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YOUTH, YOUNG ADULTS, & MENTAL HEALTH

TRAUMA-INFORMED CARE

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INTRODUCTION

TRAUMA-INFORMED CARE

Childhood adversity and traumatic experiences are pervasive among youth and young adults. It is estimated that nearly half of all youth in the United States have been exposed to at least one adverse childhood experience,[1] and that the occurrence of multiple trauma exposures is common within specific populations. What's more, childhood adversity carries with it the potential for long-term mental and physical health consequences. For instance, transition-age youth with foster care experience often have complex trauma histories and meet the criteria for post-traumatic stress disorder (PTSD) at approximately twice the rate of their peers in the general population.[2] The need for infusing trauma-informed approaches across services to transition-age youth is clear. Fortunately, a movement to implement trauma-informed practices, policies, and organizational cultures is accelerating at a rapid pace. This issue of *Focal Point* brings together multiple views and voices that underscore the need for trauma-informed care, and describe innovations within the movement.

We begin with a personal reflection from a young person who has found healing from sexual abuse through her artistic expression. Samantha Chudyk, an artist and youth mentor, shares her story about the transformative power of art in her life. Samantha reminds us that young people often communicate about their traumas more easily with images than with words. Her own artwork epitomizes how the process of healing can unfold without the expression of words. With images that are haunting, this youth artist shows us that every person's trauma and healing journey must be understood as intensely individual, unique, and multifaceted.

The articles that follow this opening story consider trauma and trauma-informed care from a variety of perspectives ranging from neuroscience to federal policy. Julie Rosenzweig offers a compelling and accessible explanation of the neurobiological adaptive responses to trauma, describing how traumatic experiences and toxic stress can literally shape our brains. Jesse Homan explores promising practices that build on this neurobiological understanding. From the service provider's perspective, Ajit Jetmalani reflects on toxic stress research that is influencing practice, and illustrates how trauma-informed care can improve outcomes. Marga-

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ret Blaustein and Kristine Kinniburgh highlight how the effects of trauma can compromise crucial developmental capacities. Their explanations of how young people with trauma histories may not have yet acquired the coping and relational skills generally expected of persons their age are powerful reminders that service delivery changes are needed.

Traumatic experiences that alter our life trajectories can also include social attitudes and systemic discriminatory practices. Melanie Funchess, a parent, describes how the roots of trauma are found in the everyday lived experiences of oppression. The story of her Black, adolescent son illustrates the effects of historical and cultural trauma on persons of color. Unfortunately, his story is one that far too many young Black men can relate to – being subjected to prejudicial treatment by counselors, school officials, and the police. Melanie recalls the overwhelming task of trying to protect all of her children from a trauma that is as pervasive as the air around them. She concludes by sharing advice from her son on how to be a supportive adult.

Supportive adults are not only essential in helping youth heal from trauma, but in bringing their voices to the dialogue on trauma-informed policy change. Debra Cady and Eric Lulow describe the TIME (Trauma Informed Method of Engagement) model for youth advocacy. The model focuses on the relationship between the young persons and the supportive adults as the key factor for success. Practical and actionable advice is offered by Cady and Lulow to make advocacy work rewarding for young people on a personal and professional level.

Diane Yatchmenoff sets the stage for understanding how policies can change – for the better – the experiences of young people, their allies, and the professionals who work alongside them. Her overview of the policy landscape from the agency to the governmental level is filled with real-world examples of trauma-informed policy in action. Guidelines for change are also offered by Rebecca Flatow, Mary Blake, and Larke Huang as they impart SAMHSA's definition of trauma, trauma-informed care, and key identifiers of a trauma-informed organization. Becoming a trauma-informed organization requires critical reflection on existing policies and practices across all levels of the system to begin the transformation process. Toward this goal, Jane Halladay Goldman of the National Child Traumatic Stress Network provides insights on trauma-informed organizational assessments. Her article is filled with questions for organizations to consider in their own movement to become trauma-informed.

Understanding the pervasiveness of trauma and the harm it causes presents new opportunities for those who work with and care for youth and young adults. Becoming trauma-informed has the potential to reshape relationships we have with young people, change our own perceptions of their behaviors, rewrite the policies that guide organizational practices, and encourage all of us to become change agents for a more just society. Throughout this issue of *Focal Point*, we hope you find useful information to implement trauma-informed care in your everyday work, organizational culture, and policy priorities.

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Art by Samantha Chudyk

HEALING THROUGH ARTISTIC EXPRESSIONS OF TRAUMA

My sexual assault happened when I was five. I didn't have words for what happened. Rape. Trauma. PTSD. They all came later. What I do recall are changes beginning to take place inside of me before I was able to work though my trauma verbally. The early manifestation of my trauma was self-destructive. Self-harm behavior was my only means of dialog around the trauma.

I have always been a self-proclaimed artist. When I was younger, I'd spend hours hunched over my Fisher Price art table manically finger painting masterpieces for the refrigerator. So, when my therapist proposed art as a way of working through my trauma, I cringed. The idea of tainting the one healthy, empowering aspect of my life with the shame of what happened to me seemed counterintuitive at the time. In fact, the very thought of spending hours over a canvas rendering the events of my early childhood seemed like torture.

Despite my early hesitations we proceeded with the assignment. First, I created a timeline of my trauma, which began as abstract strokes of color and lines. I then talked through the timeline adding emotions to each section, then names, and details. This was the first time I was able to talk about the specifics of what happened to me in therapy.

We were then able to visually unravel my trauma on the office floor, focusing in on hints of color and deep expressive marks symbolizing the events I didn't have words for. This helped my therapist identify patterns of trauma, areas I needed to work on, and provided a better understanding of my journey as a whole. For me, I was finally able to section out events of my life and attach emotions to them – something I was unable to do until then. I was also able to identify multiple points of trauma in my early childhood and adolescence.

The artistic assignment morphed and molded as my therapeutic needs shifted. The sessions became less about the actual events that happened and more and more about the impact that trauma had on my life. My identity had been shaped by the events of my life, and that is something that I had to come to terms with through art. Being able to separate different aspects of myself and put them on the canvas helped me sort through who I was, and the parts of me that had grown out of past events. Introspection was one of the most difficult aspects of recovery for me; I had to start looking at changing my perspective on what happened to me and how it defined me – and I needed the process to be visual. I needed to confront myself on paper, just as I had needed to confront the trauma on paper.

I began to see the dichotomy inside of me. The

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broken bits, the wounded parts, the sections of me that had scarred over, the sections that were still raw, the strong parts, the healed parts, parts that were still untouched, and the parts that I was still growing into. I began to see something outside of the trauma, someone outside of the trauma. Under all that soot I was still alive.

From there on I gained clarity around the parts of me that I needed to nurture and the parts of me that I hoped would eventually get quieter. Most of all it became clearer and clearer to me that I was a survivor and that I had something to say to the world through my art.

My art became my memoir. It became my voice inside and outside the walls of therapy. Art became a mechanism of empowerment, of owning what had happened to me, and not letting it define me. From my trauma had sprouted a talent I had long forgotten about, and a weak voice that grew steadier and steadier.

I now use art as a tool in my youth mentor role. Many of the youth I work with are more comfortable opening up the lines of communication with a paintbrush and a sketchbook than they are with words. Art also gives youth and adolescents who experienced trauma something that is theirs, something to build with. One of the youth I mentor describes art as her creation from destruction.

The artistic assignments I use to engage youth are very different from the assignments I was given. They depend on how trauma has shaped the youth's perception of self, and how trauma has affected their identity. Many of the assignments work on self-portraits, on seeing different sides of their self, their future, their goals, their roadblocks, their past – what propels them forward, and what holds them back. These are big questions to ask of fourteen, fifteen, and sixteen year-olds, but I find that they can better illustrate goals and roadblocks with pictures than with words.

Sometimes strengthening the voice inside means innovation in terms of looking at different modes of therapeutic communication. This can include (but is not limited to) traditional forms of art. Survivors need to process in ways they feel most comfortable, for instance: poetry, dance, music, movement, or simply talking. My own journey along this pathway taught me that if we can allow survivors to use their trauma to fuel something, it can be a very powerful experience of gaining strength and hope through healing.

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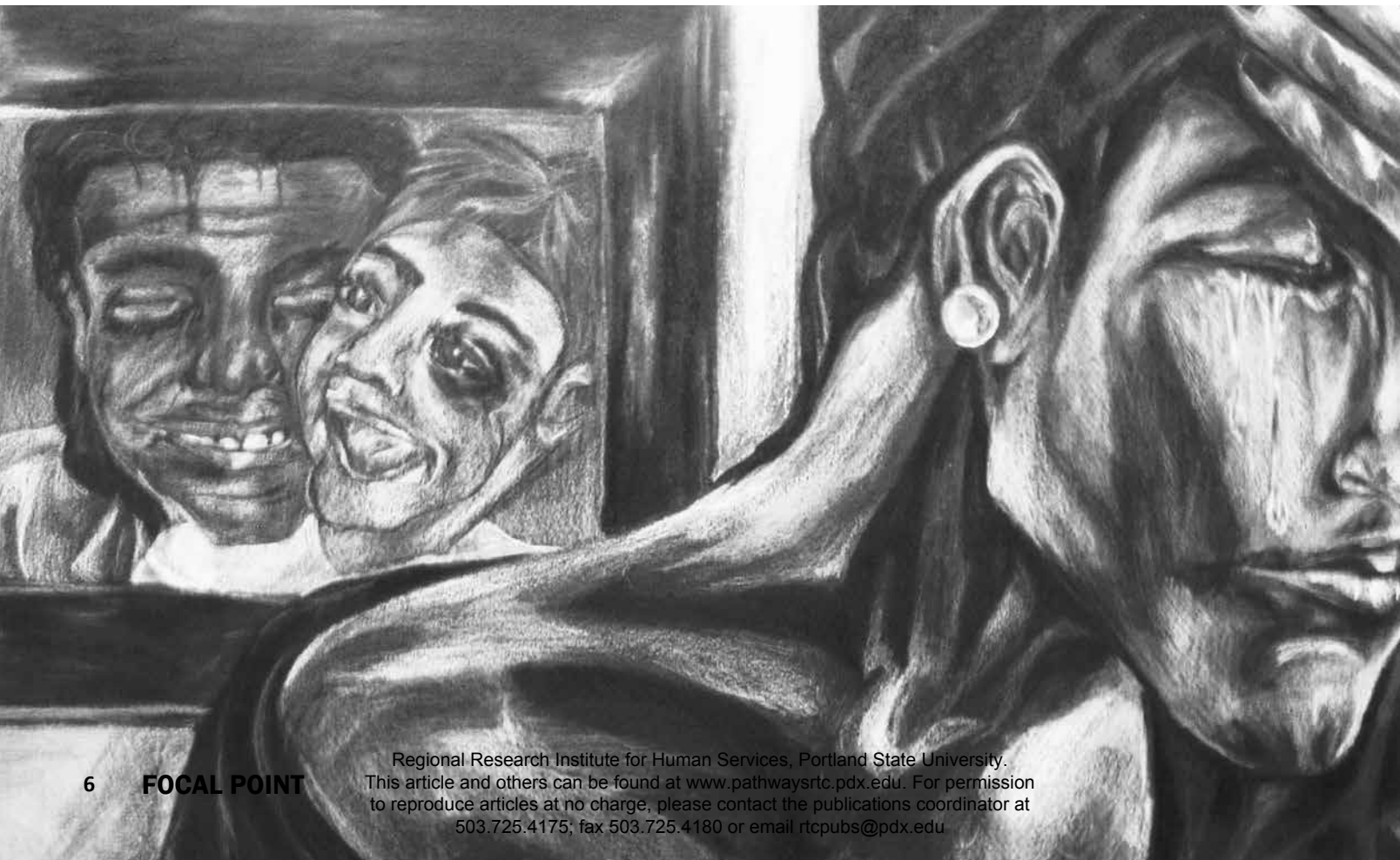
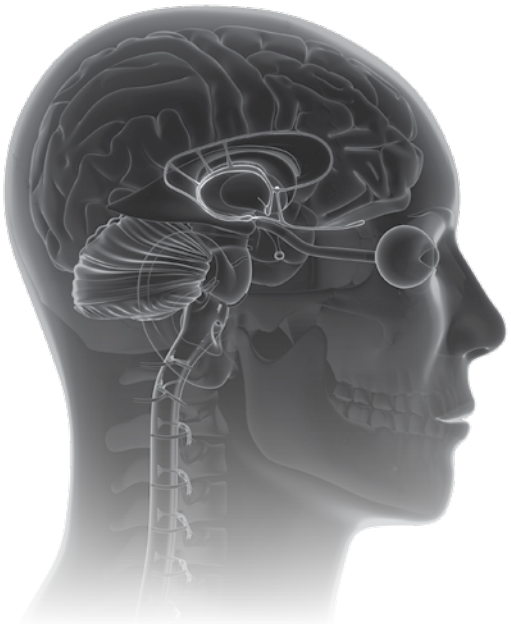
Art by Samantha Chudyk





Neurobiological Underpinnings for Trauma-Informed Care: A Primer

Your brain is on your side, even when it does not feel like it is. Those three-plus pounds of grey and white matter – approximately 86 billion neurons and trillions of synaptic connections – is an energy-hogging mass that occupies your skull and is designed for your survival. Survival is much more than your brain sending messages to your heart to keep beating, to your lungs to keep breathing, or to your gut to keep digesting. Your brain is constantly scanning for threats in your environment, looking out for your safety. When your brain detects danger, or perceives a threat to your survival, it automatically ignites your innate survival response. Your heart starts beating faster, your muscles tense, your blood pressure rises, and you sweat. This reaction is not about thinking; it is about action.

Innate survival responses not only help you stay alive; they are also essential for adapting to your surroundings. The basis of adaptation is the interaction between your genes and your environment. Some of your survival and adaptation strategies come from information encoded in your genes that is passed down from your ancestors. For example, when you spontaneously jump back from something on the ground, your survival response is being activated based on an ancestral memory of threat. Your brain perceived threat in the form of a snake, but it was only a small branch or tree root. You only realize this when you can think about, or cognitively assess, the situation. The threat that was in your ancestors' environment may not be a threat in your environment; nonetheless, this strong message is genetically encoded. Neuroscientists are gaining a greater understanding of this epigenetic transmission process and its effects on development, especially as it relates to historical trauma.

