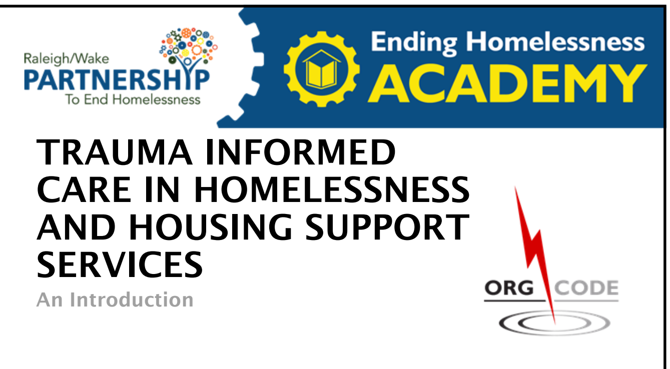

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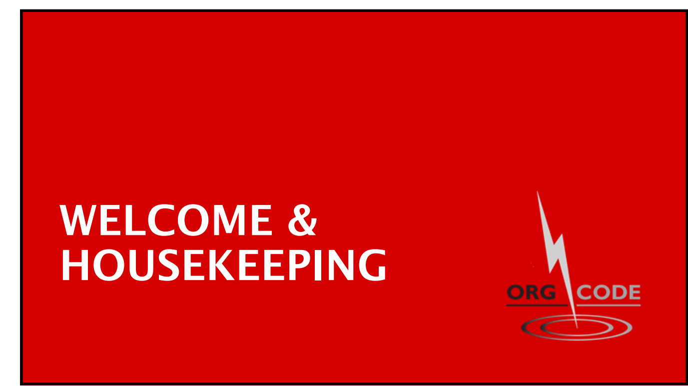

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3

A deeply distressing and disturbing **event** that has an emotional impact.

- Loss, Combat, Relationship, Accident

…How we RECOVER and RESPOND may determine if we experience

- Acute Stress
- Post Traumatic Stress
- Full Recovery

4

"Trauma is when we have encountered an out of control, frightening experience that has disconnected us from all sense of resourcefulness or safety or coping or love".

(Tara Brach)

5

TRAUMA IS…

- Widespread
- Frequently found within people with substance use disorders and/or mental illness.
- Found amongst all races, ethnicities, ages, income strata, and life experiences
- Found to have the possibility of long-term effects in impaired neurodevelopment, immune system responses, and chronic physical and behavioural health risks
- Found to increase substance use disorders, mental illness, and chronic illness

6

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

(Hopper, Bassuk, & Olivet, 2010)

7

WHAT IS POST TRAUMATIC STRESS DISORDER?

Post-Traumatic Stress Disorder (PTSD) is one specific type of response to trauma.

It is a psychiatric diagnosis based on an individual experiencing symptoms from three "symptom clusters" including:

- intrusive recollections,
- avoidant/numbing symptoms, and
- hyper-arousal symptoms.

8

WHAT IS TRAUMA INFORMED?

A **trauma-informed approach** incorporates the four "Rs":

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

9

TRAUMA INFORMED

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

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

10

TRAUMA INFORMED

We want to anticipate that people have experienced it.

Your client's worst behavior is often their best defense mechanism

We are conscious of people's past trauma and don't perpetuate it, especially since we represent institutions that can feel a lot like jail.

"Trauma-specific services" and "trauma-informed care" are sometimes used interchangeably

Both provide care for people exposed to traumatic stress.

Trauma-specific services are clinical interventions

Trauma-informed care addresses organizational culture and practice.

11

VIEWING TRAUMA IN A TRAUMA-INFORMED SYSTEM

"In a trauma-informed system, trauma is viewed not as a single, discrete event, but rather as a defining and organizing experience that forms the core of an individual's identity. The far-reaching impact, and the attempts to cope with the aftermath of the traumatic experience, come to define who the trauma survivor is."

(Harris & Fallot, 2001)

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EXAMPLES OF TRAUMA

Interpersonal	External
· Childhood abuse · Sexual assault · Elder abuse · Domestic abuse · Torture and forcible confinement	· War · Being the victim of a crime · Sudden death of a loved one · Suicidal loss · Sudden and unexpected loss of job, housing, and/or relationship · Natural disasters · Accidents · Living in extreme economic poverty

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HELPING SYSTEMS CAN RE-TRAUMATIZE

Examples include:

- Seclusion and restraints in mental health systems
- Removal of children in child welfare systems
- Invasive procedures in medical systems
- Harsh disciplinary practices in school systems
- Intimidation practices in criminal justice systems

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IMPACTS OF TRAUMA

16

3 DISCRETE COMPONENTS

1. **Event** - *one time or recurring*
2. **Experience** - *whether the event is experienced as scary or threatening*
3. **Effect** - *long-lasting and life altering*

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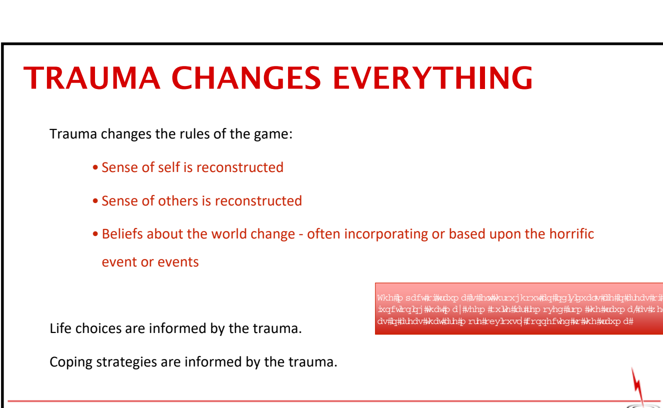

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WHY DOESN'T TRAUMA IMPACT EVERYONE THE SAME WAY?

