement | Strategies |
|-------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Chairs in the lobby too close together, location of building, locked doors that slam or require buzzes to get through.</p> | <p>Limited agency budgets, limited space, old/used furniture is the norm, our décor has nothing to do with this, building sites can't be controlled, doors locked for safety of staff.</p> | <p>What we know about trauma is that experiences of hypervigilance can cause increased sensitivity to environmental factors that others may not even notice (such as sounds, lighting, style of chairs, etc.) - locked or buzzing doors can remind those with incarceration histories of jail/prison; survival responses may kick in.</p> <p>Services may be in a location, building, or part of town that may be triggering to service users or may be the very site of past, generational, or collective trauma.</p> <p>What we know about trauma is that being in close proximity to others can be re-traumatizing or can cause stress or discomfort, especially if they have to share space with their perpetrator.</p> | <p>Work with service users to identify environmental triggers within the organization and adjust accordingly.</p> <p>Discuss environmental factors that cannot be controlled (preferably before their visit) so people know what to expect.</p> <p>Ensure people have adequate personal space, direct access to exits, and know where to find important facilities within the building (bathroom, water fountain, etc.)</p> <p>Ask what you need to know about the neighborhood, its history, and the placement of your building / agency within it.</p> <p>Ask what you need to know about peoples' experiences with your space historically or generationally.</p> |



Trauma Specific Services:

A resource for implementation and use

Purpose. This document is intended to serve as a resource to anyone seeking or referring trauma specific services (TSS) and those seeking to implement effective TSS programs, services or activities for individuals or groups.

History and Context. Individual and collective violence, abuse and other adversities have been part of human experience throughout history, as have responses to them. From body-based movement and ritual to art, music, and storytelling, individuals and communities around the world have developed naturalized strategies and formal clinical approaches intended to mitigate the immediate and long-term consequences of traumatic experiences. While some interventions and treatments have had rigorous research to measure their effectiveness and are considered to be ‘evidence-based’ⁱ, many others, though never formally evaluated, are found to be effective and helpful by those who use and promote them.

Definition. The Oregon Health Systems Division Trauma Policy defines *trauma-specific services* as, “treatment or treatment programs specifically designed to treat individuals who have experienced trauma” and highlights “the need for respect, connection, and hope for individuals, recognition of the adaptive function of any symptoms that are present; and working collaboratively and in a person-directed empowering manner with individuals who have experienced trauma.” In addition to formal treatment modalities, TIO recognizes any program, service or activity as trauma-specific if it was: a) designed specifically to, and/or b) known or expected to help alleviate, reduce or prevent the negative effects of trauma on individuals, families or communities and/or promote post-trauma growth and resilience.

Trauma Informed Care vs. Trauma Specific Services

Trauma Specific Services (TSS) are programs, interventions, and therapeutic services aimed at treating the symptoms or conditions resulting from a traumatizing event(s).

Trauma Informed Care (TIC) is an approach, based on knowledge of the impact of trauma, aimed at ensuring environments and services are welcoming and engaging for service recipients and staff.

Note: Trauma-specific services may be provided in organizations and settings that are trauma-informed, or not. Trauma-informed organizations and settings may or may not also provide trauma-specific services.

Implementing TSS. Trauma-specific services and interventions have often been developed in response to the needs of a particular group of people (e.g. survivors of domestic violence or sexual assault), or to address certain types of trauma (traumatic loss, medical trauma, violent crimes, natural disaster) or traumatic responses (eating disorder, grief, addictions, anxiety). They may also have specific implementation requirements related to service setting or provider qualifications and training.

When making a decision about the best trauma-specific services to implement, consider the following:

- 1) Understanding the identified unmet need
 - a. To address a specific type of trauma or population to be served
 - b. Non-duplication of services and/or community partnership and support
- 2) What do we know about the people the services are intended for?
 - a. Current strengths & resources
 - c. Goals and interests (including comfort with formal vs. informal services)
 - c. Age, developmental stage, culture, language, gender
 - d. Trauma history and impact (individual, intergenerational, historical)
- 3) Organizational Capacity (Do we have what it takes? Are we the best organization to do it?)
 - a. Leadership & champion(s)
 - b. Adequate organizational and financial resources (staff, money, and time)
 - c. Qualified, willing and interested providers
 - d. Adequate supervision & support (for service provision & fidelity)
 - e. High level of credibility and support within the community/population to be served
 - f. Appropriate service setting (location/place) and context (safe, trauma-informed)
- 4) Costs of Implementation (Can we afford and sustain it?)