In addition to ancestral memories of threat, your brain maintains a database of information from your own lived experiences, beginning at a very young age, that are encoded in your memory as dangerous or threatening. When the same or similar types of experiences occur, or even a small reminder (such as a smell), your brain fires up your survival response. Over time, you learn to either avoid certain known or perceived threatening situations, or develop adaptive-coping strategies that allow you to survive them. Fortunately, your brain also records positive, rewarding, and pleasurable experiences, which are also essential for your survival and adaptation.

Although you continue to consciously and unconsciously learn and revise adaptive strategies throughout life, many of the decisions you make and reactions you experience every day are based on adaptive strategies that you have learned from a very young age. For example, the earliest survival-adaptive strategies are formulated during infancy and early childhood within the context of relationships. Infants and young children are dependent upon their caregivers for protection and survival. Neural networks, specifically those located in the right side of the brain (*right hemisphere*), are designated for attachment to primary caregivers. Infants cannot regulate their physiological or emotional states; they learn both physical and emotional regulation strategies through attachment experiences with caregivers.

Positive and negative early attachment experiences of touch, smell, taste, sound, and sight, are stored as sensory memories in the *amygdala*. Each of your two hemispheres has an amygdala, a small structure the size of an almond that is responsible for much of your emotional regulation and most of your survival

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responses. The amygdala is like a smoke detector, or first responder, assessing incoming sensory experiences for threat. The *implicit memory system* is the only type of memory system that is online at birth and, in addition to encoding early life attachment experiences, is responsible for encoding traumatic experiences across the lifespan. Around 18 months of age, the *explicit memory system*, a function of a brain structure called the *hippocampus*, begins to develop. The hippocampus is particularly good at remembering place (spatial) and time details about everyday activities. The amygdala and the hippocampus are located next to one another and communicate consistently. When the amygdala registers an emotional experience, the hippocampus provides details of the effect.

You are most familiar with your hippocampal-based explicit memory system, as you use it to consciously recall information; hence it is crucial to learning. The hippocampus works closely with the *prefrontal cortex* (PFC) through neural pathways to create long-term memory storage. Best known for its role in executive functioning, including decision-making, inhibition, and anticipating consequences, the PFC, located in the exterior part of the front of the brain just below the skull and behind the forehead, is also active in affective regulation. Interestingly, the PFC is the last area of the brain to become fully functional, typically in the mid to late 20s.

Information encoded in the implicit memory system is not remembered in the same way. An implicit memory, also called an unconscious memory, is based on past experiences, surfaces without thinking, and is activated by a sensation, such as a smell or a sound, and often without your conscious awareness. When an implicit memory is present, you often have an emotional response, even if you do not understand why.

Your early attachment experiences create neural patterns: specific pathways which guide your thoughts about your self-worth, how others will respond to you, and the level of safety you feel about your environments. This is your first adaptive-survival strategy and it becomes generalized to many situations, especially social and romantic relationships. In many ways, this adaptive strategy is similar to having your own signature GPS (global positioning system), that helps you navigate relationships and real or perceived threats in your environment. Because humans are social animals, your survival and well-being depends on feeling safe with others. The most powerful resources in stressful or threatening situations are other people. Early attachment relationships that provide you with experiences of safety, protection, and caring equip you to trust others to do the same. If early attachment relationships are less optimal, you will be more hesitant to trust, both yourself and others.

TOXIC STRESS: WHEN ADAPTIVE-SURVIVAL STRATEGIES GET STUCK

Knowledge about the neurobiology of threat assessment, adaptation, and attachment is the foundation for understanding how consistently experiencing adversity (chronic stress), including psychological traumatic event exposure, changes areas of the brain both structurally and functionally. The ability of the brain to change and reorganize in response to experiences is known as *neuroplasticity*. Neuroplasticity is essential to our survival and adaptation. It is also essential to our resilience and healing from the effects of toxic stress.

In response to all types of stress (e.g., positive, physiological, temporary, chronic, or traumatic), the *Hypothalamic-Pituitary-Adrenal* (HPA) axis becomes activated. When your *HPA* system is engaged, the brain prioritizes resources for activities that are essential for survival, such as heart rate, blood pressure, and muscle tension, while processes such as digestion and higher cognitive functions not involved in fight or flight are minimized. Once the amygdala sends the message that a threat is imminent or present, the *H*ypothalamus releases corticotropin-releasing hormone (CRH), which signals the *P*ituitary gland to release adrenocorticotropic hormone (ACTH), which prompts the *A*drenal gland to release cortisol. The HPA axis is the body's stress management system and coordinates not only with the amygdala, but also with the hippocampus and the prefrontal cortex (PFC). While the amygdala sounds the alarm, the hippocampus and the PFC shut the alarm off.

When the HPA axis is continually activated by threat or chronic stressors in a person's environment, the brain adapts to these environmental demands by remaining on high alert, ready for action at all times. The body cannot effectively metabolize the high levels of cortisol (*toxic stress*), and this heightened, persistent level of stress response becomes toxic to the system. Deficits or alterations in the stress regulatory processes are the basis of many mental health impairments, including post-traumatic stress and complex trauma disorders.

Toxic stress profoundly impairs the HPA system and alters the structure and functioning of brain areas. The hippocampus appears exceptionally vulnerable to the effects of stress. When there is chronic over-activation of the stress response system resulting in the brain being flooded with excess cortisol, hippocampal-dependent learning and memory processes become impaired. When altered by toxic stress, the hippocampus has a

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significantly reduced capacity to provide important contextual information to the amygdala about which conditions represent danger and which represent safety. When the hippocampus is compromised, it is not effective in sending messages to the hypothalamus to stop producing CRH and turn off the stress response.

Likewise, the amygdala is also changed structurally and functionally by toxic stress. The amygdala is central to relational processes and development of attachment strategies, making it extremely sensitive to excessive activation in early life. Infants, children, and youth are particularly sensitive to toxic stress and impairment in regulatory functioning. Again, excessive activation in the areas that respond to emotions, and under-activation in areas involved in cognitive processes of assessment and evaluation, lead to developmental disruptions.

Functionally, when the brain detects that the threats or stressors, or the perception thereof, have been stopped or prevented, the stress system response is shut off, deactivating the cascade of chemicals and returning the brain and HPA axis to baseline or what is called *homeostasis*. However, when the threat is frequent or prolonged, the ability of the brain and HPA axis to return to homeostasis becomes impaired.

Because of this activated state, sensory information associated with the threat or chronic stressors, such as visual cues, smells, ambient sounds, or the time of day, continue to stay active in the amygdala. As a result, negative affective states (e.g., fear, shame, rage, numbing, dissociation) and physical sensations (e.g., muscle tension, increased heart rate, rapid breathing) paired with the sensory cues are easily activated even in seemingly non-threatening environments.

For example, a high school student is jumpy, feels her heart beating, and experiences the emotion of fear at the sound of a loud noise in the hallway, even though she is in a safe classroom environment with a teacher and friends she trusts. Her amygdala holds implicit memories that include loud sounds, such as gunshots or parents yelling at each other. The loud sound in the hallway represents threat and the amygdala sends a message to the HPA to release more chemicals. The hippocampus (sometimes in partnership with the PFC), may be able to intervene and slow the stress response. Based on explicit memories, the hippocampus is able to very quickly sort through its database and send a message to the amygdala that the noise is the sound of a student's locker closing and shuts off the stress response. If however, the student has chronic stressors, ongoing trauma, or complex developmental trauma, the hippocampal-based regulatory processes are significantly compromised and the student may already be enacting the survival response. For youth who are frequently in survival mode, acting on *fight or flight* or *freeze responses*, this survival-based adaptive functioning becomes a normative way of being in the world. Their brains have learned ways of protection from actual or perceived threat. In a very real way, the brain has become trauma-informed.

Trauma-informed care, whether provided by individuals or organizations, recognizes the pervasiveness of adverse experiences among service users and the real effects of toxic stress on their mental and physical health. Although these effects can be damaging, through understanding the brain's neuroplasticity and its biological imperative for relational connection, there is an abundance of hope for healing and transformation.[1]

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DATA TRENDS

CAN THE BODY HELP REDUCE ADOLESCENTS' TRAUMA SYMPTOMS?

SOURCE

Warner, E., Spinazzola, J., Westcott, A., Gunn, C., & Hodgdon, H. (2014). The body can change the score: Empirical support for somatic regulation in the treatment of traumatized adolescents. *Journal of Adolescent Trauma, 7,* 237-246.

Somatic interventions do not require people to communicate with words. Instead they use sensory motor activities that require movement, and assist people to become aware of their own internal sensations.

The majority of children and adolescents who enter residential treatment centers have histories of numerous traumatic experiences.[1] Many of these youth have problems with behavior, affect, and emotion dysregulation; that is, they likely have intense emotions, and behave in a way that is impulsive, reactive, aggressive, withdrawn, depressed, numb, or detached.[2] For many of these traumatized youth, traditional talk-based therapy approaches do not work,[2] and they are unable to achieve regulation through thought-based processes.[3] In an attempt to address the need for new trauma treatments, this study investigated the effectiveness of a manualized sensory motor intervention for traumatized youth: Sensory Motor Arousal Regulation Treatment (SMART).

The International Society for Traumatic Stress Studies recommends that treatment of trauma occur in phases, with the primary goal of Phase One being self-regulation.[4] Somatic interventions do not require people to communicate with words. Instead they use sensory motor activities that require movement, and assist people to become aware of their own internal sensations in order to help them increase their ability to regulate their emotions. For example, Trauma-Sensitive Yoga is a somatically based intervention that has been shown to reduce PTSD symptoms in adults.[5] Another approach, Sensory Integration Occupational Therapy, has shown that activities that involve integrating sensory input with movement can help people regulate.[6]

THE SMART MODEL

The SMART model was designed primarily for traumatized children and adolescents who were receiving talk and symbolically based therapies, and who were not succeeding with these treatments. The goal of the SMART model is to increase regulation in traumatized youth

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so that they may benefit from conventional means of therapy. In order to do this, therapists utilize a variety of sensory motor equipment that targets the different body systems involved with organizing and calming the body.[2] Youth are invited to interact with the equipment of their choice. The authors expected that the invitation to use this equipment would help to begin the therapy process with youth who were distrustful and fearful, and that children and adolescents who participated in SMART would be able to more rapidly engage in processing trauma.

METHOD

This study used a matched group design comparing 10 young people assigned to the SMART intervention group with 21 who were in treatment as usual (TAU). The TAU condition consisted of weekly individual talk therapy sessions. Both groups engaged in milieu therapy at the residential centers that were trial sites. Groups were matched on age, ethnicity, number and types of traumatic experiences, and severity of clinical symptoms. The authors collected data before and after the intervention, with the average length of treatment being 9 months, and a range of 6 to 12 months.

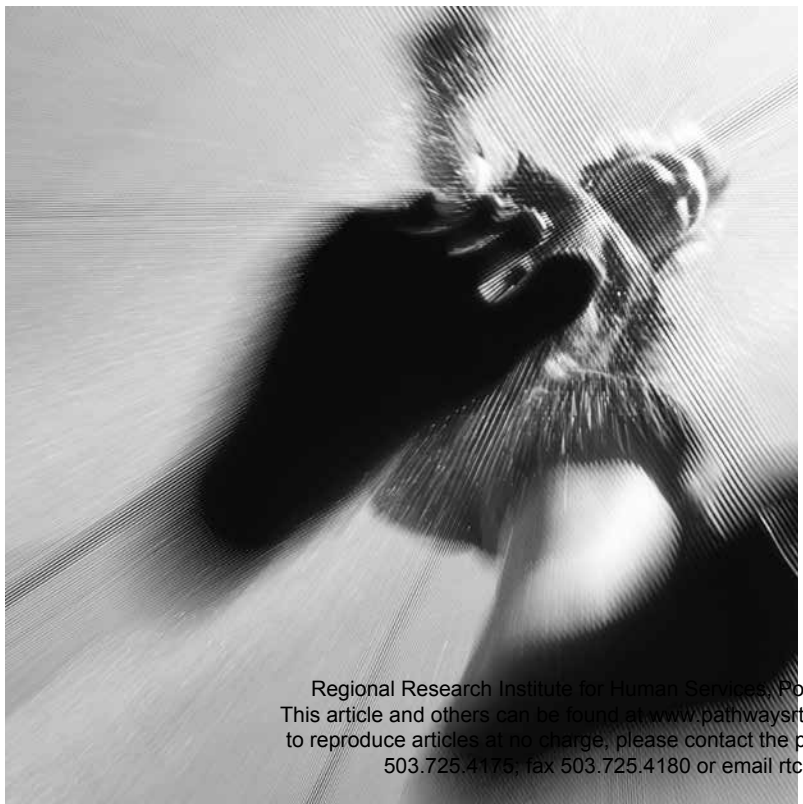
Study participants ranged from age 13 to 20 with an average age of 16; 90% were female. The young people were diverse: 55% Caucasian, 20% Hispanic/Latino, 16% African-American, and 7% biracial. The majority of the study participants met criteria for multiple mental health diagnoses, and trauma histories included emotional, physical, and sexual abuse; neglect; and impaired caregiving. The average number of reported traumatic experiences was 6.5.

For the SMART condition a room was created within the treatment centers in which all office furniture was removed, athletic floor mats were put down, and equipment used in sensory integration therapy such as fitness balls, mini trampolines, weighted blankets, large floor pillows, and balance beams were installed. The room was equipped with a videotaping system that recorded all sessions. All participants signed consent forms to be video recorded. Participants were invited to examine and try out the equipment. Therapists would then work with the participants to assist them in becoming aware of how to self-regulate, and/or co-regulate with the help of the therapist and using the equipment.

The Trauma History Profile[7] was used to collect baseline data from multiple sources: the participants, parents/caregivers, and relatives. The Child Behavior Checklist (CBCL),[8] completed by parents/caregivers, reported on behavioral and emotional problems in children and adolescents, and measured externalizing behaviors (focused towards others; e. g, aggressive and defiant behaviors) and internalizing behaviors (focused towards self; e.g. depression, anxiety, withdrawal). The PTSD-RI,[9] a self-report scale, assessed symptoms of PTSD in participants.