- Circumstances of the traumatic event
- Genetics
- Previous life experience(s)
- Availability of supports
- Response right after the traumatic event
- How social services respond to the long term impacts

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ALL TRAUMA HAS 3 KEY ELEMENTS

1. It was unexpected.
2. The person was unprepared.
3. There is nothing the person could have done to stop it from happening.

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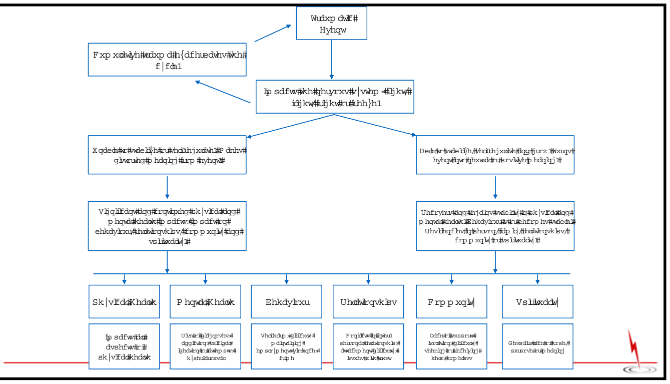

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WHAT IS HAPPENING IN THE BRAIN

In the brain, when confronted with triggers, the left frontal cortex shuts down (speech) and autonomic arousal on the right side (emotion) lights up. People cannot create a coherent narrative of what happened or is happening.

Hippocampus shrinks. Old memories and new memories are indistinguishable.

Norepinephrine and cortisol gets over-produced resulting in hyper-vigilance and amygdala over-activation.

Inability to distinguish false threat from real threat.

Directs muscles to prepare for emergency. Heart races. About 70% of brain-bound oxygen is diverted to muscles.

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PROLONGED TRAUMA IS LIFE THREATENING

- Higher risk of cardiovascular disease.
- Liver enzymes place you at greater risk for Type 2 diabetes.
- Release of cortisol impacts the immune system making you at greater risk of viral infections and other illness.
- Sleep, especially deep REM, is compromised and meaning of life events cannot be processed and sorted. Insomnia is common.

23

TRAUMA AND SUBSTANCE USE DISORDERS

"THEY DIDN'T KNOW THEY WERE TRAUMATIZED. THEY THOUGH THEY WERE JUST ADDICTS. THEY DIDN'T REALIZE THAT THEY WERE USING THE ADDICTION TO SOOTHE A DEEP PAIN THAT WAS ROOTED IN TRAUMA. THE ADDICTION IS THE PERSON'S UNCONSCIOUS ATTEMPT TO ESCAPE FROM THE PAIN."

(DR. GABOR MATÉ)

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TRAUMA INDUCED ADDICTION CAN START AT A YOUNG AGE

- Young people that experience trauma are 3x more likely to form a substance use disorder than those without a comparable trauma experience
- Addiction recovery studies show 7 out of 10 young people in recovery have trauma in their history
- Peer-reviewed published literature shows a strong relationship between those that experience repeated or exacerbated trauma at a young age and those that use specific substances.

(Khoury et al, 2010)

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A SELF-MEDICATING RESPONSE TO TRAUMA

Self-medicating through use of substances can be a relatively early trauma response

When PTSD goes undetected and without supports, people are more likely to develop a substance use disorder

Substance use disorders and PTSD are comorbidities

26

SUD & PTSD

Amongst people with a Substance Use Disorder (SUD), Post Traumatic Stress Disorder (PTSD) is one of the most common co-occurring mental disorders found in people participating in substance use treatment

People in treatment for PTSD may use a wide range of substances for different effects

People in treatment for PTSD ***AND*** SUD tend to have a more severe and complex profile than those with just one of these disorders

PTSD places people at significantly increased risk of suicidality, with or without major depression

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TRAUMA AND ACUTE STRESS DISORDER

ASD represents a normal response to stress.

Symptoms develop within 4 weeks of the trauma and can cause significant levels of distress.

Most individuals who have acute stress reactions never develop further impairment or PTSD.

Acute stress disorder is highly associated with the experience of one specific trauma rather than the experience of long-term exposure to chronic traumatic stress.