Initial implementation:

 - a. Consultation and training
 - b. Proprietary materials
 - c. Staff

Ongoing:

 - a. Adequate staff (supervision and service provision)
 - b. Consultation and training
 - c. Participant recruitment
 - d. Service materials and supplies
 - e. Evaluation
- 5) Type of program, service or activity (How do we decide on a specific intervention or program?)
 - a. Clinical or community-based
 - b. Traditional/holistic/complementary
 - c. Group or individual d. Evidence of effectiveness
 - i. Research evidence & fidelity
 - ii. Survivor reports/experiences
 - iii. Anecdotal evidence
- 6) Accessibility for those accessing services (Can they afford it? Is it offered in the right place by the right people? Will it be seen as legitimate and relevant to them?)
 - a. Cost
 - b. Location/transportation
 - c. Setting
 - i. Culturally appropriate
 - ii. Language
 - iii. Safe and welcoming
- 7) Sustainability (for the duration required to meet identified need)
 - a. Positive outcomes
 - b. Funding
 - c. Organizational support and commitment
 - d. Community support

For Seekers of Services. Most trauma-specific activities, services, and programs have been developed to

- meet the needs of certain groups of people (e.g. women, men, vets, adolescents, young children, parents),
- address certain types of trauma (domestic violence, sexual assault, violent crimes, natural disaster) or,
- help people with specific problems they have after a traumatic experience (anxiety, grief, or addictions).

Services may be provided in a variety of settings by trained professionals, peers, traditional healers, or healing arts practitioners. Some providers and practitioners must be licensed depending on the type of intervention or service.

When making a decision about which trauma-specific services might be best for you or someone else, consider the following:

- 1) The needs, interests and goals of yourself or the person seeking services:
 - Immediate crisis support, ongoing support, desire or motivation for a better quality of life
 - Preferred service type (formal, informal, holistic, culturally specific, clinical treatment or support)
 - Current strengths & resources
- 2) Characteristics of yourself or the person seeking services:
 - Think about age, developmental stage, cultural background, language, gender, other identities
 - Their past experience with services
 - Their trauma history and its impact (individual, intergenerational, historical)
- 3) The most important qualities about the service and provider
 - Provider/Practitioner qualities (e.g. licensed, familiar, well-regarded, culturally similar)
 - Accessibility (location, transportation, available in preferred language)
 - Affordability (cost, insurance coverage, required time away from work)
 - Effectiveness (evidence-based, known to be helpful, regarded as helpful by others)
 - Type of service or resource (clinical, traditional, holistic, group or individual, peer run)
 - Flexibility (frequency, times of services and ability to take a break and return)

Resources.

SAMHSA's National Registry of Evidence-based Programs and Practices

<http://www.nrepp.samhsa.gov/>

National Child Traumatic Stress Network Empirically Supported Treatments and Promising Practices

<http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices>

Health Services Division Trauma Policy (Oregon)

<http://www.oregon.gov/oha/amh/trauma-policy/Trauma%20Policy.pdf>

Health Services Division Trauma-Informed and Trauma-Specific Services Pages

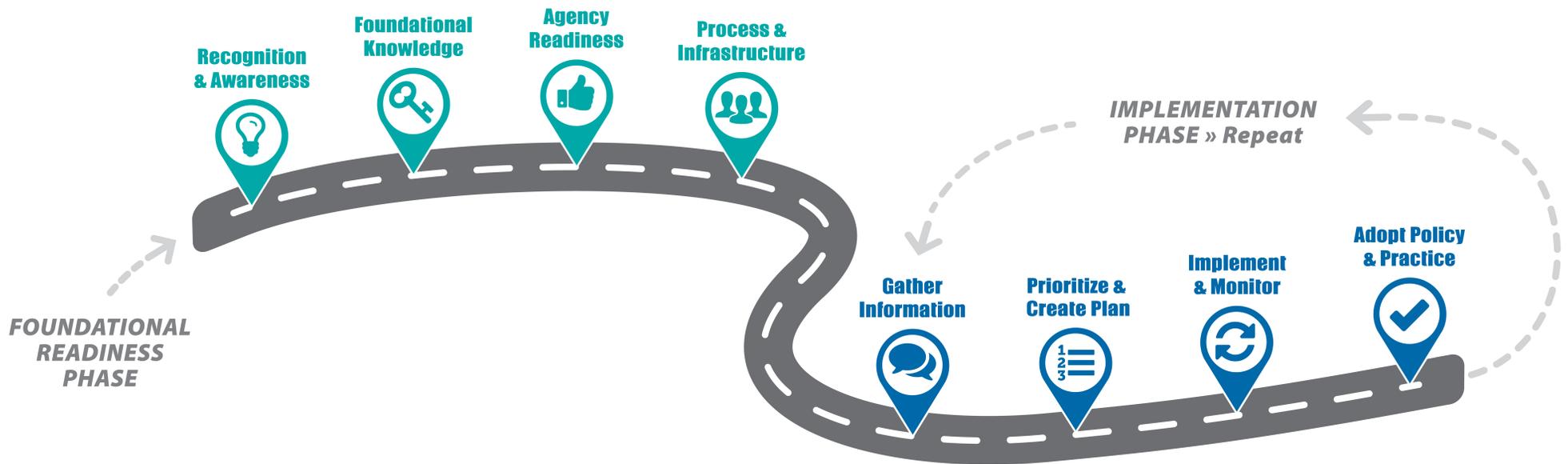
<http://www.oregon.gov/oha/amh/pages/trauma.as>