RESULTS

Analysis of the data showed that both the SMART and TAU groups experienced reductions in symptoms measured by the CBCL externalizing scale, and the



The SMART group showed clinically significant reductions on the internalizing scale of the CBCL, as well as the Somatic Complaints, and Anxious/Depressed subscales.

overall PTSD-RI scale. The differences between the two groups were not statistically significant. The SMART group showed clinically significant reductions on the internalizing scale of the CBCL, as well as the Somatic Complaints, and Anxious/Depressed subscales compared to the TAU group. SMART group members had greater reductions in the PTSD-RI subscales of over-arousal and re-experiencing subscales than the TAU group, however the differences were not statistically significant. Both groups had lower scores on the PTSD-RI avoidance subscale at post-treatment, however the decrease was not statistically significant.

CONCLUSION

The authors reported that this study provides preliminary support for the possible effectiveness of the SMART model in reducing internalizing symptoms often linked with complex trauma in children and adolescents. The authors stated that the SMART model may be particularly effective at reducing anxious and depressed moods, as well as problems of hyper-arousal in this population. More meticulously controlled research with a larger sample size is needed before more conclusive statements about the efficacy of the SMART model can be made.

One strength of the study is that the measures used reported on the level of functioning across all hours of the day, not just what occurred within the therapy session, which resulted in more accurate reports of overall effectiveness of an intervention. Secondly, therapists, educators, milieu staff, and participants who completed measures were not aware that the data might be used to measure the effectiveness of the SMART model, thereby controlling for bias.

A limitation of the study was the potential for selection bias as some youth and/or guardians did not consent to the youth being video taped. This prevented them from participating in the study. Therapists and supervisors chose which conditions to place participants in based on severity of symptoms and clinical need, again introducing the possibility of bias.

This study offers preliminary support for the SMART intervention, and is an important step in adding empirical evidence for sensory motor-based interventions to the field of trauma-informed care.

The SMART model may be particularly effective at reducing anxious and depressed moods, as well as problems of hyper-arousal.

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The Impact of Toxic Stress on the Developing Person:

Becoming a Trauma-Informed Service Provider

AN "UNCOOPERATIVE PATIENT"

Sarah was a 16 year old youth living with a foster family, admitted to a pediatric hospital for a "routine" surgical procedure. Prior to admission, her physicians expected that she would be released after a three-day hospitalization. Hours after she arrived, she was described as "defiant, combative, hostile, and uncooperative" and her surgical procedure was postponed. She remained in the hospital for 30 days while service providers struggled to find a place for her to live.

In 1998, Vincent Felitti and colleagues published a landmark study examining the correlation of adverse childhood experiences (ACE) to health outcomes in 13,494 members of a large health maintenance organization (HMO).[1] As part of the research, 70% of HMO members responded to a questionnaire that listed seven categories of adverse childhood experiences: psychological, physical, or sexual abuse; violence against mother; or living with household members who had substance use disorders or mental illness, or were suicidal or ever imprisoned. The authors found that individuals with four or more categories of adverse experience (ACE Score of four or more) had 2-fold to 12-fold increased rates of mental health, substance abuse, and physical health conditions. The findings of this study are shifting public policy as well as health care delivery, and have invigorated research in many related fields.[2,3] As depicted in the ACE pyramid (see Figure 1),[4] adverse early experiences shift a person's thinking, judgment, and social relationships leading to increased risk behaviors that produce adverse social, economic, and health outcomes.

A DIFFICULT LIFE

Sarah was born to drug addicted parents. By the time she was five she had been removed multiple times due to severe neglect and physical abuse. She was eventually adopted, but her adoption failed and she had placements in multiple foster homes in the years and months that preceded her admission to the hospital. She had complicated medical challenges that required daily care to prevent deterioration in her condition. This care required her participation but she also struggled with severe behavioral outbursts, which had led to medical complications and greatly

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Figure 1. The ACE Pyramid

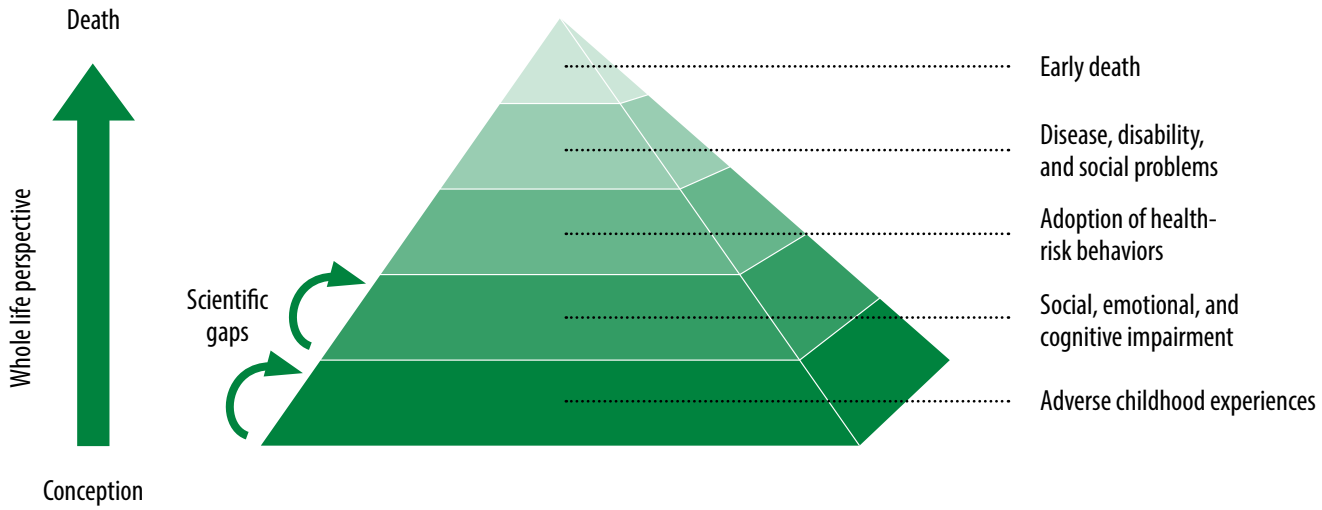

Figure adapted from http://www.cdc.gov/violenceprevention/acestudy and used with permission.[4]

limited options for stable living situations. Families who cared for her quickly found themselves in power struggles leading to a long string of failed placements.

"Defiant, combative, hostile, and uncooperative" were labels used by many people who knew Sarah…but what if we saw her as "frightened, struggling to cope, confused, and abandoned" and dealing with the effects of extreme stress?

TOXIC STRESS

One can think of stress as on a spectrum from normal health building stress (exercise) to toxic, overwhelming stress. It is toxic levels of stress that adversely impact health through the release of chronic stress hormones which impact gene expression, memory, learning, and brain development.

Poorly regulated behaviors and emotions further impact social, academic, and vocational functioning leading to cycles of failing and destructive experiences. People who have traumatic histories may interpret routine communications as hostile and respond with a fight or flight reaction that is out of proportion, from the perspectives of others. When these behaviors are interpreted from a typical lens, the result is often misunderstanding and escalating patterns of negative communication or avoidance. Over time the individual comes to expect poor outcomes and enters triggering situations (such as health care settings) with anticipatory fear and anger or avoidance.

THE DEVELOPING PERSON

Human development is the result of a complex interplay between gene and environment during brain development and through a cumulative process of building capacities. The foundations of healthy development depend on stable and secure relationships, which are influenced by a myriad of factors ranging from family structure and function to public policy and generational cultural influences. This is well represented in a diagram from an article entitled "The Lifelong Effects of Early Childhood Adversity and Toxic Stress"[5] (see Figure 2).

Brain development is a sequential process with the formation of primitive structures first (brain stem controlling basic functions such as breathing and heart rate), progressing eventually to cortical structures responsible for complex thought and emotional regulation. The process is punctuated by a number of sensitive periods where brain cells (neurons) respond to environmental experience. Some neurons are experience-dependent, meaning that their survival depends on appropriate and organized stimulation. A disorganized, traumatic, or under-stimulating environment has lifelong impacts on this complex process. The timing of trauma and neglect may result in later challenges, which reflect the associated developmental periods affected. Struggles with becoming easily overwhelmed with sensory experiences, regulation of emotions, processing of information, understanding language, and the development of effective interpersonal skills are related to specific brain regions and developmentally sensitive periods. Knowledge of these complex processes and residual effects

may shape our understanding and result in better-targeted therapies for each individual.[6,7]

HEALTHY RELATIONSHIPS ARE PROTECTIVE

The quality of relationships and attachment between caregivers and their children may be defined by distinctive types of child responses to separation,[8] and the type of attachment is predicted by the parents' recollection of relationships and attachment to their parents.[9] This generational transmission of relational health interacts with environment and genetics to create vulnerability and resilience in the face of environmental stress. Secure attachments provide protective and reparative capacity in the face of what would otherwise become toxic stress.[10]

TRAUMA-INFORMED APPROACH

An understanding of the impact of trauma on the developing person creates a frame for how organizations and individuals can design services that create a sense of safety, which is the foundation of healing relationships. The Substance Abuse and Mental Health Services Administration (SAMHSA) lists six core principles for trauma-informed care: (a) Create a sense of safety; (b) Practice trustworthiness and transparency; (c) Utilize collaboration and mutuality; (d) Practice empowerment; (e) Foster voice and choice; and (f) Recognize cultural, historical, and gender issues.[11] While working with Sarah, service providers incorporated trauma-informed principles in their practice.

HELPING SARAH

When the child psychiatrist and the resident entered Sarah's room, she was on the phone yelling at the person on the other end. The interviewer sought to introduce himself and Sarah yelled "Shut up!"

When caregivers are confronted with another human being in distress, how we choose to support that person is informed by our understanding of what is causing the distress. If we think she is rude and inconsiderate and needs to use better behavior, we might say "That's not appropriate"…or… "You can't use the phone if you are yelling at people." The consultants in this case assumed that the behavior was a sign that Sarah was struggling to cope and needed support.

The interviewer started with an empathetic stance and said: "Sorry, I'm just going to wait until you're free." When Sarah hung up she was crying and exclaimed, "Don't you know it's hard for me to understand two people taking at once!"

Figure 2. An Ecobiological Framework for Early Childhood Policies and Programs

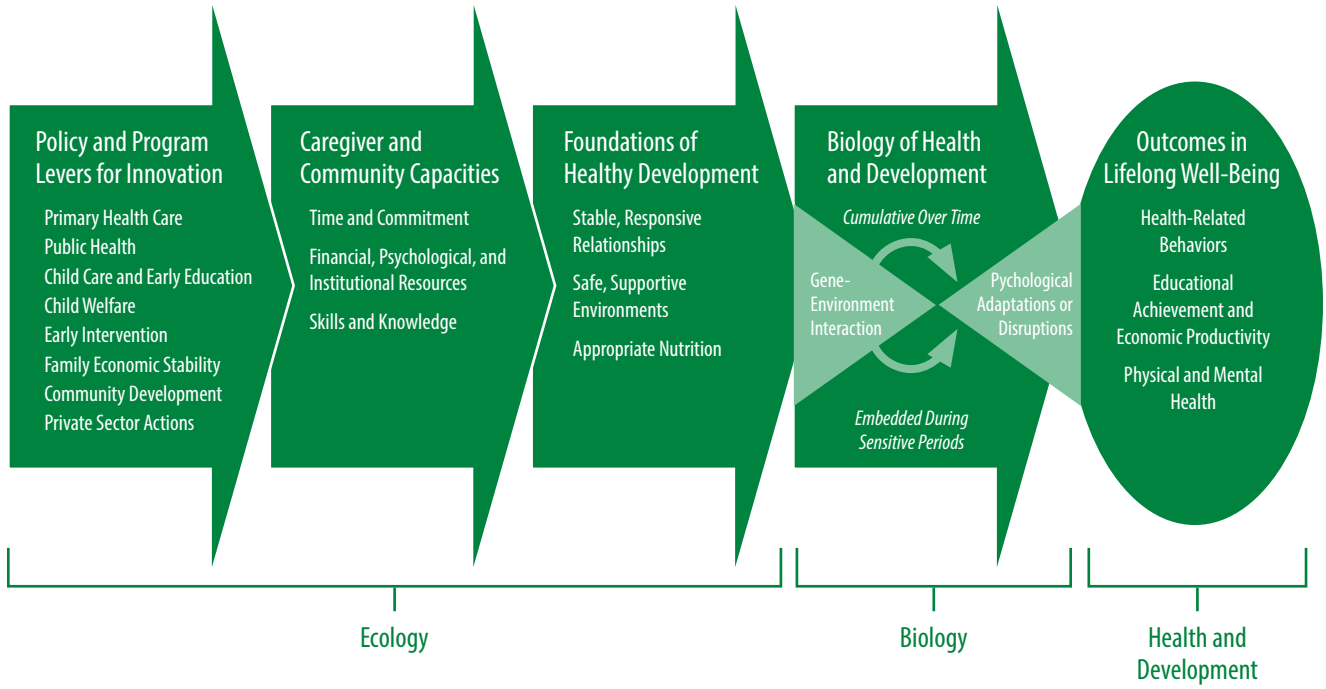

*Figure adapted from "*The lifelong effects of early childhood adversity and toxic stress," *Pediatrics, 129*(1), *and used with permission.*[5]

Response: "Sorry Sarah, thank you for explaining that to me." "You're really upset; can you tell me what's going on?" They got permission to sit at eye level and gave her space. They learned about her struggles through gathering information, reassuring, reflecting, and some educated guessing. That was followed by strategizing with Sarah about how to get her needs met as well as the needs of staff and other young people on the floor (collaborative spirit). The psychiatry team also gathered information from Sarah's caseworker. They learned about her many losses, her interests in animals and art, her sense of humor and her desire to stick up for others (strengths). They also learned that she had learning challenges of various types and struggled with loud noises and speech (lagging skills). The medical team was informed about her history and the impact of trauma and loss on her behaviors. The consultants discussed strategies to avoid power struggling and triggering of explosive behavior.

Overall this approach was consistent with the philosophy of *Collaborative Problem Solving* as defined by the Think:Kids program at Massachusetts General Hospital (see http://www.thinkkids.org). This approach utilizes the frame that youth do well if they can, and if they are struggling, it is the adults' job to understand why. Ultimately the goal is to improve the skills of the young person rather than impose the will of the adult.