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TRAUMA AND POST TRAUMATIC STRESS DISORDER

PTSD is the most commonly diagnosed trauma-related disorder

Symptoms of PTSD can be debilitating over time

Important to remember that PTSD symptoms are represented in a number of other mental illnesses, including major depressive disorder, anxiety disorders, and psychotic disorders

DSM-5 identifies four symptom clusters for PTSD: presence of intrusion symptoms, persistent avoidance of stimuli, negative alterations in cognitions and mood, and marked alterations in arousal and reactivity. Individuals must have been exposed to actual or threatened death, serious injury, or sexual violence, and the symptoms must produce significant distress and impairment for more than 4 weeks

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DIFFERENCES BETWEEN ASD & PTSD

The primary difference is the amount of time the symptoms have been present. ASD resolves 2 days to 4 weeks after an event, whereas PTSD continues beyond the 4-week period.

The diagnosis of ASD can change to a diagnosis of PTSD if the condition is noted within the first 4 weeks after the event, but the symptoms persist past 4 weeks.

ASD diagnosis requires 9 out of 14 symptoms from five categories, including intrusion, negative mood, dissociation, avoidance, and arousal. These symptoms can occur at the time of the trauma or in the following month.

Studies indicate that dissociation at the time of trauma is a good predictor of subsequent PTSD

ASD is a transient disorder, meaning that it is present in a person's life for a relatively short time and then passes. In contrast, PTSD typically becomes a primary feature of an individual's life.

There are common symptoms between PTSD and ASD, and untreated ASD is a possible predisposing factor to PTSD, but it is unknown whether most people with ASD are likely to develop PTSD.

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CO-OCCURRING PTSD & OTHER MENTAL ILLNESSES

Individuals with PTSD often have at least one additional mental illness.

The presence of other illnesses typically worsens and prolongs the course of PTSD and complicates clinical assessment, diagnosis, and treatment.

The most common co-occurring disorders, in addition to substance use disorders, include mood disorders, various anxiety disorders, eating disorders, and personality disorders.

Exposure to early, severe, and chronic trauma is linked to more complex symptoms.

Certain diagnostic groups and at-risk populations (e.g., people with developmental disabilities, people who are homeless or incarcerated) are more susceptible to trauma exposure and to developing PTSD if exposed but less likely to receive appropriate diagnosis and treatment.

(Dom, De, Hulstijn, & Sabbe, 2007; Waldrop, Back, Verduin, & Brady, 2007).

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SYMPTOMS OF TRAUMA EXPOSURE

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IMMEDIATE AND DELAYED RESPONSES TO TRAUMA - *EMOTIONS*

Immediate Emotional Reactions

- Numbness and detachment
- Anxiety or severe fear
- Guilt (including survivor guilt)
- Exhilaration as a result of surviving
- Anger
- Sadness
- Helplessness
- Feeling unreal; depersonalization (e.g., feeling as if you are watching yourself)
- Disorientation
- Feeling out of control
- Denial
- Constriction of feelings
- Feeling overwhelmed

Delayed Emotional Reactions

- Irritability and/or hostility
- Depression
- Mood swings, instability
- Anxiety (e.g., phobia, generalized anxiety)
- Fear of trauma recurrence
- Grief reactions
- Shame
- Feelings of fragility and/or vulnerability
- Emotional detachment from anything that requires emotional reactions (e.g., significant and/or family relationships, conversations about self, discussion of traumatic events or reactions to them)

(Southwick and Grant et al, 2011)

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IMMEDIATE AND DELAYED RESPONSES TO TRAUMA - *PHYSICAL*

Immediate Physical Reactions

- Nausea and/or gastrointestinal distress
- Sweating or shivering
- Faintness
- Muscle tremors or uncontrollable shaking
- Elevated heartbeat, respiration, and blood pressure
- Extreme fatigue or exhaustion
- Greater startle responses
- Depersonalization

Delayed Physical Reactions

- Sleep disturbances, nightmares
- Somatization (e.g., increased focus on and worry about body aches and pains)
- Appetite and digestive changes
- Lowered resistance to colds and infection
- Persistent fatigue
- Elevated cortisol levels
- Hyperarousal
- Long-term health effects including heart, liver, autoimmune, and chronic obstructive pulmonary disease

(NCBI; Southwick and Grant et al, 2011)

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IMMEDIATE AND DELAYED RESPONSES TO TRAUMA - *COGNITIVE*

Immediate Cognitive Reactions

- Difficulty concentrating
- Rumination or racing thoughts (e.g., replaying the traumatic event over and over again)
- Distortion of time and space (e.g., traumatic event may be perceived as if it was happening in slow motion, or a few seconds can be perceived as minutes)
- Memory problems (e.g., not being able to recall important aspects of the trauma)
- Strong identification with victims

Delayed Cognitive Reactions

- Intrusive memories or flashbacks
- Reactivation of previous traumatic events
- Self-blame
- Preoccupation with event
- Difficulty making decisions
- Magical thinking: belief that certain behaviors, including avoidant behavior, will protect against future trauma
- Belief that feelings or memories are dangerous
- Generalization of triggers (e.g., a person who experiences a home invasion during the daytime may avoid being alone during the day)
- Suicidal thinking

(NCBI; Southwick and Grant et al, 2011)

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IMMEDIATE AND DELAYED RESPONSES TO TRAUMA - *BEHAVIORAL*

Immediate Behavioral Reactions

- Startled reaction
- Restlessness
- Sleep and appetite disturbances
- Difficulty expressing oneself
- Argumentative behavior
- Increased use of alcohol, drugs, and tobacco
- Withdrawal and apathy
- Avoidant behaviors