Trauma Informed Oregon is funded through Oregon Health Authority, and is a partnership between Portland State University, Oregon Health Sciences University and Oregon Pediatric Society.

In writing these TIPs, Trauma Informed Oregon will strive for easy to read text, avoiding technical language and spelling out acronyms as needed. For TIPs that include information from other sources this may not always be possible.



ROADMAP TO TRAUMA INFORMED CARE



AGENCY WIDE COMMUNICATION | ONGOING EDUCATION & TRAINING



WHAT YOU NEED TO KNOW: These questions were developed to review a specific policy about service exclusion through a trauma informed lens. Some of these questions may be helpful as you are developing or reviewing policies. (TIO, 2013)

Guide to Reviewing Existing Policies

Safety:

Does this policy put service recipients' safety at risk?

If so how? What precautions are in place to prevent, mitigate, or respond?

Does this policy put staff's safety at risk?

If so how? What precautions are in place to prevent, mitigate, or respond?

Is the policy clear and understandable to those who implement this policy?

Are all impacted parties trained on this policy?

Who, how, when, frequency?

Are service users informed of this policy?

Who, how, when, frequency?

Are partner agencies informed of this policy?

Who, how, when, frequency?

Is this policy carried out consistently across programs, staff, and agencies?

When it is not consistent is there an explanation given (consistent but flexible)?

Does this policy ask staff to work outside of their job or skill level? What support do they have?

Does this policy result in confidences being broken?

Can staff from one program explain another program's decision or have a way to find this out?

Are policy decisions communicated in a timely manner within the agency?

Restore Power:

Are policy decisions made in collaboration with other staff?

Do staff know what they can decide without approval?

Are staff trained in de-escalation so as to avoid unnecessary power struggles?

Are policies and procedures easily accessible (e.g. location, language)?

Are skills necessary to implement the policy provided and practiced (simulations)?

Is it clear how and why this policy was developed (transparency)?

Value Individuals:

Have staff been consulted about the policy?

Have service recipients been consulted about the policy?

Are mental health advanced directives in place where necessary?

Have service recipients been asked what is helpful and not asked about the implementation of this policy?

Are staff debriefed after events (exclusions, suicidal calls, police calls, aggressive behavior)?

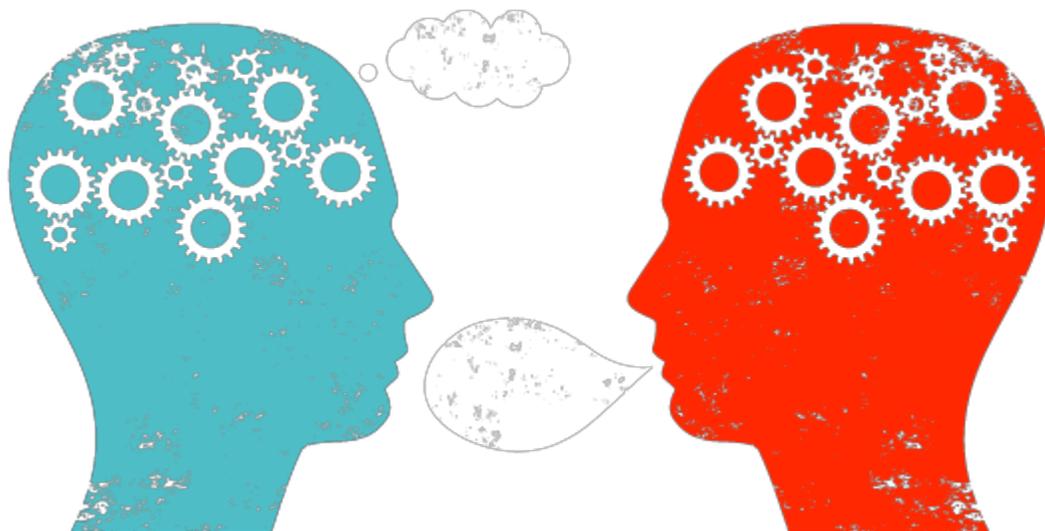
How, when, by whom?