Over time Sarah let her caregivers help. She formed relationships with them and navigated her medical care as a partner with her team. Physical and chemical restraints were avoided throughout her stay and the nursing staff grew fond of her. She was eventually placed with a family who celebrated Sarah's strengths and invited her to join in solving the challenges of her day to day life.

A CHANGING PARADIGM

The ACE study and subsequent analysis and investigation are driving changes in health care policy and delivery. Health care costs are directly correlated to early childhood experience. Understanding and preventing child maltreatment, improving resilience, and building skills for later life form the foundation for a healthier population. Researchers, service providers, and policymakers are investigating and implementing a range of principles and promising approaches to supporting traumatized individuals. All of us have the opportunity to improve our ability to help others by shifting our explanation of the actions and emotions of those we wish to support.

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When Age Doesn't Match Stage: Challenges and Considerations in Services for Transition-Age Youth with Histories of Developmental Trauma

Philip is 19 years old. He has been in the care of child welfare since the age of 10 and has lived in 8 placements and attended 5 schools. When he graduates next month, his eligibility for his group home will end. Although his clinician has been trying to support him in applying for further services, resources are limited, and waiting lists are long. Philip's caseworker is new, and he is not her top priority. Philip has little family to speak of. His father died three years ago; his mother continues to struggle with mental illness. His younger sister was adopted and he does not have contact with extended family.

Philip is motivated, hard-working, and wants to have a different life than his parents, but – like them – he struggles to cope with his anxiety and depression. He becomes overwhelmed in the face of pressure and either freezes or explodes, which has made employment seem unattainable.

Philip is 30 days from independence.

TRAUMA-IMPACTED TRANSITION-AGE YOUTH

In the past decade, there has been a shift in the field of traumatic stress. Children who have suffered chronic early abuse, neglect, and chaotic parenting were for far too long not seen, and then seen only through the lens of adult and acute traumatic events. While there is now growing recognition of the toxic nature of trauma and adversity on developmental processes there is still too large a gap between knowledge and policy, particularly as it relates to one of our most vulnerable populations: those young adults who, like Philip, become "adult" in chronology but lack the developmental capacities and external supports that will allow them to thrive in the adult world.

In this next year, thousands of youth like Philip will fall through the cracks. One in ten children discharged from foster care is discharged to emancipation, rather than to a placement resource, often after years in state care.[1] While some will succeed despite the long odds, many more will become statistics of other systems: mental health, homelessness, unemployment, and chronic disability.[2-4] Thousands more will transition out of juvenile justice systems close to their age of legal majority, many without support networks.[5] These youth, almost entirely made up of young people with histories of abuse and neglect[6] are at risk for numerous negative outcomes including re-arrest and transition into the criminal justice system.

In defining this population, it is crucial to establish who these youth are. They are young adults who have often intersected with numerous systems in childhood. They have complex diagnostic pictures and – because of that complexity – may receive denials of eligibility from multiple adult service systems leaving these most complicated youth devoid of any supports.

DEVELOPMENTAL TRAUMA IN ADOLESCENCE AND EARLY ADULTHOOD

Complex developmental trauma has been defined as the experience of childhood-onset, chronic adversity which is interpersonal in nature, and often occurs or co-occurs in the context of the child's primary caregiving system.[7-9] Expert consensus and research suggest that developmental trauma both drives significant mental health and child welfare service utilization[8,10] and leads to pervasive impacts across developmental domains.[11]

Development in general relies upon the scaffolding of skills: the growing child's emerging abilities are built

upon his or her own pre-existing capacities, and by the ways that the external world provides support for functioning above that which would be possible independently. In the absence of this scaffold (reasonably safe, consistent supports), youth lag in development, and in turn continue to be vulnerable to the cumulative effect of ongoing failure experiences.

The expression of developmental trauma varies across individuals, but there are core domains of influence that are generally agreed upon. These include the following:

Regulation: Trauma-impacted adolescents may struggle with understanding, tolerating, and managing feelings and physiological states. Without age-appropriate coping skills, these youth may rely upon unhealthy strategies (substance use, high-risk behaviors, self-injury) or withdraw.

Relationships: Forming and maintaining safe connections is challenging for trauma-impacted youth. Interpersonal difficulties may stem from belief systems – for instance, a profound felt sense of vulnerability in relationships and distrust of others – and/or may stem from skills deficits in development of mutually satisfying interactions. Mistrust may lead some youth to isolate while others may fill relational needs in ways that leave them vulnerable to further victimization.

Identity: Self-perception is strongly affected by experience and relationships, and youth with a history of trauma have an understanding of self that is often marked by negativity, confusion, and fragmentation. They may feel damaged and incapable, and may approach new tasks with a deep lack of faith in their own ability to succeed. A common outcome is a loss of the ability to perceive the self in the future – along with the possibilities that future typically holds for youth.

Information Processing: Broadly, trauma influences reflective capacities: the individual's ability to take in, make meaning about, and act on internal and external information in a goal-oriented way. Trauma-impacted youth often struggle with executive functions. They may also have difficulty with many skills that support cognitive capacities – for instance, the ability to seek and tolerate support in problem-solving.

THE DISTORTED LENS: THE IMPACT OF MIS-ATTUNED EXPECTATIONS

It is increasingly accepted that the period we think of as adolescence extends beyond 18, the age of legal majority, and into the early 20's. In normative development, late adolescence is a phase of growth and exploration. With access to a widening world of peers and community and growing capacity for independent functioning, superimposed upon often intense emotional experience, changes in physiology, and as-yet-not-fully-developed prefrontal cortical functioning, late adolescents may operate as "almost adults" in appearance, but still need support to navigate both their internal and external worlds successfully.

All of us lose access to emerging skills during stressful times: when we shift jobs, homes, relationships, and/or roles we fall back on coping strategies which have served us in earlier, more solid periods of our life. Emerging skills are available only when there are sufficient resources to access them. This is particularly true for children and adolescents, whose skill sets are often qualitatively distinct from one stage to the next. Concretely, this means that as youth transition out of their childhood world into their adult world, they may show a temporary regression in skills and capacity.

Luckily, many young people have a safety net. For transition-age youth in the system, this safety net disappears. Adding insult to injury is the societal expectation that these youth be ready to face the world independently when the age of majority is reached, an expectation often not placed upon their more resourced peers. Indeed, the very language of "independence" that is used to describe services during this stage suggests the expectation that the 17- to 19-year-old youth will be functioning in the absence of supports.

As an analogy, imagine that someone who has no idea how to swim is thrown off a bridge into a rushing river after having been shown a video of someone treading water. Though she tries to keep her head above water, the current is too strong and she has no idea how to translate the observed video into action. As she starts to drown, a crowd gathers and insults her for her lack of skill. Eventually a lifeline is thrown and she grabs it, but when she is pulled ashore she is told she will be charged for the resources that ensured her survival.

In many ways, this is the story of Philip, and many of his peers.

CHANGING THE STORY: SUPPORTING TRAUMA-IMPACTED TRANSITION-AGE YOUTH

In considering ways to change this story, we must consider where in the process we want to intervene: do we start after Philip is drowning in the water, by planning a better rescue? Do we want to give him better skills up on the bridge, before throwing him in? Or do we want to start far earlier, support him as we go, and rather than throw him off a bridge, perhaps enter the water with him?

To support system-involved youth in successful

transition, we must have a paradigm shift: rather than considering transition as occurring only during the final years of adolescence, we must nurture and create opportunities for growth as early as is feasible.

At minimum, if we are to do right by youth whose lives have been held by care systems then we need to consider ways to achieve the following:

1. *Develop a toolbox:* The literature on resilience identifies key qualities and capacities that predict healthy functioning in early adulthood including:
   a. *Affect management:* Ability to tolerate and manage emotion,
   b. *Executive control:* Capacity to make thoughtful choices,
   c. *Awareness of self:* Frame of self that is coherent and generally positive,
   d. *Relational skill:* Ability to access, make use of, and maintain relational resources, and
   e. *Life skills:* Ability to engage in self-care and use independent daily living skills.

   In intervention for trauma-impacted youth, far too often we zoom in for our treatment, focusing on symptom management, and playing crisis manager rather than resilience developer. Instead, our lens needs to become a wide-angled one.

   Early childhood intervention should include evaluation and enhancement of developmental and life skills as a primary intervention target for this population. We can and should begin to build and support these capacities at age- and stage-appropriate levels at the start of a youth's involvement in the system, rather than at the end of it.
2. *Identify long-term resources:* One primary goal of child-treating systems is the achievement of permanency and safety for youth in stable homes. When youth fail to transition to such placements successfully, we often select a starkly dichotomous choice: preparation for independence. Rather than considering *solitary* as the logical counterpart to *nurtured*, we must redefine permanency and consider ways to build permanent attachment resources for all children in care, regardless of placement. These resources may serve multiple functions over time: mentor, coach, and cheerleader as youth navigate their worlds.

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3. *Create a network:* As youth enter into late adolescence a key goal should be identifying, accessing, and connecting to a wide support network. Systems that provide comprehensive services to high-risk populations should serve as models of an efficient way to offer this continuum of care; in the absence of such a singular resource, agencies that support this population might consider formation of linked networks to facilitate access to services.

4. *Enhance intensive supports for those youth that require them:* Many youth transitioning out of care can be successfully supported in functioning at increasingly age-appropriate levels with coaching, support resources, and opportunities, and consequently have the capacity to develop autonomous, successful functioning over time. Other youth, however, may have more significant challenges: for instance, diagnostic pictures complicated by significant mood or reality-testing disturbances, or trauma exposures and responses overlaid upon significant developmental or cognitive challenges.

   For these youth, more intensive supports are required; for example: longer-term housing and congregate care, intensive treatment supports, and opportunities for skills training and for job placement. These resources are few, the need is great, and the bar for accessing them is often placed too high. It behooves us to examine ways to shift our system of care so that intensive supports become more readily accessible. This may include a redefining of *adaptive skills* to include those in the toolbox above.

For youth like Philip, the conclusion of their story has often been predetermined – by the youth, by the system, and by society. But as with all our young people there should be no limit to the number of possible paths their lives may take. The age of legal majority (the exiting of childhood) must not be thought of as an endpoint by our child-treating systems, but rather as a milestone along the way – a meaningful one, to be sure, but one of many. With this view, we can conceptualize our services and supports as both building toward, but also continuing well beyond this marker.

Philip and his peers deserve no less.

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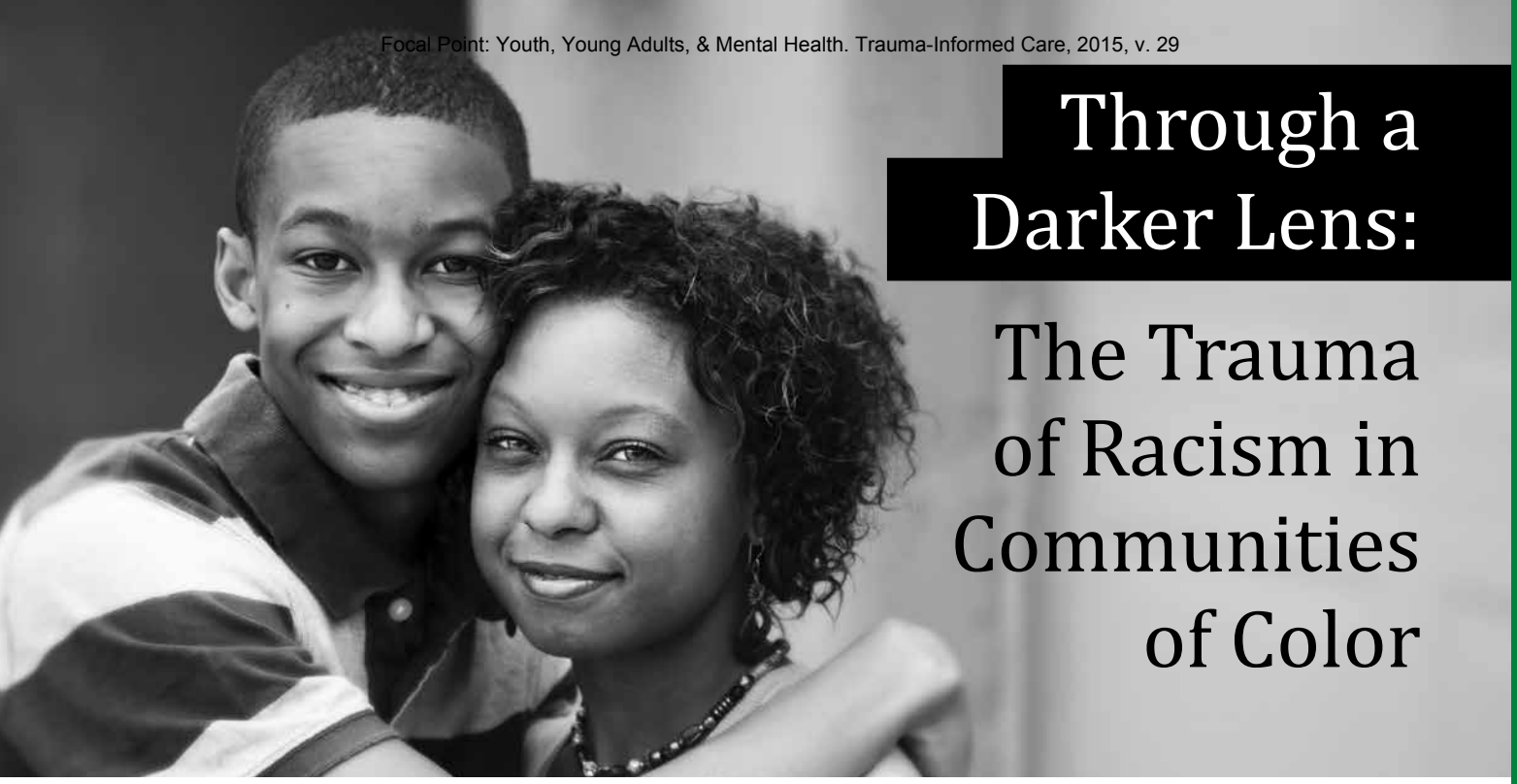

Through a Darker Lens:

The Trauma of Racism in Communities of Color

As I watched my son walk across the stage at his high school graduation I was a ball of emotions. I was happy and excited to watch my firstborn reach this pivotal milestone. I was a little sad because this event officially signaled the end of his being "my baby." I was excited for all the adventures that he was about to experience in this new phase of his life. Underneath all of this were more two emotions that I never wanted to feel but are never far from my consciousness: anger and fear. I felt anger from knowing all that my son had to endure to get to that point. I was also constantly fearful for what he would face as he went forth boldly into his destiny. There was sadness and frustration because the challenges, the pain, and much of the frustration that my child would face were because of something completely out of my control: because my child was born Black and male.