Delayed Behavioral Reactions

- Avoidance of event reminders
- Social relationship disturbances
- Decreased activity level
- Engagement in high-risk behaviors
- Increased use of alcohol and drugs
- Withdrawal

(NCBI; Southwick and Grant et al, 2011)

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IMMEDIATE AND DELAYED RESPONSES TO TRAUMA - *EXISTENTIAL*

Immediate Existential Reactions
- Intense use of prayer
- Restoration of faith in the goodness of others (e.g., receiving help from others)
- Loss of self-efficacy
- Despair about humanity, particularly if the event was intentional
- Immediate disruption of life assumptions (e.g., fairness, safety, goodness, predictability of life)

Delayed Existential Reactions
- Questioning (e.g., "Why me?")
- Increased cynicism, disillusionment
- Increased self-confidence (e.g., "If I can survive this, I can survive anything")
- Loss of purpose
- Renewed faith
- Hopelessness
- Reestablishing priorities
- Redefining meaning and importance of life
- Reworking life's assumptions to accommodate the trauma (e.g., taking a self-defense class to reestablish a sense of safety)

(NCBI; Southwick and Grant et al, 2011)

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UNDERSTANDING SYMPTOMS & TRIGGERS

Remembering FIGHT, FLIGHT, or FREEZE

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

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

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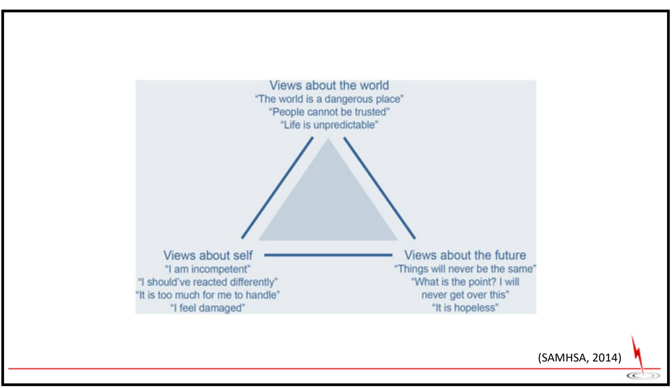

(SAMHSA, 2014)

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40

"We need to hold them accountable"

"I'm not going to work harder than they are"

"People need to meet us half-way"

"They've burned too many bridges"

"They're sabotaging their opportunity"

"We are enabling them"

Others?

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SYMPTOMS OF TRAUMA

The symptoms of trauma range from mild to severe. Many factors determine how a traumatic event affects a person, including:

- their characteristics
- the presence of other mental health conditions
- previous exposure to traumatic events
- the type and characteristics of the event or events
- their background and approach to handling emotions

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RECOGNIZING SYMPTOMS OF TRAUMA

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

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

While there may be a co-occurring mental health issue, symptoms of trauma cannot automatically be considered mental illness.

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UNDERSTANDING SYMPTOMS AND TRIGGERS

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

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

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RECOGNIZING SYMPTOMS OF PTSD

The psychological symptoms of PTSD fall within three main categories:

- **Hyperarousal**
  "the persistent expectation of danger:" startles easily, reacts irritably to small provocations, sleeps poorly
- **Intrusion**
  "repetitive reliving of the traumatic experience in thoughts, dreams and actions:" static, sensory flashbacks and nightmares accompanied by terror and rage
- **Constriction**
  "the numbing response of surrender:" detached states of calm or dissociation impeding voluntary action, initiative, critical judgment and perception of reality

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

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SYMPTOMS OF TRAUMA

Intrusive memories

- Recurrent, unwanted distressing memories of the traumatic event
- Reliving the traumatic event as if it were happening again (flashbacks)
- Upsetting dreams or nightmares about the traumatic event
- Severe emotional distress or physical reactions to something that reminds you of the traumatic event

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SYMPTOMS OF TRAUMA

Avoidance

- Trying to avoid thinking or talking about the traumatic event
- Avoiding places, activities or people that remind you of the traumatic event

Negative changes in thinking and mood

- Negative thoughts about yourself, other people or the world
- Hopelessness about the future
- Memory problems, including not remembering important aspects of the traumatic event
- Difficulty maintaining close relationships
- Feeling detached from family and friends
- Lack of interest in activities you once enjoyed
- Difficulty experiencing positive emotions
- Feeling emotionally numb

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SYMPTOMS OF TRAUMA

Changes in physical and emotional reactions

- Being easily startled or frightened
- Always being on guard for danger
- Self-destructive behavior, such as drinking too much or driving too fast
- Trouble sleeping
- Trouble concentrating
- Irritability, angry outbursts or aggressive behavior
- Overwhelming guilt or shame

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SYMPTOMS IN FAMILIES

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

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TRAUMA IMPACT ON CHILDREN

- Research indicates that children are especially vulnerable to trauma because their brains are still developing.
- Children experience a heightened state of stress during terrible events, and their bodies release hormones related to stress and fear.
- This type of developmental trauma can disrupt normal brain development. As a result, trauma, especially ongoing trauma, can significantly affect a child's long-term emotional development, mental health, physical health, and behavior.
- The sense of fear and helplessness may persist into adulthood. It leaves the person at a significantly higher risk of the effects of future trauma.