Have staff been asked what is helpful and not asked about implementing this policy?

Do all parties have a voice in decisions? How? If not, why not or when?

“Mindfulness is the aware, balanced acceptance of the present experience. It isn’t more complicated than that. It is opening to or receiving the present moment, pleasant or unpleasant, just as it is, without either clinging to it or rejecting it.” - Sylvia Boorstein

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**What to expect from the
TIC Advisory Committee in 2016?**

It's 2016 and this means that the TIC Advisory Committee has recruited new members and is in the process of strategizing on how to continue to build upon the foundation that has been laid over the past two years. As part of our commitment to continue the momentum we are excited to announce that we will be releasing an edition of TIC Talk every month. You can expect each issue to be a condensed version of trauma informed care resources, success stories, and updates on TIC Advisory Committee projects and progress. As always, we encourage you to share your own trauma informed practice related success stories and questions with us [here](#).

Stories from Within...

The Turning Point

Aglahia Blanco

Rachel and her mother started out having a lot of distrust with the system and were very difficult to engage. This was evident by Rachel's anger outbursts and Mom's minimizing her daughter's charges. Rachel was already on probation when I got her case. She then had three additional assaultive-type charges within three months and four probation violations after that. She was close to being committed to OYA/YCF by the court.

I decided to contact Rachel's attorney and explain my intentions and goals for Rachel. [READ MORE](#)

TIC Advisory Committee goes to Portland State University

Chris Larsen

On February, 22nd, 2016, Senior Manager Deena Corso and Chris Larsen, (JCSS, on-call) gave a presentation about our efforts to implement Trauma-Informed Care (TIC) here at Multnomah County Juvenile, which happens to be the largest and most comprehensive endeavor of its kind in Oregon.

The class was the Abuse and Trauma class at the Portland State University graduate program, taught by Mandy Davis, who is also our DCJ Trauma-Informed Care consultant. [READ MORE](#)

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Upcoming Events

Compassionate Communications
March 29th and May 24, 2016
8:30 am-12:30pm
McCoy Building
[Sign Up Here](#)

Trauma Informed Care and Practice-Intro
June 30, 2016
8:30am-12:00pm
SE ADS Tabor Square
[Sign Up Here](#)

Trauma Informed Care and Practice
May 3, 2016
8:30am-12:00pm
Multnomah Building
[Sign Up Here](#)

Trauma Informed Care and Practice- Applied
June 2, 2016
8:30am-4:30pm
Multnomah Building
[Sign Up Here](#)

Practicing Mindfulness in the Workplace
8:30am-12:00pm
May 3, 2016
Multnomah Building
[Sign Up Here](#)

TIC TIP! Do you know that County Wellness offers a wide array of wellness and fitness classes for employees? For just \$20.00 per month you can access an unlimited amount of classes. Both Yoga and Zumba are offered right down the street from JSD on Tuesday's and Thursday's at the Tabor Square Office Building. Additional classes are offered at multiple sites throughout the County. To learn more about the various classes, schedules and locations offered click [here](#).

TECH TIP! Looking for a new resource to support your mindfulness practice or to help you learn to practice meditation? Get meditating in 5 easy minutes with [Stop, Breathe, & Think](#), a cool new website and app to guide people of all ages and backgrounds through meditations for mindfulness and compassion.



STOP

Stop what you are doing. Check in with what you are thinking, and how you are feeling.



BREATHE

Practice mindful breathing to create space between your thoughts, emotions and reactions.



THINK

Learn to broaden your perspective and strengthen your force field of peace and calm by practicing one of the meditations.

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Have something to share with the TIC Advisory Committee, something you would like to contribute to TIC Talk or a question you want answered? You can email us [here](#).



Mindfulness helps you go home to the present. And every time you go there and recognize a condition of happiness that you have, happiness comes.
- Thich Nhat Hanh

[View this email in your browser](#)

Welcome to TIC Talk, an e-newsletter to share information, success, and resources related to Trauma Informed Care.



2015 Year in Review

BACKGROUND:

The TIC Project was launched in September of 2013. The first meeting of the TIC Project Planning Team was convened on October 16, 2013. For one year, the planning team met and developed a plan for implementation of trauma-informed practices at JSD. During that year, every JSD employee (regular and on-call) participated in a mandatory 3-part training on trauma-informed care. JSD managers received additional training on trauma-informed supervision. The planning team also developed a newsletter, TIC Talk, as a mechanism for communicating TIC-related information with employees. At the conclusion of the planning phase, a TIC Advisory Committee was developed and tasked with moving the implementation forward.