According to the American Psychological Association "trauma is an emotional response to a terrible event like an accident, rape or natural disaster."[1] In communities of color traumatic events are commonplace. When I say this people often go to thoughts of gang and gun violence, drug related crime, or other things reported on the evening news. While those things are present they do not constitute the lion's share of traumatic experiences I am speaking of. For communities of color we must look at the trauma caused by structural oppression, implicit bias, and racism. These experiences might, on the surface, seem to be inconsequential, however they have left scars that have endured for generations.

As I gave birth to each of my four children I was both overjoyed and worried. I had infinite hopes and dreams for them. I also had a sense of dread at the thought of the treacherous road that lay before them, the perpetual trauma of racism and oppression that would most surely be as much a part of their journey as kindergarten, little league, and scouts. I would work with all my might to shield them from the sting; but how do you protect a child completely from the air? Oppression and trauma are the air we breathe. Its effects are all around: in school, in the neighborhood, everywhere… like the air.

When my oldest child was five my husband was diagnosed with stage 4 cancer and was given two weeks to live. During the course of my husband's battle with cancer he would often become sick and be hospitalized for weeks without warning. During this time our children couldn't see him because his immune system was so compromised. My son was deeply affected by "daddy going away to the hospital." At one point my husband suffered a heart attack and fell at my son's feet. I took my son to a local mental health provider to help him deal with the trauma of these experiences. I was told by the therapist that my son had no issues because "he had two married parents in the home and he wasn't killing small animals and setting small fires because that's what Black boys do." I looked at the therapist incredulously. Due to the implicit bias of the therapist my son was denied proper care. The family

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structure and the situation that was presented did not fit the "the profile" for an African American family in the mind of this therapist so there couldn't possibly be anything that needed to be addressed. You may say that this is an isolated incident with one bad therapist. The fact is that social science research shows that there is significant bias against Black boys. According to psychologist Phillip Atiba Goff and his research team, "Black boys can be misperceived as older than they actually are and prematurely perceived as responsible for their actions during a developmental period where their peers receive the beneficial assumption of child-like innocence."[2]

When my son was in seventh grade he began experiencing challenges with maintaining focus in class. He had always been a very popular and chatty child which, in combination with attention difficulties, caused him to talk in class. He wasn't disrespectful or mean in any way; he was what is often known as a "Class Clown." There were quite a few of these class clowns in that particular seventh grade class. The way the individual "Clowns" were treated was quite different. The White boys were reprimanded in class and the Black students would either receive in-school suspension or out-of-school suspension. I went to the school several times to advocate for my child. I requested testing for my child to see if there was some challenge that could be helped with some extra supports. I was bcc'd in an email exchange between some of the teachers and the Special Education Coordinator for the school who indicated that she didn't want to "waste services" on my child who was clearly suffering from a lack of discipline for his behavior problem. After I took him for an outside evaluation, he was diagnosed with severe ADHD and started medication. His symptoms improved and he did much better in a different school. However, once again my son was profiled. He had never fought, never been disrespectful, or never did anything other than be a good student with a motor mouth.

During my son's high school career I went to his school several times to advocate for him against the "Thug" label. A teacher once told him that he was headed straight to prison because he had skipped a class. This wasn't a normal behavior for my son; he was an honor roll student who had completed the majority of his high school requirements by the end of tenth grade. After a number of these interactions with teachers my son became disengaged in school. His grades dropped, he was frequently late and he stopped doing his homework. When I tried discussing this with him he said: "Those folks don't care about me…They said that I'm not going to be anything anyway." I went to his administrator who told me not to worry because he would graduate because of all the work he had already done. I said, "What about college? He needs the grades to get into a good college." She told me, "He will graduate on time!" I knew in that moment that despite all of the excellent work that my son had done he was not seen as college material. The Black boy bias strikes yet again.

During the summer before my son's senior year of high school he was beaten in an attempted robbery while he was returning to his friend's house after a trip to the store. When we called the police to report the crime we told the dispatcher the address and we were told that we couldn't get a police response because "it had been more than five minutes since the attack." I took my son to the hospital (in my car) to get care for his injuries. Upon our arrival at the hospital the triage nurse asked us what happened and when we described the events to her she said incredulously: "No one responded to you?" Then she said, "Call from here, use this phone, you will get two cops." I didn't understand but I complied, and just like she said we had two officers on the scene in a matter of minutes. When the officers arrived they looked very concerned and asked the nurse for my son. However, when they saw my son their demeanor changed. Along with a couple of obligatory questions, they talked about and asked questions regarding his sneakers. There were two witnesses (my son's two best friends) who were never questioned. I later heard that the two people who tried to rob my son robbed two other people that same night. My son said that his interaction with the police was worse than

getting beaten and almost robbed. He said that they made him feel "like a criminal." "They asked me about my shoes like as if to say: 'How could a Black kid from the city afford such shoes?'" The officers' bias impacted the way they interacted with my son. Their interaction further traumatized him, and because of his previous experience with systems he had no hope for a positive outcome or any desire to pursue anything further.

Despite these experiences my son does well. He's in his first year of college and is very engaged. He recognizes injustices and also knows that he, and other young men like him, can persevere and be successful. I asked him what was helpful. What could adults in the lives of Black youth do to support resilience? He said three things:

1. *Be consistent in your engagement.* If it's once a week or once a month, whatever it is, be consistent.
2. *Be real!!!* Don't sugar coat stuff or be fake. Acknowledge challenges and provide guidance in overcoming them.
3. *Don't let stuff slide.* If you see bias/profiling happening call it out!! Much of the hurt comes from watching good people do nothing.

Every child is our own and the trauma of racism, institutional oppression, and bias are very real for Black youth. However, through awareness, acknowledgment, and action by adults, that trauma can be mitigated, paving the way for bright futures.

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PROJECTS AND STAFF

PROJECT FUTURES: FOSTERING UNITY TOWARDS UPLIFTING RESILIENCE, EDUCATION, AND SUCCESS tests an approach to enhancing self-determination and community participation to help young adults with a history of mental health challenges to build skills to navigate the university system and increase postsecondary success and engagement.

Sarah Geenen, Laurie Powers, and Jessica Schmidt, Co-Principal Investigators; Shannon Turner, Project Manager.

EASA CONNECTIONS brings together young adults who have been part of Oregon's early psychosis initiative to develop and test a peer-delivered series of web-based decision support tools for new individuals entering into early psychosis services.

Tamara Sale and Ryan Melton, Co-Principal Investigators; Dora Raymaker, Project Manager; Christina Wall, Young Adult Coordinator.

TEC-PD: TECHNOLOGY-ENHANCED COACHING FOR POSITIVE DEVELOPMENT tests a workforce intervention using state-of-the-art technology to implement high-quality coaching and supervision with practitioners employing the Transition to Independence Process intervention with emerging adults with serious mental health challenges.

Janet Walker, Principal Investigator; Celeste Moser, Project Manager; Mary Welch, Research Analyst; Eleanor Gil-Kashiwabara, Cultural Consultant.

S/PAC: SYSTEM/POLICY ASSESSMENT AND CHANGE PROJECT documents and analyzes processes, strategies, and outcomes by which organized groups of young adults engage in policy analysis and action relevant to transition, and develops knowledge about key systems factors at the state level affecting transition services.

Nancy Koroloff and Barbara Friesen, Co-Principal Investigators; Nicholas Buekea, Research Assistant; Pauline Jivanjee, Project Consultant.

AMP+: DEVELOPING THE YOUNG ADULT PEER SUPPORT WORKFORCE tests a workforce intervention focused on training and coaching peer support providers who work with emerging adults with serious mental health conditions, and prepares agencies to supervise and support them.

Janet Walker, Principal Investigator; Celeste Moser, Project Manager; Mary Welch, Peer Support Training Specialist; Sharice Jackson, Research Analyst.

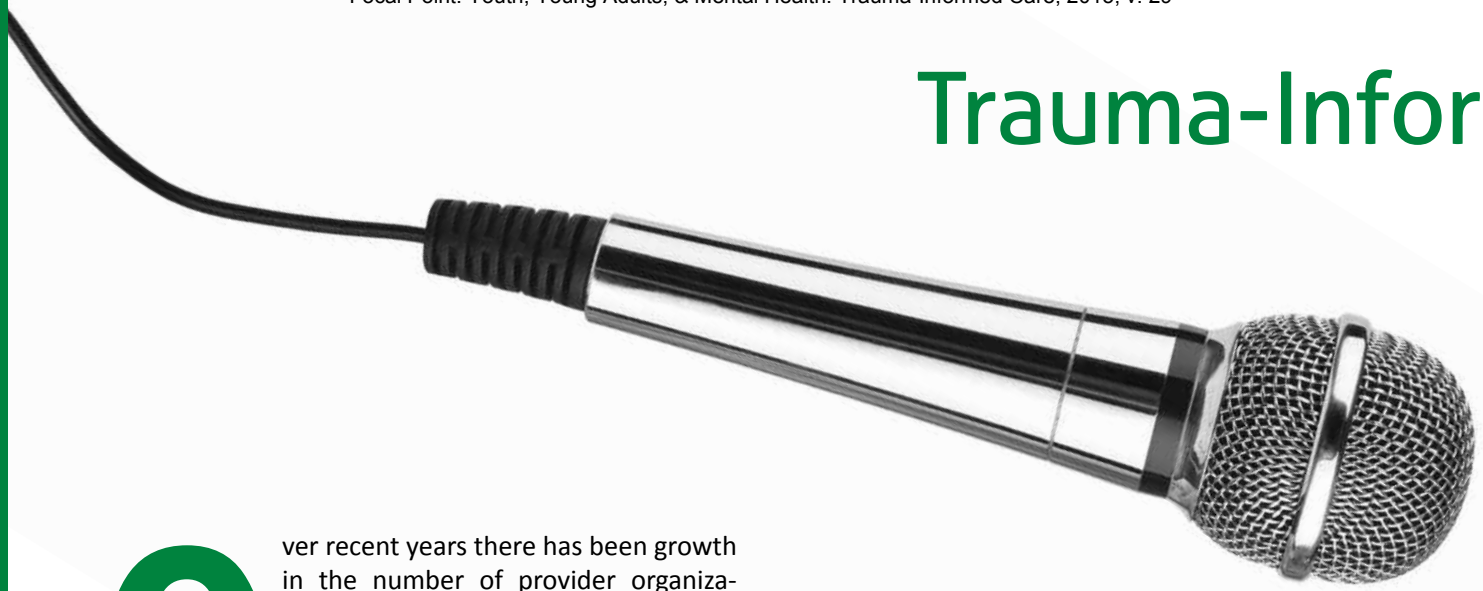
MENTEE-NOMINATED MENTORING adapts and tests a promising mentoring approach – youth-initiated mentoring – for young people who are living in residential treatment settings after stepping down from more acute psychiatric care.

Jennifer Blakeslee, Tom Keller, and Janet Walker, Co-Principal Investigators; Celeste Moser, Project Manager; Mary Welch, Research Analyst.

THE PATHWAYS TRANSITION TRAINING PARTNERSHIP is forming partnerships with service provider organizations that will participate in testing the effectiveness of an online training program, will survey service providers regarding their training needs and preferences, and develop new training materials in response.

Eileen Brennan and Pauline Jivanjee, Co-Principal Investigators; Claudia Sellmaier, Project Manager; Juliette Sanchez, Video Production Intern.

Trauma-Inform



Over recent years there has been growth in the number of provider organizations and agencies that require youth and young adults who are current or former recipients of services to participate in their own care planning and take an active role in systems reform efforts. In an attempt to better incorporate these young adults (YAs) in systems reform, many supportive adults (SAs) are directed to find young persons who have a "success story" and ask them to serve on a committee/board, or speak at some event. While this effort has given youth and young adults an opportunity to share their experiences, it has come with little awareness or guidance on how to prepare them. When youth share their stories they often talk about very traumatic life experiences, and this can lead to unintended negative consequences. Such consequences can cause severe effects such as re-traumatization, flashback episodes, overwhelming feelings of hopelessness, severe emotional responses, substance abuse relapse and/or mental health episodes, and even suicidal thoughts or ideation.

The Trauma-Informed Method of Engagement (TIME) model is designed to guide SAs on how to effectively engage, prepare, support and debrief YAs in doing advocacy work while minimizing any negative impacts and creating opportunities for the YA to grow both personally and professionally. The TIME model is relationally-based, trauma-informed, and has implications for the development of self-efficacy in young adults. The basic premise is that proper support from adult allies and/or peer mentors is used to create an environment where young adults can effectively share their stories in a positive way to promote system reform. Figure 1 shows the TIME model and its four Components.

RELATIONSHIP

The relationship between the YA and the SA is the core component to the model with the focus on establishing trust and rapport between the YA and SA. Much like anyone else, YAs want to feel respected as professionals and as peers in the workforce, leave a good impression, and be treated as equals. There are several strategies that SAs can use in order to help build rapport and establish trust.

1. **Provide a Safe Environment**

   Initiate engagement in a place where the YA feels physically and emotionally comfortable. Also assess if immediate needs are met. For example, if the youth disclose how they are worried about their housing situation or they just had a falling out with a close loved one, first help them identify resources and supports that can address these needs. Experiencing anxiety or stress over issues like these can contribute to YAs having a negative experience at your event. It also shows them that the SA cares about their personal well-being and not just about what their story brings to the table.

2. **Learn About the Youth's Culture and Values**

   YAs come from various backgrounds and cultures, and may identify with values that are not easily discernable from the surface. It is important to understand what cultures the youth identifies with, and to be sensitive about thoughts, ideas, and behaviors affiliated with that culture.