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4 PILLARS OF A TRAUMA-INFORMED RESPONSE

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1. TRAUMA AWARENESS

- Trauma awareness is the foundation for trauma-informed practice.
- Being "trauma aware" means that individuals understand the high prevalence of trauma in society, the wide range of responses, effects and adaptations that people make to cope with trauma, and how this may influence service delivery (e.g., difficulty building relationships, missing appointments).

Being "trauma aware" means asking "What has happened to this person?" rather than "What is wrong with this person?"

Nathoo, T., Poole, N. and Schmidt, R. (2018). *Trauma-Informed Practice and the Opioid Crisis: A Discussion Guide for Health Care and Social Service Providers*. Vancouver, BC: Centre of Excellence for Women's Health.

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2. SAFETY & TRUSTWORTHINESS

- Physical, emotional, spiritual, and cultural safety are important to trauma-informed practice.
- Safety is a necessary first step for building strong and trustworthy relationships and service engagement and healing.
- Developing safety within trauma- informed services requires an awareness of secondary traumatic stress, vicarious trauma, and self- care for all staff in an organization.

People need to feel they are out of immediate danger before they can engage with services.

Nathoo, T., Poole, N. and Schmidt, R. (2018). *Trauma-Informed Practice and the Opioid Crisis: A Discussion Guide for Health Care and Social Service Providers*. Vancouver, BC: Centre of Excellence for Women's Health.

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3. STRENGTHS-BASED & SKILL BUILDING

- Promoting resiliency and coping skills can help individuals manage triggers related to past experiences of trauma and support healing and self-advocacy.
- A strengths-based approach to service delivery recognizes the abilities and resilience of trauma survivors, fosters empowerment, and supports an organizational culture of 'emotional learning' and 'social learning.'

A strengths-based perspective focuses on "what works" for a person and how to do more of "what works."

Nathoo, T., Poole, N. and Schmidt, R. (2018). *Trauma-Informed Practice and the Opioid Crisis: A Discussion Guide for Health Care and Social Service Providers*. Vancouver, BC: Centre of Excellence for Women's Health.

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4. CHOICE, CONNECTION & COLLABORATION

- Trauma-informed services encourage opportunities for working collaboratively.
- They emphasize creating opportunities for choice and connection within the parameters of services provided.
- This experience of choice, collaboration, and connection often involves inviting involvement in evaluating the services, and forming service user advisory councils that provide advice on service design as well as service users' rights and grievances.

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6 TENETS OF A TRAUMA INFORMED APPROACH

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6 TENETS OF TRAUMA INFORMED CARE

Safety – ensuring physical and emotional safety

Trustworthiness – transparency by maintaining appropriate boundaries and making tasks clear

Peer Support

Collaboration – maximizing collaboration and mutuality

Empowerment and Choice – prioritizing program participants' empowerment and skill-building and prioritizing participants' choice and control

Cultural, Historical and Gender Issues

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HOW TO INCREASE *SAFETY* IN THE DELIVERY OF SERVICES

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

Throughout the organization, staff and the people they serve feel physically and psychologically safe.

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

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HOW TO INCREASE *SAFETY* IN THE DELIVERY OF SERVICES

To what extent are we **ensuring safety**?

Think about:

- Do **staff** in your organization feel safe? Why or why not?
- Do the people served feel safe? How do you know?

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HOW TO INCREASE *SAFETY* IN THE DELIVERY OF SERVICES

To what extent are we **ensuring safety**?

Think about:

- What could be done to **increase safety** for staff and clients?
  - Better lighting in parking lots, effective grievance procedures or mediation programs to resolve internal conflicts, individualized safety plans for both clients and staff, team support, more transparent staff evaluation procedures, reduced used of coercive measures, etc .

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HOW TO BUILD *TRUSTWORTHINESS* THROUGH *TRANSPARENCY* IN THE DELIVERY OF SERVICES

Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients, and family members of those receiving services.

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

All about relationship and connectivity

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HOW TO BUILD *TRUSTWORTHINESS* THROUGH *TRANSPARENCY* IN THE DELIVERY OF SOCIAL SERVICES

Think about:

- How is trust affected by trauma?
- How does lack of trust affect relationships?
- Can you see why this would be a big issue for trauma survivors?

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HOW TO BUILD *TRUSTWORTHINESS* THROUGH *TRANSPARENCY* IN THE DELIVERY OF SERVICES

- Give people full and accurate information about what your role is, how you are able to assist, and what their role is in the process, as well as what is going to happen and then happen next
- Being clear is essential. Telling people they have more control than they really do will eventually destroy trust. For example, calling a program "peer-run" when in fact key decisions are made by the host organization is not trustworthy. Much better to explain what decisions are made by peers and what decisions are not.
- Openly share confidentiality policies and what your duty to report is.
- Be authentic. Trauma survivors often have finely tuned "radar" to detect other people's emotional states—they have had to develop this capacity, a form of vigilance, to protect themselves.