THE LAST YEAR:

On October 29, 2014, the TIC Advisory Committee held its first meeting. The committee is comprised of staff and managers from throughout the Division and has met monthly for the

past year (with the exception of July and November). Highlights of the TIC Advisory Committee's work include:

- Developed a structure for the meetings and protocols for how the group will operate. This included the creation of three subgroups: Communication, Hotspots, and Community of Practice.
- Prioritized trauma "hotspots" that were identified by participants of the Core Skills (part 3 in the series) training.
- Created a newsletter, TIC Talk, as a way to share information, resources, and success stories with JSD employees.
- Served as "champions" for trauma-informed care, role modeling TIC with co-workers.
- Began adapting practices (targeting "low hanging fruit") that did not require policy changes. Examples include: making space for detained youth to talk through struggles rather than focusing solely on consequences for behavior; conducting pat-downs and room searches in a respectful and trauma-informed manner; discussing ways to deliver difficult news to staff in a trauma-informed manner; encouraging self-care with co-workers; beginning team meetings with a brief mindfulness exercise; storing handcuffs and shackles in a location that is not immediately visible to staff and youth; considering TIC when making decisions about what movies youth are allowed to view in detention; sharing additional training materials with co-workers to increase knowledge and understanding of TIC; creating a library with TIC books and resources; developing and piloting an Employee Wellness Plan tool; exploring the possibility of creating an Employee Wellness Room for use during staff breaks.

LOOKING AHEAD:

The TIC Advisory Committee is beginning its second year. A new recruitment was conducted in November to provide employees who are interested in this work with an opportunity to join the committee, and to give members who have served for the past year with an opportunity to re-commit or to step aside if they so chose. The first meeting of the newly formed TIC Advisory Committee will take place on January 13, 2016 from 1:00 to 2:30pm in the JSD Large Conference Room.

Want to learn more about Trauma Informed Care?

Trauma Informed Care (TIC) recognizes that traumatic experiences **terrify, overwhelm, and violate** the individual.

Trauma Informed Care is a commitment not to repeat these experiences and, in whatever way possible, to **restore a sense of safety, power, and self-worth.**

* Taken from [Trauma Informed Oregon](#)

Did you know that meditation can improve the structure in your brain? Listen to [this 10 minute Here & Now segment](#) on Oregon Public Broadcast.

Upcoming Event:

6th Annual Psychological Trauma & Juvenile Justice: Impact on Mind, Body, Behavior and Community Current Research and Practice Trends Conference
June 6-8, 2016
Des Moines, IA

Visit the [Trauma Informed Care Project's website](#) for more information.

Additional Resources:

[National Center for Trauma Informed Care](#)

[Trauma Informed Oregon](#)

TIC Tip: Want to hear about a particular topic? Want to share a Trauma Informed Care success story or how you have implemented trauma informed practice in your work? Know of a Trauma Informed Care related training or event? [Let us know](#) and we'll include it in our next newsletter.

***Sometimes the most important thing in a whole day
is the rest we take between two deep breaths.
- Etty Hillesum***

[View this email in your browser](#)

Welcome to TIC Talk, a quarterly e-newsletter to share information, success, and resources related to Trauma Informed Care.



Stories from Within

Part of our goal of this newsletter is to provide an opportunity for staff to share their own experiences and how this affects them personally and as a professional. This first article is written by Esteban Mendez, a staff who works on the Senderos unit in detention. Esteban has extensive experience with our youth and wanted to share this story as an example of how trauma in his workplace affects him and the hopes he has as we move forward.
- Carin Cunningham, LPC

The Trauma Informed Care Advisory Committee has asked me to write a little bit on the effects trauma has on our staff and in particular, how it translates into our personal life. The past couple of months on our unit are particularly difficult to write about due to the challenges we have faced.

We've had an increase in the number of back-up calls these last few months, causing a lot of stress on the clients and staff. Some of the back-ups are for the normal physical fights where we have to separate the youth. The others, however, have been those of attempted self-harm prevention. The clients involved have a severe mental health history that are unable to process the trauma from their past and, as a result, self harm. Our staff have had to endure this traumatic experience at times through physically assisting the prevention of attempted self-harms. Having to physically restrain a youth in this capacity, it is likely that staff also experience trauma as well. The relationship we have with trauma is one that doesn't tend to stay at work, but that we take it home with us in various forms. Whether it's through physical stress on the body, mental exhaustion, or as basic as

continued rehashing of what occurred, we take some form of vicarious or direct trauma with us after our shift ends.