   It is also important for SAs to find out who YAs consider as their "family of choice" and learn about their social network. Being aware of what natural supports the young person has can help SAs link YAs

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ed Method of Engagement (TIME) *for* Youth Advocacy

with appropriate coping skills when they become triggered.

3. **Learn About Trauma Triggers and Coping Skills**

   As the relationship develops, YAs will feel more comfortable opening up and sharing on a more personal level. It will become easier for YAs to talk about things like trauma triggers, and if they are aware of them and how they manage them. At this point, the SA can start having conversations about how the young person copes with trauma or stress, and provide strategies for connecting with these supports when and if the YA becomes triggered.

PREPARATION

There are several basic skills that YAs need in order to feel more confident, be effective, and minimize the chance of re-traumatization to themselves or the audience. The preparation process should include trainings, strategies to help prepare the YA for specific events, and opportunities for the YA to practice these new skills.

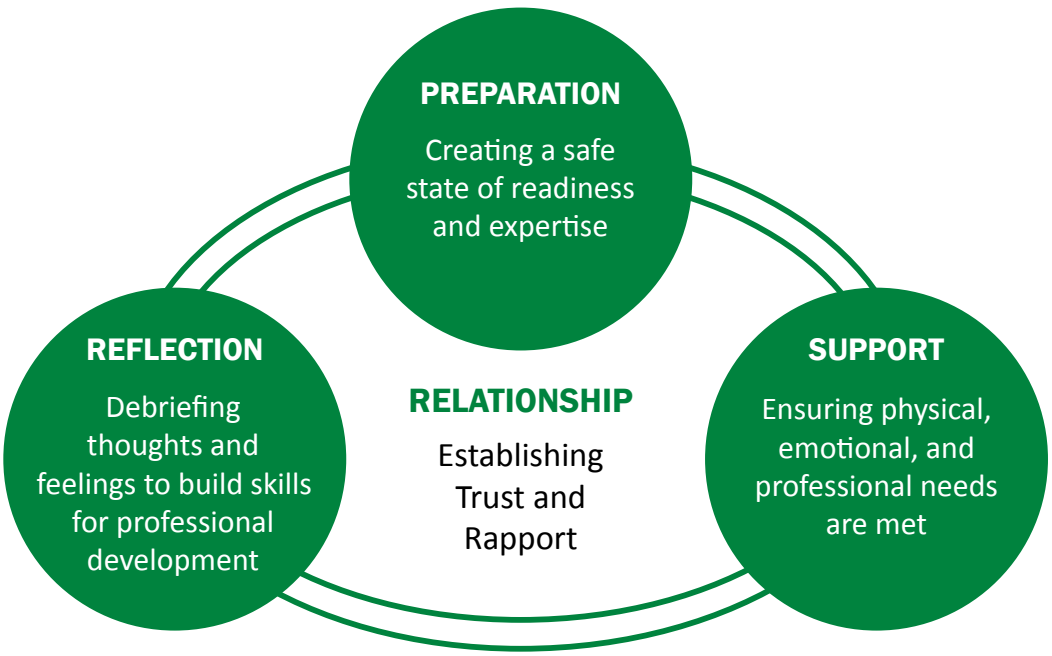
1. **Describe the Event**

   Review with the YA the type of event, agenda, and the audience that will be attending. Include how many people are expected to attend, if the audience is comprised of youth or adults (or both), and what professional fields are represented in the audience. Talk with the YA about what aspects of their lived experience might be most relevant and what they feel is important for the audience to know.

2. **Strategic Sharing Training**

   Strategic Sharing Training is designed to help youth tell their story in a way that is both safe and effective. The most important objectives are for YAs to know their audience, tailor their story to the audience, be strategic to ensure the audience is left

Figure 1. The TIME Model and its Four Components



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with the primary message, and manage appropriate responses to questions.[1,2,3]

3. **Help Develop Message and Method of Delivery**

   Work with YAs to choose a method of delivery they will be most comfortable with (speaking, using PowerPoint slides, other visual aids, etc.) Once a method is chosen, help YAs think through and research what information is available on the topic. Although the YAs' stories should illustrate problems, they also need to present solutions to what they experienced, including what resources and services they found helpful, as well as what evidence and best practices are available.

   The SA may want to sit with YAs as they talk through their message and method of delivery. It may be beneficial to have the YAs practice with a variety of people, potentially their peers, other SAs and/or a mental health professional.

4. **Develop a Support/Wellness Plan**

   Create a "support/wellness plan" outlining action steps in case a YA is triggered during participation. This plan will serve as a guide on how to access positive coping mechanisms and avoid negative ones.

5. **Review Logistics**

   The SA or asking organization should talk through the logistical details for participating in the event. Not having appropriate preparation for support for logistics can be traumatizing and leave young people feeling alone or abandoned. This can result in stress which may lead to relapse into substance abuse or mental health episodes. National Resource Center for Youth Development[3] has a comprehensive youth travel guide that the SA should use when developing a travel plan with YAs.

SUPPORT

Support, the third component of the model, seeks to ensure that physical, emotional and professional needs are met during the event. While support of YAs is necessary throughout the entire process, this component is focused on the event itself. Key strategies for supporting the youth during the event are as follows.

1. **Set Up for Success**

   Ideally, the SA will be onsite to meet the YAs if they did not travel together. The SA should ensure that the agreed upon details are in place. The SA should also provide encouragement during the event if present, or connect the YAs with other potential allies to provide support through the event.

   Check in and arrive at the room early to get a feel for the event. Have the YAs stand in the spot from which they will be delivering the speech, and if time allows, have the YAs practice at least the major points of their message.

2. **Visible Support**

   If the SA is neither moderating the panel nor onstage with the YAs, the SA should sit in a position where there is good visual contact. The SA should provide ongoing encouragement and reassurance throughout the message through non-verbal cues such as nodding, smiling, eye contact, etc. The YAs and SA should also implement agreed upon non-verbal cues to communicate "slow-down," "speed up," "speak louder," "five minutes left," etc.

   If a YA does get triggered during the event, implement the Support/Wellness Plan that was developed beforehand. This may include the SA fielding questions for the YAs, offering an 'additional thought' to allow them a moment to manage their emotions, or delivering a previously agreed upon message on behalf of the YAs.

3. **Post Presentation Support**

   After the YAs finish the event, audience members are likely to approach them to talk further about their message. During this time, it can be helpful for the SA to be near the YAs to help assess for emotional vulnerability, field questions, and help facilitate networking opportunities.

   Immediately after the audience members are addressed, a short check-in should occur with two primary components: emotional support and professional development. It is important to focus separately on the emotional processing and professional processing by first validating the YA's feelings and experience, and then asking about the content and delivery of the event.

REFLECTION

The last component is Reflection. During this component, the SA reflects on strengths and needs of each youth during the event. The purpose is to help the YA further improve professional skill development, identify safety issues like trauma triggers, and provide support in helping the YA access appropriate coping mechanisms and/or resources to address triggers. The effectiveness of the Reflection component relates back to the level of trust and relationship between the YA and SA, and other supports that the YA has or needs. Key strategies during the Reflection component include the following:

1. **Debrief the Event Thoroughly**

   While some of this may have happened in the immediate debrief of the event, for the YA's professional and personal development it is important to revisit what was discussed based on the goals of the YA. The YA might have a different opinion once given time to process everything that occurred during the event. The SA should provide constructive feedback and encouragement, discuss strengths and areas for growth, discuss personal insights gained, and discuss additional goals, including resources and trainings for future professional development.

2. **Personal and Professional Development Opportunities**

   Encourage YAs to:

   - Access peer networking and support
   - Find and stay connected to formal/informal peer support groups
   - Obtain additional advocacy trainings
   - Talk to a therapist, mentor and/or adult support partners about new insights
   - Engage in activities that help with cultural healing and growth
   - Explore awareness of new triggers and coping strategies
   - Refine their support/wellness plan
   - Identify and participate in other advocacy events
   - Take on a leadership role and participate in leadership training
   - Develop future goals

All of the components can be fluid based upon the needs of the YA. Throughout all of the components of the TIME model, it is important to keep in mind that the relationship with the young person is critical and should be addressed continuously to ensure successful engagement.

IMPLICATIONS

Having youth voice present in organizations and at events is one of the critical components for changing the way systems improve their outcomes for children, youth, young adults, and families. However, because of potential unintended consequences that arise when youth are engaged in system reform efforts, it is critical for both SAs and YAs to be trauma-informed. The risk of being negatively impacted by sharing one's traumatic experiences can be greatly reduced when proper preparation and supports are put in place.

The TIME model provides a foundation for the development of policies and guidelines that can help to minimize the likelihood and potential negative impact of re-traumatization for YAs. Organizations that engage YAs should incorporate TIME model practices into their engagement activities to help ensure safer and more productive advocacy.

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CREATING THE CONDITIONS FOR CHANGE:

Emerging Policies to Promote and Support Trauma-Informed Care

All over the country, across multiple systems serving vulnerable or underserved populations, there is increasing understanding about the long-term impact of adversity on health and well-being. Developments in neuroscience and developmental neurobiology, combined with findings from the seminal Adverse Childhood Experiences study,[1] have heightened awareness of a reality that is no secret to individuals with lived experience and the providers who offer them support: painful, traumatic experiences in childhood and across the lifespan have a powerful impact on life trajectories. Moreover, while adversity is surprisingly common in the general population, this fact pales beside the prevalence among youth and adults in community-based mental health services and certainly among transition-age youth and emerging adults using these services, where estimates of childhood trauma are as high as 94%.[2] This information has been the impetus for a paradigm shift in how we think about mental and behavioral health.

On the ground, however, the real game changer is understanding how the impact of trauma manifests in service settings. We now have evidence for what survivors, advocates, and many providers have been saying all along: our service systems have frequently re-traumatized those we are trying to help, making it difficult or impossible for individuals to engage in and benefit from services. This more widespread understanding has resulted in an explosion in demand for training, resources, and technical assistance to transform programs and agencies to be more responsive to trauma survivors.

WHAT HAS BEEN THE ROLE OF POLICY IN THIS TRANSFORMATION?

The term *policy* is used in different ways, but fundamentally refers to a course of actions or a set of decisions that is designed to shape what happens in the future. Often, policy establishes principles or guidelines as well as actions, and this has been very much the case with Trauma-Informed Care (TIC). Policy occurs at the macro level when government (whether federal, state, or local) creates policies to influence large spheres of activity. Policy can also be created across systems; for example, when state agencies co-create policies for children or adults they serve in common (such as county-wide housing systems that agree to common criteria for entry) or when a consortium of local providers decides on a common referral and intake process. Policy, of course, also occurs at the agency and even program level, directly affecting employees, service provision, and the individuals receiving services. Policy can be written into federal or state law through legislative action, formally written in agency policy manuals, or – particularly at the agency level – understood and operationalized in practice, but not necessarily documented.

Federal policy is critical because it brings funding. Federal priorities are reflected in the allocation of grant dollars that drive research and stimulate new programming and innovation in the field. For example, the Children's Health Act of 2000 established the National Child Traumatic Stress Network (NCTSN).[3] This critical policy decision created regional trauma initiatives all over the country. NCTSN efforts have directly fostered

training, inter-agency collaboration, learning collaboratives, and, in some cases, statewide efforts to ensure that all services to vulnerable children and families are informed by an understanding of TIC.

More recently states have come forward to establish policies that set broad expectations for how providers will operate, and in some cases, offer incentives or resources for implementation. These are some examples of what state policy can do:

- Convey a commitment to TIC. Connecticut wrote a set of guiding principles into policy for the Department of Mental Health and Addiction Services.[4] These include a mix of specifics (universal screening, for example) and broader principles such as collaboration and client-centered care.
- Establish an office or project coordinator for Trauma-Informed Care within health or behavioral health divisions that is charged with creating a strategic plan, developing regional learning collaboratives, or providing technical assistance (for examples, see Ohio[5] and Wisconsin[6,7]). A number of states, including Wisconsin[6,7] and Nebraska,[8] have created state TIC advisory workgroups to ensure sustained commitment and action or have established public-private partnerships.
- Require contracted providers to demonstrate their commitment to TIC. Oregon's new trauma policy[9] in the Addiction and Mental Health Division of the state's Health Authority sets overall guidelines but also an expectation that funded and/or licensed services and supports will outline a process to become trauma-informed, ensure the availability of trauma specific services, and follow specified implementation plan guidelines.
- Offer incentives or support for implementation efforts. Nebraska's Region V has offered mini-grants for agencies participating in the statewide workgroup to "promote and support efforts in creating agency cultures of trauma-informed service delivery and enhance the trauma specific service options available".[8] Suggested activities for these mini grants cover a wide range of possible ways that an organization might choose to move forward.[8] Oregon's policy specifies that the state will provide resources for education, technical assistance, toolkits and other supports.[9]
- Build trauma-informed care into health care transformation. With the emphasis on integrating mental and behavioral health into a *medical home* – combined with the compelling evidence from the Adverse Childhood Experiences study[10] – some state legislatures, notably Vermont, have grappled with whether to institutionalize the routine screening of children and/or parents for ACEs in pediatric care.[11]

In Oregon, renewed advocacy for trauma-informed care took root in the Children's System Advisory Council (CSAC) and with other key partners at the Oregon Health Authority Addiction and Mental Health Division, but it was 10 long years before it resulted in legislative action. When it did, in 2014, a comprehensive policy was passed and Trauma Informed Oregon (TIO) was established.[12] TIO is a partnership between the state and two universities that brings social work and health care together. TIO is charged with coordinating and disseminating resources and information, providing training across the state, increasing training capacity and sustainability, providing technical assistance and evaluation, and bringing the voice of providers, youth, families, persons with lived experience, and diverse communities into policy decisions.