65

LET'S ASK OURSELVES…

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

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

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

66

ENSURING *PEER SUPPORT* IS PART OF SERVICE DELIVERY

Peers – also called Trauma Survivors - refers to individuals with lived experiences of trauma

These are integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety, and empowerment.

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ENSURING *PEER SUPPORT* IS PART OF SERVICE DELIVERY

- Comes from the work of pioneers in the early consumer/survivor/ex-patient movement in the 1970s.
- These activists developed what was then referred to as self- help or mutual support.
- It grew from the recognition that people who had been disempowered by the mental health system could come together as equals and develop supportive relationships to help reclaim their power.
- Examples:
  - Survivor responsive Crisis lines or programming
  - NA/AA 'sponsors'

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ENSURING *PEER SUPPORT* IS PART OF SERVICE DELIVERY

- Peer support is not "Peer Counseling", which implies that one person knows more than the other—peer support is about power-sharing
- The heart of peer support involves building trust. That isn't possible if people feel that peer support staff are acting as proxies for clinicians, case managers, or administrators, or are reporting on people's behavior.
- Trauma-informed peer support is not just important for people who receive services. It is important that staff who are trauma survivors have access to peer support, too.

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ENSURING *PEER SUPPORT* IS PART OF SERVICE DELIVERY

Think about:

- Does your organization offer access to peer support for the people who use your services? If so, how?
- Does your organization offer peer support for staff?
- What barriers are there to implementing peer support in your organization?

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HOW TO SUPPORT *MUTUALITY AND COLLABORATION* IN THE DELIVERY OF SERVICES

There is recognition that healing happens in relationships and in the meaningful sharing of power and decision making.

The organization recognizes that everyone has a role to play in a trauma-informed approach.

One does not have to be a therapist to be therapeutic.

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HOW TO SUPPORT *MUTUALITY AND COLLABORATION* IN THE DELIVERY OF SERVICES

Think about:

- Can you think of examples from your agency of true partnership between staff and people served?
- What about partnerships between leaders and front line staff?
- What changes would need to occur to decrease the power differentials in your agency?

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HOW TO SUPPORT *MUTUALITY AND COLLABORATION* IN THE DELIVERY OF SERVICES

Overcoming challenges:

- Most professionals have been trained to think that their job is to have answers, to maintain clinical distance, and to know the right techniques to fix a given problem.
- A trauma-informed model recognizes that healing happens in authentic relationships; how to establish a true partnership while also maintaining healthy personal boundaries.
- It may also be hard for people to break down the barriers between different levels of staff.

73

HOW TO ENSURE *EMPOWERMENT AND CHOICE* FOR PEOPLE THAT MAKE USE OF SERVICES

Aims to strengthen the staff, client, and family members' experience of choice and recognizes that every person's experience is unique and requires an individualized approach.

This builds on what clients, staff, and communities have to offer, rather than responding to perceived deficits.

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HOW TO ENSURE *EMPOWERMENT AND CHOICE* FOR PEOPLE THAT MAKE USE OF SERVICES

Strengthens clients and family member's experience of choice
Recognizes that every person's experience is unique
Provides an individualized approach

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HOW TO ENSURE *EMPOWERMENT AND CHOICE* FOR PEOPLE THAT MAKE USE OF SERVICES

Building on people's strengths and resilience
Turning problems into strengths
Empowerment, voice and choice apply to staff as well as the people served.
What are some ways you can use your clients' strengths?

- Asking, 'What do you bring to your community?'
- Having client's artwork decorate the walls
- Leveraging their lived experience to develop and evaluate programs and services

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HOW TO ENSURE *EMPOWERMENT AND CHOICE* FOR PEOPLE THAT MAKE USE OF SERVICES

Think about:

- Are there currently opportunities for empowerment, choice, and voice in your agency/program?
  - Opportunities for people to lead community meetings and program activities?
  - Are former participants interested in being involved in developing or providing services?
  - Are current or former participants in leadership positions, such as sitting on a board?
- Can you think of policies or procedures that do the opposite?

77

CONSIDERATION OF CULTURAL, HISTORIC, AND GENDER ISSUES

The organization actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, religion, gender-identity, geography, etc.)

Offers, either directly or through referral, access to gender responsive services

Leverages the healing value of traditional cultural connections

Incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; and recognizes and addresses historical trauma.

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CONSIDERATION OF CULTURAL, HISTORIC, AND GENDER ISSUES

Trauma is context specific. That's why the first "E" in SAMHSA's definition is "event."

Women and men often experience different kinds of traumatic events, so gender-responsiveness is important in trauma work.

Culture, gender and history are not just "value-added" but are in fact essential in a trauma informed approach.

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INTERSECTIONALITY AND TRAUMA

- Extends the notion of Trauma-Informed Practice/Care:
  - Trauma and violence (interpersonal, structural, gendered) are root causes of poor mental and physical health
  - Looks beyond 'choices' of individuals and considers structural violence and conditions that support it
  - Recognizes client responses (coping mechanisms, physical and mental health problems, etc.) as predictable consequences of highly threatening events and as connected to structural violence

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INTERSECTIONALITY AND TRAUMA

Within the population experiencing homelessness at any given time:

- Discrimination results in a disproportionate representation of racial minorities, women, LGBTQ2+, and persons with health issues in homeless Populations
- The discriminatory cycle of homelessness and incarceration results in a disproportionate representation of formerly incarcerated individuals
- The Failure to address the challenges associated with military service results in a disproportionate representation of Veterans
- The Failure to address the local need for affordable and accessible housing options exacerbates homelessness

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TRAUMA INFORMED HOMELESSNESS AND HOUSING SUPPORT SERVICES

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THE GOAL OF TRAUMA-INFORMED CARE

The goal of trauma-informed care is to:

- avoid re-traumatizing individuals and
- support safety, choice, and control in order to promote healing.