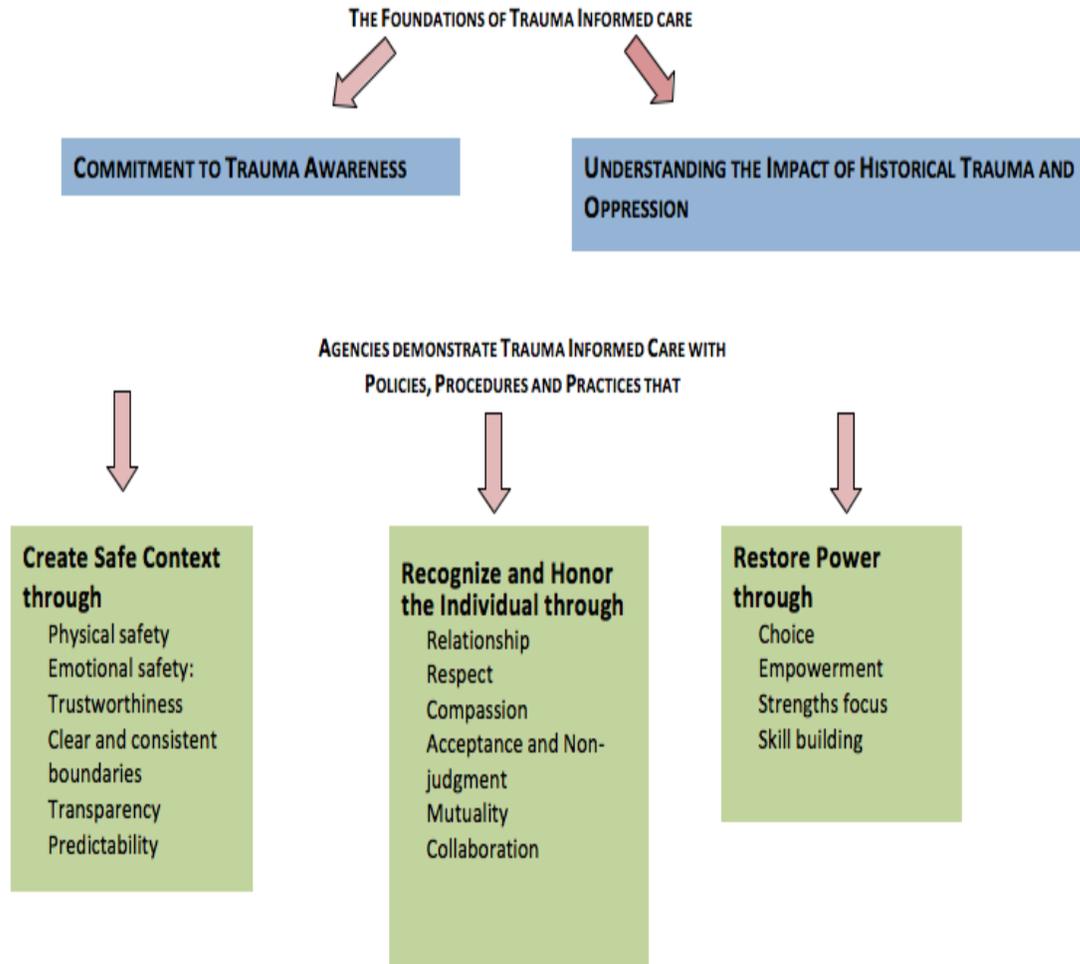
It is our goal as the Trauma Informed Care Advisory Committee to eliminate any potential unnecessary stress and trauma through identifying potential triggers and evaluating different approaches that would relieve some of the trauma. It's important that we take care of each other and check in with your coworkers and be part of that support system that we all need in this field.

-Esteban Mendez

Want to learn more about Trauma Informed Care?

Trauma Informed Care (TIC) recognizes that traumatic experiences **terrify, overwhelm, and violate** the individual.

Trauma Informed Care is a commitment not to repeat these experiences and, in whatever way possible, to **restore a sense of safety, power, and self-worth.**



* Taken from [Trauma Informed Oregon](#)

Upcoming Events:

Community Resiliency Model™ Skills Training
Oregon City, OR
July 16-17, 2015
[Website](#)

Additional Resources:

[National Center for Trauma Informed Care](#)
[Trauma Informed Oregon](#)

Trauma Informed Care: A New Path for Compassionate, Evidence-Based Care of Infants and Families
June 15-16, 2015

Portland, OR
[Registration Form](#)

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Trauma Informed Care at REACH

February 2016

What's new with TST?