POLICY AT THE PRACTICE LEVEL

Within community-based organizations providing direct services, policy to support trauma-informed care is relatively new but emerging rapidly. Practice level policy change is likely to be the fastest growing aspect of transformation across mental and behavioral health-care systems over the next few years. Why is this so? In some cases, state policies require contracted agencies to incorporate TIC into their mission and programming. However, local policy is also emerging in response to the groundswell in the workforce and among advocates, youth, adults, and families who "get it" and are asking for meaningful and sustained change. As little as five years ago, champions for TIC were focused on building awareness, and educating and convincing others. This is still the case in some of our service systems but in others, little convincing is needed. It is rapidly becoming a question of not whether it's important, but of what to do about it. Policy is both leading and following the charge, supported by a growing body of knowledge and resources; for example, see SAMHSA's "Concept of Trauma and Guidance for a Trauma-Informed Approach."[13]

The deputy director and senior colleagues at Impact Northwest, a multi-service organization in Portland, OR, implemented an agency-wide self-assessment process developed by Community Connections in Washington, DC (see http://www.communityconnectionsdc.org). They also created a multi-level workgroup, and developed a strategic plan to address key findings from the assessment. This included making significant shifts in staff training, supervision, and practice as well

Our service systems have frequently re-traumatized those we are trying to help, making it difficult or impossible for individuals to benefit from services.

as rewriting the manual on Standard Operating Procedures to reflect the principles of TIC. At Clackamas Behavioral Health Care (see http://www.clackamas.us/behavioralhealth), also in Oregon, the executive director wanted to set a standard for the agency. In addition to supporting a workgroup to prioritize and address issues affecting staff and clients, she created an agency-wide TIC policy that includes guiding principles; such as client-centered, culturally responsive, and collaborative planning, as well as specifics such as education and training for staff and expectations for screening and assessment of clients.

Sometimes, however, change comes from the bottom up. At Human Solutions, a large housing and anti-poverty agency in the Portland area, resident services staff joined a county-wide Trauma-Informed Care Learning Community and subsequently created a small support group to talk about what they could do in their own work that would make a difference. The group created and delivered a presentation to the agency's board of directors (with permission). It was not difficult to get buy-in at that level, and an expanded workgroup developed and delivered training modules to each department. What started as a very small effort has resulted in policy changes that are accumulating across the entire system:

- Trauma-informed care has been incorporated into hiring and onboarding for all staff, with special orientation for new supervisors.
- A skills survey that is part of annual employee reviews includes TIC goals for the coming year and reflection on how TIC was incorporated in the previous year.
- Forms and procedures that affect staff and clients are reviewed through a lens of trauma-informed care before they are implemented.

Policy changes also include care of the workforce and and should involve program participants as well. This was the case, for example, in a women's residential treatment program, where the program director established a resident council that meets weekly. These local policy actions cluster into three important categories:

- Agencies can *ADD* critical policies, as in some of the examples noted above, to reflect a commitment to TIC and the principles that are needed to implement it.
- Agencies can also reflect their commitment to TIC by *DROPPING* policies that, upon review, are recognized as *not* trauma-informed and unnecessary, such as intake procedures that require answering intrusive questions likely to activate a trauma response with no real purpose. Other examples include unexamined rules in residential facilities regarding "lights out," cell phones, cigarette breaks, or computer or television use that have an historical basis but may have no current value and have not been reconsidered in decades.
- Some policies cannot be eliminated – either because they serve a legitimate purpose (e.g., keeping everyone safe) or because they are required by law and are beyond the agency's control. Frequently, TIC workgroups can *AMEND* these necessary policies, changing the provisions and/or the wording to be more respectful and sensitive to the needs of trauma survivors. The TIC Workgroup from the Homeless Youth Continuum, in Multnomah County, OR, for example, reviewed and made substantial changes in the joint *exclusion policy* that specifies whether a youth might or might not be allowed to return for services after termination.

WHAT'S NEXT?

These examples are a tiny fraction of all that is happening as more states, health and behavioral health systems, providers, and advocates come on board every day. As this transformation continues to unfold and gain momentum in systems that are newer to trauma-informed care, there are several areas where thoughtful policy development will be greatly needed. They include:

- Integration of principles of equity and empowerment into TIC training and implementation. The impact of historical trauma, community and system oppression, and micro-aggression cannot be overstated.

- Inclusion of individuals with lived experience, youth, families, diverse communities, and populations in every aspect of policy development at all levels.
- Inclusion of parallel process in policy;[16] i.e., the understanding that TIC cannot be implemented unless it addresses the experience of the workforce along with the experience of the individuals seeking services or supports.
- Standards of practice for trauma-informed care. Much progress is being made to operationalize the principles of TIC, but concrete measures of implementation are lacking.
- Evidence for the impact of TIC. Along with assessing implementation, we need to demonstrate that it makes a difference in the engagement, retention, and outcomes for individuals seeking services, and for the health and well-being of the workforce.

Policy to support TIC is emerging and changing so rapidly that this article will be outdated well before it goes to press. Some of that policy will be effective and some may not be, but the movement to better address the needs of trauma survivors is here to stay. Whether policy change happens at the federal, state, or agency level – and whether it happens from the top down or the bottom up – if it acknowledges the impact of trauma on survivors and their support networks, it will help improve the quality of care.

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If policy change acknowledges the impact of trauma on survivors and their support networks, it will help improve the quality of care.

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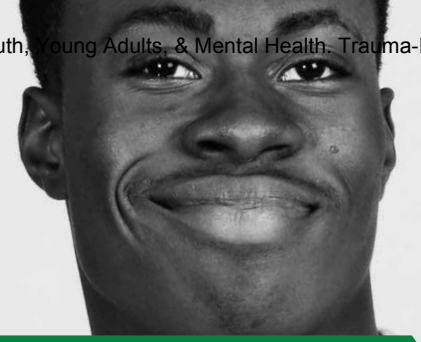

SAMHSA'S CONCEPT OF TRAUMA AND GUIDANCE FOR A TRAUMA-INFORMED APPROACH IN YOUTH SETTINGS

Unaddressed trauma and violence against children, youth, and adults affects all of us. Violence occurs at all ages and in all settings, and its consequences affect all of our communities and social institutions. Youth with significant traumatic experiences are found in every community and youth-serving system. The impact of this violence over the lifespan is profound. Epidemiological research shows strongly proportional and significant relationships between trauma in childhood (adverse childhood experiences) and a variety of health, behavioral health, and social problems – even decades after the trauma. Depression; hallucinations; suicide; substance abuse; multiple sex partners, and heart, lung, and autoimmune disease[1,2] are but a few of the consequences of early traumatic experiences. This is why it is critical for all youth-serving systems to recognize the importance of addressing trauma in our prevention, treatment and recovery interventions.

SAMHSA'S COMPREHENSIVE PUBLIC HEALTH APPROACH TO TRAUMA

Over the last 20 years, the Substance Abuse and Mental Health Services Administration (SAMHSA) has been a leader in recognizing the need to address trauma as a fundamental obligation for public mental health and substance abuse service delivery. Consequently, SAMHSA has supported the development and promulgation of trauma-informed systems of care. SAMHSA's Trauma and Justice Strategic Initiative focuses on integrating a trauma-informed approach throughout health, behavioral health, and related systems to reduce the harmful effects of trauma and violence on individuals, families, and communities. The initiative also focuses on using innovative strategies to reduce the involvement of individuals with trauma and behavioral health issues in the criminal and juvenile justice systems.

SAMHSA's comprehensive public health approach to addressing trauma includes a framework that describes: trauma, a trauma-informed approach, key principles, and guidance for implementation of a trauma-informed approach. This framework builds from the work of key thought leaders[3,4] in the field and is designed to be used across service systems that interface with youth – whether juvenile justice, child welfare, primary care, education, housing, and/or community support.

TRAUMA: THE THREE Es

The experience of trauma is complex and particular to each individual's life circumstances. Traumatic events and circumstances may happen as a single occurrence or repeatedly over time. Youth may experience multiple categories of traumatic events and circumstances – sexual abuse, bullying, and witnessing violence in the home or community, to name a few.

Building on input from researchers, practitioners, and people with lived experience, SAMHSA developed the following definition of trauma: *"Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."*[5]

Inherent in the definition are the "Three "Es:" an *Event*, an *Experience* of the event and the *Effects*. The Threes Es describe how an event, and the experiences or perception of an event, can have unique effects on a particular individual's well-being. *Events and circumstances* may include the actual or extreme threat of physical or psychological harm (i.e. natural disasters, abuse, physical or sexual violence, etc.) or severe, life-threatening neglect that imperils a child's healthy development.

The individual's *Experience* of these events or circumstances and the way in which it shapes the individual's worldview helps to determine whether the events were traumatic. A particular event may be experienced as traumatic for one individual and not for another. How the individual labels, assigns meaning to, and is disrupted physically and psychologically by an event will contribute to whether or not it is experienced as traumatic. Traumatic events by their very nature set up a power differential where one entity (whether an individual, an event, or a force of nature) has power over another. They elicit a profound question of "Why me?" The individual's experience of these events or circumstances is shaped in the context of this powerlessness and questioning.

The long-lasting adverse *Effects* of the event(s) and how they are experienced are a critical component of trauma. These adverse effects may occur immediately or may have a delayed onset. The duration of the effects can be short to long term. In some situations, the individual may not recognize the connection between the effects and the events. Examples of adverse effects include an individual's inability to cope with the normal stresses and strains of daily living; to trust and benefit from relationships; and to manage cognitive processes, such as emotions, memory, attention, thinking, and behavior. In addition to these more visible effects, there may be an altering of one's neuro-physiological make-up and ongoing health and well-being.

TRAUMA-INFORMED APPROACH: THE FOUR Rs

The high prevalence of trauma and violence in the lives of young people across the developmental spectrum make it imperative that organizations and systems serving and supporting youth understand the importance of a trauma-informed approach. SAMHSA's framework describes the four elements of a trauma-informed approach through the "Four Rs:" *"A program, organization, or system that is trauma-informed: realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization."*[5]

In a trauma-informed approach, everyone at all levels of the organization or system has a basic *Realization* about trauma and understands how trauma can affect families, groups, organizations, and communities as well as individuals. People in the organization or system are also able to *Recognize* the signs of trauma, which may be gender-, age-, or setting-specific and may appear in those individuals seeking or providing services in these settings. The program, organization, or system *Responds* by applying the principles of a trauma-informed approach to all areas of functioning. Staff in every part of the organization, from the person who greets clients at the door to the executives and the governance board, have changed their language, behaviors, and policies to take into consideration the experiences of those who have trauma histories (including the staff members themselves). Ultimately, a trauma-informed approach seeks to *Resist* traumatizing or *Re-traumatizing* clients and staff. Staff are taught to recognize how organizational practices may trigger

painful memories for clients with trauma histories.

A trauma-informed approach does not simply raise awareness of the issue of trauma, but fundamentally changes an organization or system's culture, behavior, actions, and responses. All components of the organization incorporate a thorough understanding of the prevalence and impact of trauma, the role that trauma plays, and the complex and varied paths in which people recover and heal from trauma. A trauma-informed approach can be implemented in any type of service setting or organization and is distinct from trauma-specific clinical interventions, such as trauma-informed cognitive behavioral therapy.

SIX KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH

A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be specific to a particular setting or service sector. They underlie the values, beliefs, and attitudes of individuals and organizations offering a trauma-informed approach:

- **Safety:** Throughout the organization, the staff and the people they serve feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety.
- **Trustworthiness and transparency:** Organizational operations and decisions are conducted with transparency and with the goal of building and maintaining trust among clients, family members, staff, and others involved with the organization.
- **Collaboration and mutuality:** There is true partnering and leveling of power differences between staff and clients and among organizational staff, from direct care staff to administrators; they recognize that healing happens in relationships and in the meaningful sharing of power and decision-making.
- **Empowerment:** Throughout the organization and among the clients served, individuals' strengths are recognized, built on, and validated. New skills are developed as needed.
- **Voice and choice:** The organization aims to strengthen the experience of choice for clients, family members, and staff. It recognizes that every person's experience is unique and requires an individualized approach.
- **Culture, historical and gender issues:** The organization incorporates policies, protocols, and processes that are responsive to the racial, ethnic, and cultural needs of individuals served, that are gender-responsive, and that incorporate a focus on historical trauma.

GUIDANCE FOR IMPLEMENTING A TRAUMA-INFORMED APPROACH

Developing a trauma-informed approach requires change at multiple levels of an organization and systematic alignment with the key principles described above. SAMHSA's suggested framework can provide a roadmap to help individuals and agencies get started.

This guidance can also assist in developing a change strategy, help identify organizational strengths and weaknesses, provide milestones to measure progress, and prevent re-traumatization. While the list of domains is similar to those in any basic organization change model, it is the infusion of the six key principles that makes it trauma-informed. The following guidance can be a useful starting point:

- **Governance and leadership:** The leadership and governance of the organization support and invest in implementing and sustaining a trauma-informed approach. There is an identified point of responsibility within the organization to lead and oversee this work and peer voices are included.
- **Policy:** There are written policies and protocols establishing a trauma-informed approach as an essential part of the organizational mission. Organizational procedures and cross-agency protocols reflect trauma-informed principles.
- **Physical environment of the organization:** The organization ensures that the physical environment promotes a sense of safety.
- **Engagement and involvement of people in recovery, trauma survivors, consumers, and family members receiving services:** These individuals have significant involvement, voice, and meaningful choice at all levels and in all areas of organizational functioning (e.g., program design, implementation, service delivery, quality assurance, cultural competence, access to trauma-informed peer support, workforce development, and evaluation).
- **Cross-sector collaboration:** Collaboration across sectors is built on a shared understanding of trauma and principles of a trauma-informed approach. While a trauma focus is not the stated mission of different service sectors, understanding how trauma impacts

those served and integrating this knowledge across service sectors is critical.

- **Screening, assessment, and treatment services:** Interventions are based on the best available empirical evidence and science, are culturally appropriate, and reflect principles of a trauma-informed approach. Trauma screening and assessment are an essential part of the work. Trauma-specific interventions are acceptable, effective, and available for individuals and families seeking services. When trauma-specific services are not available within the organization, there is a trusted, effective referral system in place that facilitates connecting individuals with appropriate trauma treatment.
- **Training and workforce development:** Continuous training on trauma, peer support, and how to respond to trauma is available for all staff. A human resource system incorporates trauma-informed principles in hiring, supervision, and staff evaluation; procedures are in place to support staff with trauma histories and/or those experiencing significant secondary traumatic stress from exposure to highly stressful material.
- **Progress monitoring and quality assurance:** There is ongoing assessment, tracking, and monitoring of trauma-informed principles and effective use of evidence-based and trauma-specific screening, assessments, and treatment.
- **Financing:** Financing structures are designed to support a trauma-informed approach which includes resources for staff training, development of appropriate facilities, establishment of peer support, and evidence-supported trauma screening, assessment, services, and interventions.
- **Evaluation:** Measures and evaluation designs used to evaluate service or program implementation and effectiveness reflect an understanding of trauma and appropriate trauma-research instruments.