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CONSIDERATIONS FOR ENGAGEMENT & INTAKE

- Welcoming intake procedures
- Adapting the physical space to be less threatening
- Providing clear information about the programming (i.e., who does what and how)
- Ensuring informed consent
- Demonstrating predictable expectations • Scheduling appointments consistently
- Non-judgemental interactions

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CONSIDERATIONS FOR ENGAGEMENT & INTAKE

Who greets people? What are some of the things they might say? Does someone provide an orientation to the physical space?

Examples:

- Showing people where they can sit or wait;
- Offering or showing them where they might be able to get something to drink or eat;
- Mentioning any activities happening in the building that might be contributing to noise;
- Providing directions to the bathroom;
- Giving people an opportunity to ask questions?

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CONSIDERATIONS FOR ENGAGEMENT & INTAKE

Is the program space organized in such a way that recognizes people might require different things to be comfortable and that staff might need to accommodate a wide range of behaviours?

Providing choices about where people can wait and providing information about how long the wait might be can help people feel more in control.

Examples:

- Is there a quieter place where someone can wait for an appointment if they are unsettled by noise or clutter?
- Some clients might prefer to wait outside or need to move around more. Is it possible for a staff member to meet them outside the building or in a hallway or text them when they are ready?

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CONSIDERATIONS FOR ENGAGEMENT & INTAKE

There are many aspects of the physical environment that can be triggering and/or potentially re-traumatizing for people. While it's impossible to address all possible triggers, there are some changes that might be easy to make or important to consider when working with specific populations.

Examples

- Is it possible to make certain physical spaces feel less "institutional", perhaps with plants, a box of toys, art or posters that are reflective of the community or population the program serves, neutral colours?
- Policies about lights and locks – considering both clients and staff, what feels restrictive and what contributes to feelings of safety?

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CONSIDERATIONS IN SHELTERING

- **Diversion** – Safe and Appropriate Alternative to shelter can be useful to prevent trauma.
- **Environment** – Line-ups for entry visibility? Bed assignment preferences or perceived bias?
- **Programming** – Longer length of stay in shelter increase opportunity for trauma are programming necessary? Do 'required' programming prevent rapid exit from shelter?
- **Floor staff engagement** – Are they easily identifiable (uniform/shirt) and available? Are they passively or actively engaging with shelter guests?
- **Use of security** – Is the focus on control or creating an environment of safety and support? Safety Ambassador model that is supportive rather than punishing. De-escalation skills more important than law and order
- **Safer storage** – Traumatizing to lose photos and keepstakes. Store and File IDs.

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CONSIDERATIONS IN STREET OUTREACH

- **Identifying oneself** – T-shirt/vehicle ID. Betransparent about who, what is your purpose.
- **Approach** – Present at an angle
- **Body language –** Open body stance, hands visible,
- **Providing open space during engagement** be in their natural setting, not coming into a van or car
- **Outlets to exit unsheltered homelessness**
- **Avoiding duplication of service –** Coordinate among all teams, rather than re-telling the story

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CONSIDERATIONS IN HOUSING SUPPORTS

- **Trying to keep to a set schedule** – KEEP Schedule, avoid unexpected. NO SURPRISES.
- **Announcing oneself upon arrival** – Call / text reminder and as approaching unit. NO SURPRISES.
- **Establishing objectives for the visit (no surprises!) –** Establish what the purpose of the meeting. Expected. Client has some control. Expected Agenda.
- **Progressive engagement –** Helping people continue to build their own skills. Offering the level of support needed and guiding them to support rather than overwhelming with every possible support at once.
- **Strengthening results of referrals** – Don't just TELL where resources, assure connection and got the benefit. Maybe calls, follow-ups, agency follow-ups.
- **Respecting people's place and things –** Sensitivity to all belongings in a space…they give us consent
- **With consent, collecting information from others rather than repeating oneself over and over again**

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HOW TO IMPLEMENT TRAUMA INFORMED PROGRAMMING & POLICY

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TRAUMA INFORMED PROGRAMMING

- Reframe 'defiance' behaviors as **resilience and survival** skills
- Reframe 'consequences' as results of decisions made
- **Slow down** and **explain** every process and step – *this is how, why we do what we do*
- Let participants know that they have the right to share only the information that they want to share – *Establish opportunity for control over experience*
- Do not expect immediate rapport and do not assume that immediate rapport means trust has been built
- Boundaries – *staff should never attempt to play or replace friends or family*

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TRAUMA INFORMED PROGRAMMING

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

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TRAUMA INFORMED PROGRAMMING

Program uses "people-first" language rather than labels (e.g., "*people who are experiencing homelessness*" rather than "*homeless people*")

"We would like…" rather than "***You need to…"***

Staff uses descriptive language rather than characterizing terms to describe program participants

Example: Describing a person as *"having a hard time getting her needs met"* rather than *"attention-seeking"* or this person *"has substance – use issues"* rather than they are *"an addict."*

Acknowledging the humanity of thier experience rather than casting, labeling and judging.