We will be putting out a newsletter once a quarter. In between we are also sending updates to Senior Managers and All Staff whenever we can. Here's what's new....

- We've **welcomed Tahlia Martinez-Parker** to the team. Her work in the Community Builders Program is giving us great insight to the connections we make with our elderly and disabled homeowners and helps translate to the work to our properties.
- We have come up with a quick **Resident Death Check-List** to help on site staff in the event of a death on the property. This is to be used as a companion to the current Property Management Operations Manual. In times of crisis we look to find easily accessible information. We created this step by step guide to help staff navigate in the immediate moments after learning of a resident's death. The goal is to help offset some of the symptoms of the traumatic experience.
- In addition to the written guide, we've also produced a prototype for a kit containing many of the necessary supplies

staff use in the event of a resident death. We hope to gain more feedback from site teams and roll them out at high risk buildings. Our TST maintenance staff members will assist with set up and give a quick how-to.

- We previously provided **Important Numbers** lists to the properties. We will be adding and updating some numbers and will send those out when they are ready. Also let us know if you'd like to get a copy in large print to help with those with visual impairments.

- **As recommended by the TST , Project Respond** came out to the last PM-RS monthly meeting to provide staff with some information about utilizing their services. We are working bringing a **de-escalation training at next month's all-staff meeting**. We're excited to support staff in becoming more equipped to deal with the day to day in a trauma informed manner.

Examples of Trauma Informed Care.....

Each quarter, we would like to share with you some positive examples of how REACH staff have used trauma informed care. If you have examples, please, let us know!

The Community Builders team does amazing work in the community to provide home repairs to some of our most vulnerable populations. They are known for their kind and caring attitudes and we wanted to share a quote from a recent client about the work they did on their home.

"Their contributions made me feel grateful in the present and hopeful in the

future. In addition, it makes one feel valued at a time in life when hopelessness and invisibility feel crushing."

Let's give a huge shout out to the Community Builders team for going above and beyond to make such a huge impact in the lives of those we serve. They set a great example of how our work can change lives.



Your Trauma Support Team:

Thalia Martinez-Parker
 Austin Erdman
 Carol Patty
 Erica Tucker
 Heather Middleton
 Kim Matic
 Laura Blades
 Mike Gould
 Pam Minor
 Reed Morrison

Next meeting:
March 9th

Email:
traumasupportteam@reachcdc.org

Care of Staff After Trauma



**“Traumatic
reactions are
NORMAL
responses to
ABNORMAL
situations.”**



The following was created to help support staff after experiencing trauma in the work place. This will be provided for your reference in the shared drive as well as on the employee intranet, but we wanted to first introduce it here in our newsletter.

When there is an activating event (whether a relative 'small' thing or a major horrifying incident), the brain and nervous system is flooded with stress hormones. These stress hormones have a purpose related to our biological heritage as mammals. They can be 'maladaptive' in the present conditions (i.e., we're not actually being chased by tigers). The science is complex (many different hormones and receptors in the brain are involved), but part of the typical reaction (in some form or other) might be: fight, flight, or freeze. This means the pre-frontal cortex (the 'executive' brain, rational, problem-solving thought) may not be as available. Reactions are highly individual: for some folks, problem solving may be or feel MORE available (intense focus, for example). After the activating event is over, in order to return to a state of balance (right brain/left brain harmony; stress hormones back to normal levels, etc.), the following is advised:

Self-Care

- Physical activity to help release those hormones.
 - Go for a walk
 - Stretch near your desk
 - Do jumping jacks or other exercise
- Fluids, which also help to flush those hormones.
 - Drink some water
 - Be careful choosing drinks with caffeine or sugar which can make those nerves more intense
- Nutrition.
 - Eat something!
 - Protein is best (non-sugary, i.e. peanuts)
- Debrief
 - Talk it out with a peer or supervisor and brainstorm ideas for future prevention.
 - The Trauma Support Team is a great resource for information on how to handle trauma and to offer advocacy if you need support from your supervisor
 - You can advocate for each other as well. Don't hesitate to ask for or offer help.

Support for staff

- Depending on the situation (how scary, how intense), time away from the site of the incident; possibly support to shift work schedule or responsibilities for a time, etc.
- Recognition that the impact may last for a while, or resurface in different ways or may possibly be delayed and may not show up right away.
 - Flashbacks
 - Inability to sleep
 - Loss of appetite
 - Loss of focus
 - Stress, stress, stress!
- Skillful support: Not “are you okay?” BUT
 - “We know there's likely to be some lingering effects of what happened.”
 - What are you noticing? “Any challenges being here?” “Trouble sleeping?”
 - “We can offer some resources if you're struggling, through our EAP, for example”
- Support for the individuals' needs for self-care. Everything might not work for everybody. Be aware that we are all individuals with our own histories, personalities, and quirks. Ask staff what would work best for them.