MOVING FORWARD

SAMHSA continues to carry out this framework through its policies, initiatives, grant programs, and technical assistance to the field, as well as via collaborations with federal partners and experts in the field. As more federal, state, and local agencies embrace an understanding of trauma and implementation of a trauma-informed approach, SAMHSA will continue to promote a shared understanding of this conceptual framework. A unified working concept will serve to advance the understanding of trauma and a trauma-informed approach and to develop measurement strategies for successful implementation that will lead to better outcomes for children, youth, families, and communities.

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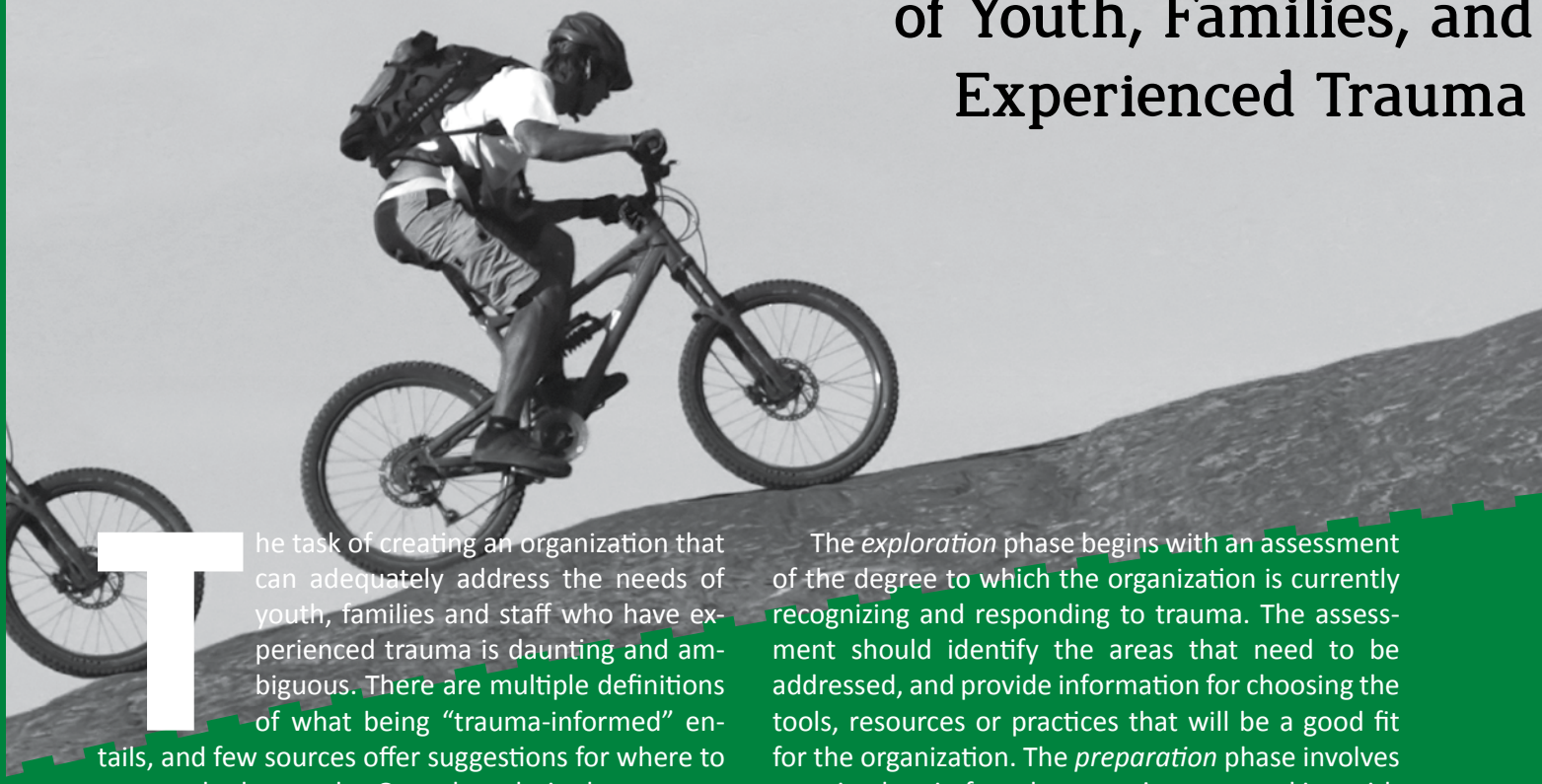
Creating Organizatio

of Youth, Families, and Experienced Trauma



The task of creating an organization that can adequately address the needs of youth, families and staff who have experienced trauma is daunting and ambiguous. There are multiple definitions of what being "trauma-informed" entails, and few sources offer suggestions for where to start and what to do. One obstacle is that no two human service organizations are alike – offering the same types of services to the same age groups who have experienced the same adversities and who are interacting with the same service systems in the same type of setting. There is no one-size-fits-all approach, and it is never a linear process. However, the National Child Traumatic Stress Network (NCTSN), a unique group made up of researchers, family members, front line providers, and national partners, has identified domains, resources, and practices that help create trauma-informed organizations.

AN OVERVIEW OF IMPLEMENTING TRAUMA-INFORMED ORGANIZATIONAL CHANGE

In addition to the tools and practices needed to address trauma, a process of implementing organizational changes is essential to successfully establish and sustain trauma-informed practices. The four-phase EPIS (Exploration, Preparation, Implementation and Sustainment) model[1] has been used successfully to implement evidence-based practices that address child maltreatment within child and family serving agencies. A similar system can be helpful with trauma-informed organizational change.

The *exploration* phase begins with an assessment of the degree to which the organization is currently recognizing and responding to trauma. The assessment should identify the areas that need to be addressed, and provide information for choosing the tools, resources or practices that will be a good fit for the organization. The *preparation* phase involves securing buy-in from key constituents, working with them to determine what tools and practices will be implemented, and developing a plan for implementation. The plan is carried out and monitored in the *implementation* phase. Finally, in the *sustainment* phase, financial and practical considerations inform long-term plans for continuing trauma-informed practices. In reality, this process is never linear and involves much going back and forth between phases as obstacles and opportunities impact the process.

TRAUMA-INFORMED ORGANIZATIONAL ASSESSMENT

As is true with any change process, an organization needs to know where it currently stands in order to determine where it needs to go and how it should get there. This can be determined through a trauma-informed assessment of the organization. There are existing tools for this purpose created with different populations in mind.[2,3] Most are based on the work of Harris and Fallot,[4] who first laid out the parameters for a trauma-informed system. The NCTSN has combined many of these parameters with experience gleaned from its diverse group of member organizations to develop a definition of

ns that Address the Needs

Staff Who Have

a trauma-informed service system.[5] The current article uses that definition to identify the domains of a trauma-informed program. These domains create a structure for assessing an organization's strengths and gaps related to trauma-informed practices.

In addition to determining an organization's starting point, an organizational assessment is key to implementing trauma-informed practices. Key steps in the assessment process lay the groundwork for engaging leadership, staff and families in the process of creating trauma-informed organizational change. Assessment offers opportunities to describe what a trauma-informed organization may look like, identify ways that staff are already doing work that helps to address trauma, and draw a clear picture of how this work might impact each member of the organization. Additionally, an assessment can identify people who might become "trauma champions" – staff and consumers who exhibit an understanding of the potential impact of addressing trauma in their organization, and who will sustain and spread new practices.

The domains identified below can be assessed in a number of ways. In fact, applying different methodological approaches will strengthen the quality and reliability of the information collected. Interviews with administrators and key program leaders, a review of organizational materials, staff surveys, follow-up focus groups with staff, and interviews and focus groups with consumers will together uncover the strengths and challenges of trauma work in an organization.

ASSESSING THE DOMAINS OF A TRAUMA-INFORMED ORGANIZATION

Screening, assessment, and intervention. In order to better treat a young person who has experienced trauma, traumatic exposure and the resulting symptoms must be identified, explored and treated. This requires an examination of the process and tools used to identify whether a youth has experienced trauma (screening); the ways a mental health and trauma assessment are conducted (assessment); and how treatment plans are developed and executed (intervention). These tasks should be strongly connected to each other and incorporate a deep understanding of trauma and the impact of the traumatic event(s) (including trauma reminders, changes to the youth's family and caregiving system and environment following a trauma; and appropriate, trauma-informed treatments). The goals of assessing organizational processes are to:

1. identify methods of screening that will most accurately identify youth and families who could benefit from trauma-informed services;
2. create a complete picture of the youth, his or her trauma history profile, an understanding of current reminders of past traumatic experiences and how they influence current functioning, and the impact of the traumatic event(s) on caregiving and family systems;
3. identify the most culturally and developmentally appropriate trauma-informed services and interventions; and
4. form the foundation for case-planning.

Additionally, organizational process issues are also examined. Who in the agency is administering the screening, assessment, and treatment? Are they receiving proper training and meaningful supervision? When are these tasks performed? Each step should inform the next so that the most appropriate services or treatment can be provided by the most appropriate service provider.

Strengthening the resilience and protective factors of youth and families. A trauma-informed organization builds the capacity of youth and families to heal by strengthening factors and characteristics associated with resiliency.[6] Key questions include: How

do programs, clinicians and staff support or provide opportunities for peer support with families? Do they outreach to fathers and other caregiving adults? Do they utilize family strengthening tools? Are they advocates for families in other systems (such as juvenile justice, child welfare, healthcare, and schools)? What type of work is done at the agency around strengthening the parent/child bond, parenting skills, connecting families to community resources, identifying family stress, addressing concrete needs, teaching skills related to social/emotional competence, and strengthening sibling relationships?

An organization cannot be trauma-informed if its staff are experiencing STS, compassion fatigue, or burnout.

Trauma competence and awareness. Staff at all levels and in all programs need to have an understanding of trauma and how it impacts youth and families. Mimicking a client's experience of a program by walking through it and noting who and what they see will provide additional opportunities to help a family feel physically and psychologically safe. This can be followed up by asking clients and family members about their experience at each point of their visit and about how they feel in the physical spaces they occupy when they are on site.

Staff should have training opportunities related to trauma and trauma-informed practices. When trainings are implemented, pre- and post- tests of knowledge, beliefs, attitudes and behavior change related to trauma can help ascertain whether and how the training was effective.

Parent and caregiver trauma. Organizations often face obstacles related to providing trauma-focused treatment to adult caregivers when their mission and resources are aimed at youth. However, this creates a great opportunity for trauma-informed change. Key questions in assessing this domain include: Are staff at all levels aware of the impact of trauma on parents, and its potential impact on parenting? Do the agency's assessments include measures of parent trauma? What does the treatment of parents with trauma histories look like, and how is it accessed? What skills and knowledge do staff who work with parents have to help guide parents to appropriate treatments? What resources are available in the community to treat adult trauma, and how collaborative are those providers with the agency being assessed? The greatest level of coordinated care occurs when caregivers are treated within the same agency as young people. When that is not possible, developing collaborative relationships with providers of adult services can be a good alternative.

Continuity of care and collaboration across systems. Organizations should establish strong collaborations to promote a continuous system of services for youth and families. This helps prevent retraumatization by coordinating services to achieve shared goals. This domain is assessed on two levels: (a) the individual/family and (b) the organization/system.

A trauma-informed agency would work with others providing services in a family's life to coordinate care, work towards shared goals, and minimize further traumatization of the family. Collaboration might occur through family team meetings, co-located services, technology or tools which allow for easier and better communication between systems, or multi-disciplinary approaches to treatment. An agency can increase opportunities for collaboration with other systems by providing or attending cross-trainings, co-locating services, jointly developing protocols for collaborative services, and developing technologies or tools for more effective communication between systems.

Secondary traumatic stress (STS). An organization cannot be trauma-informed if its staff are experiencing STS, compassion fatigue, or burnout. One of the most essential components of a trauma-informed organization is that it creates an environment for staff that recognizes the impact of working with trauma survivors. It considers how STS can impede staff's ability to do their job effectively, how the work may remind staff of their own trauma histories, and how to minimize the STS risk factors through its training and supervision practices.

Staff at all levels should receive training on healthy boundaries between professional and personal life, self-care, and managing difficult feelings and reactions. An agency should provide supervision to all direct-care staff by a supervisor trained to understand trauma. Supervision time should be spent helping staff understand their own stress reactions and how they impact their work. Team and administrative meetings should address STS topics. In addition to asking administrators and staff about organizational practices that promote staff

resiliency, an assessment can include instruments that measure STS in individuals, such as the Professional Quality of Life Scale (Pro-QOL.)[7] This can be re-administered when policies to address STS have been implemented to determine their effectiveness.

Cross-domain themes. Throughout this organizational assessment, there are two additional factors that should be examined within each of these domains. First, to what extent does the organization partner with its youth and families, both in its clinical engagement and treatment, as well as in making programmatic and agency-wide decisions? Research supports that family involvement in clinical services promotes positive changes in a youth's care and improves outcomes.[8] The NCTSN offers two assessment tools for examining how an organization is partnering with youth and families, and suggests changes to clinician and organizational practice to improve those partnerships.[9]

The second cross-domain theme is cultural competence. Culture is inherently tied to both trauma and resilience. In the development of a trauma-informed organization, cultural competence promotes empowerment, a sense of belonging, and opportunities to incorporate cultural healing practices. It also reduces instances of retraumatization due to cultural insensitivity. The National Center for Cultural Competence has developed the Cultural and Linguistic Competence Family Organization Assessment Instrument (CLCFOA) for organizations that serve youth and families with behavioral health needs.[10] Incorporating questions from the CLCFOA into a trauma-informed organizational assessment can show how a culturally competent organization will be better able to address the needs of diverse youth, families, and staff who have experienced trauma.

Creating trauma-informed organizations is meaningful work that can be accomplished through the systematic process of exploring, preparing, implementing, and sustaining practices that address the domains discussed above. Variability of youth-serving organizations prevents a one-size-fits-all approach. However, with careful assessment of an organization's existing resources and needs, the selection and implementation of the right evidence-informed strategies is a less overwhelming and more worthwhile task.

Culture is inherently tied to both trauma and resilience.

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