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TRAUMA INFORMED PROGRAMMING

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

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

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

Understanding WHY these behaviors are present rather than judging.

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SUPPORTING STAFF DEVELOPMENT

Staff members are required to complete a certain amount of staff development time (e.g., trainings, conferences, etc.) per year

Coverage is in place to support training and Financial assistance/paid time-off is available for staff to attend trainings

ONBOARDING ESSENTIALS TO STAFF:

The program educates staff members about:

- Confidentiality
- Informed consent
- Roles and responsibilities
- Professional boundaries

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CREATING A SAFE, SUPPORTIVE ENVIRONMENT

Establishing a **safe physical environment** – *Difficult to be Trauma Informed when the physical environment that is chaotic, non-therapeutic.*

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

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CREATING A SAFE, SUPPORTIVE ENVIRONMENT

Establishing a supportive environment:

- **Information sharing** – Too many posters and brochures everywhere (overload) or structured, approved, supportive information
- **Cultural competence** – Cultural safety, humility, gender
- Privacy and confidentiality
- Safety and Crisis prevention planning -
- Open and respectful communication – Two-way communication, guests can engage with staff as well as staff to guests
- Consistency and predictability – Consistency between shifts. Especially the overnight shift to day-staff. Support throughout the service day (24 hours), not support by day and then "command and control" over night.

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ASSESSING AND PLANNING SERVICES

Conducting intake

Developing goals and plans – Not use of established 30 day forms. Rather, develop what they believe they can accomplish, rather than imposed. Center on their changes they wish to make and how ready they are to take action. Readiness Ruler: *"Scale of 1-10 how ready are you….how important is it…how confident are you…." "What would it take to move you from a 4 to a 5 in readiness…"*

Offering services and trauma-specific interventions - Counseling, groups, therapy

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INCLUDING THE PEOPLE WE SERVE

- Giving service recipients a **voice**
- Giving them **choice** in how and where they receive services
- Enabling **trained peers**
- Providing opportunities for **developing and evaluating program activities** – *Develop methods of feedback to improve our trauma informed response and delivery.* EXAMPLE: Weekly Peer-Led community meeting to hear responses to what is occurring in the facility.
- Former clients can have staff and **leadership** positions – *Experience of employment is NOT retraumatizing and appropriate training and support for their employment*
- **Client grievance policy** – Transparent and easy and well analyzed by management

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ADAPTING POLICIES

Establish and review written policies:

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

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REVISITING POLICIES

Let's talk about RULES…

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

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MOVING FROM RULES TO EXPECTATIONS

RULES by definition mean that authority is exercised over another

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

Example: Barring for behavior or adopt a dialogue to explain the behavior expectation and why the expectation exists.

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TRAUMA INFORMED SYSTEMS

Deficit Based ➲ Asset Based

Relationships Based on Hierarchy ➲ Power Sharing

Behavior/Choices Seen as Bad ➲ Understand Mechanisms for Coping

Policies/Process Triggering ➲ Trauma-Informed Practices

Providing Social Control ➲ Providing Social Services

Rules ➲ Expectations

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

(Shallcross, 2013)

A result of compassion and empathy as an approach to our work in the helping space.

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WHAT ARE SYMPTOMS?

- Lingering feelings of rage/anger about clients
- Becoming overly involved emotionally
- Experiencing bystander guilt, shame self-doubt
- Preoccupied with thoughts of clients outside work
- Over-identification with clients
- Loss of hope, pessimism, cynicism – *We're never going to end homelessness*
- Distancing, numbing, detachment – *Avoiding our engagements, meetings with clients*
- Difficulty in maintaining professional boundaries with the client, overextending

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Risk and Resiliency Factors

Personality and Coping Style

Spiritual Resources

Social Support

Current Life Circumstances

Work Style

Past Trauma History

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ORGANIZATIONAL STRATEGIES TO SUPPORT TRAUMA INFORMED PRACTICE

Provide adequate **clinical supervision**, including reflective supervision – *Not just HR but connect to clinical perspectives for non-clinical workers*

Maintain **caseload balance** – Balance between range of complex cases

Support **workplace self-care** groups – Outreach relief, how we are doing

Enhance the **physical safety of staff** – de-escalation training, back up

Offer flextime scheduling – support a place of wellness

Train organizational leaders and non-clinical staff organizational leaders on organizational implementation and assessment

Provide ongoing **assessment of staff risk** and resiliency – Check-in, organized and intentional to understand how coping and risks

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SUPPORTING STAFF DEVELOPMENT

Mechanisms for encouraging self-care as a Regular Practice:

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

Decreasing Vicarious Trauma

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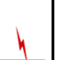
INDIVIDUAL STRATEGIES

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

We do not want to be Trauma-Inducing to our program participants because of we are experiencing ongoing Vicarious Trauma



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