What are some ways YOU handle trauma? What post-trauma routines work for YOU??



Trauma Informed Care at REACH

November 2015



Your Trauma Support Team:

Amanda Nabors
Austin Erdman
Carol Patty
Erica Tucker
Heather Middleton
Jennifer Neilson
Kim Matic
Laura Blades
Mike Gould
Pam Minor
Reed Morrison

With support from:

Diane Yachtmenoff

Next meeting:
Thursday November 5, 2015

Email:
traumasupportteam@reachcdc.org

What's it all about?

First we want to start off by refreshing everyone's understanding of trauma informed care. This information was sent out in August, but with new faces here at REACH, we'd like to present it again.

What Trauma Informed Care IS:

- Takes the trauma into account.
- Avoids triggering trauma reactions and/or traumatizing the individual.
- Adjusts the behavior of staff and the organization to support the individual's coping capacity.
- Allows survivors to manage their trauma symptoms successfully so that they are able to access, retain and benefit from the services.

Makes it possible for consumers to participate in their own care.

What Trauma Informed Care is NOT:

- It doesn't mean excusing or permitting/justifying unacceptable behavior.
 - It doesn't mean just being nicer
- It doesn't 'focus on the negative', yet encourages skill-building, empowerment and recognizes strengths

Why is TIC important?:

- Trauma is pervasive and its impact is broad/life-shaping
 - Trauma, especially interpersonal violence, is often self-perpetuating.
 - Trauma differentially affects the more vulnerable.
 - Trauma affects how people approach services.
- The service system has often been re-traumatizing.

What is the function of REACH's Trauma Support Team?:

- Bring an awareness of trauma into view
- Support and prepare All REACH Staff to approach their work with a trauma lens
- Guide policy, practice, and procedures based on the understanding of trauma

What have we done?

On average, the Trauma Support Team has been meeting every two weeks. We are constantly working on ways to address the different kinds of trauma we encounter working at REACH. From resident incidents to inter-office communications, we have discussed what we can do to be more aware.

One of the first tasks we've completed is the creation of an **important numbers list** for use at our properties. We list the manager's number, non-emergency police, and suicide hotline to name a few. These lists were created as a quick guide for both REACH staff and residents when

encountering different forms of trauma. Look out in your mailboxes for your buildings' copies this week.

What are we working on?



Here are some of the things the Trauma Support Team has been working on:

- We are teaming up with Project Response to provide PM/RS and front desk staff with more information on how their program works.
- Diane will be working with HR to schedule a de-escalation training for REACH staff after the first of the year.
- TST is creating a mortality kit to assist property staff in the event of resident deaths. We hope to provide high-risk buildings with kits first and then roll out to the remaining properties.
- We have had to say goodbye to a few members of our team so we are looking at the possibility of filling spots. If you are interested in joining, please email us at traumasupportteam@reachcdc.org with a few sentences about why you'd like to join and what you feel you have to offer.

Examples of Trauma Informed Care.....

We would like to share with you some positive examples of how REACH staff have shown trauma informed care.

“No one is immune to the impact of trauma.”

- A few weeks ago one of our maintenance techs witnessed a horrible motorcycle accident in front of a REACH property. Upon hearing about the incident, Dana Fulkerson, our interim facilities manager offered the tech a day off to process and recover from the trauma.
- Amanda Nabors received a housing inquiry call. The caller was experiencing abuse and asked that any information could be mailed in an unmarked envelop so as not to alert their abuser of their desire to move. Amanda took the extra step to ensure the caller received our information packet safely.
- Reed Morrison shared a bonding experience with residents over a comically large pair of lock cutters as they celebrated the removal of a few abandoned bikes.
- Austin Erdman faced an intense situation with a resident. Although concerned with his personal safety, he approached the situation cool, calm and collected. And he remembered to care for himself afterward by taking a walk to re-center

Tip of the month



One of the most important, but easiest things to forget after experiencing a traumatic incident is self-care. Working in service means we're often so used to addressing the needs of others that we forget our own. Here are a few things you can do to make sure YOU are okay:

- Talk it out with a peer or supervisor
- Go for a walk
- Take a break
- Drink some water
- Don't forget to eat
- Journal your thoughts
- BREATHE!
- Listen to music
- Exercise, stretch, Yoga