Childhood Trauma Task Force

July 23nd

1pm – 3pm

OCA
MASSACHUSETTS
Office of the Child Advocate

Agenda

- Welcome and Introductions
- Approval of Minutes from May & June Meeting
- Presentation from DMH
- Discussion: Creating Guidelines for Trauma-Informed Practice in Massachusetts

OCA
MASSACHUSETTS
Office of the Child Advocate

Recognizing & Responding to Trauma:
The Dept. of Mental Health's Efforts

Janice LeBel & Emily Sherwood
DMH CYF Division
Child Trauma Task Force
July 23, 2019

Outline

- Background
- Current & Shared Efforts
- On the Horizon & Parting Thoughts

DMH's Trauma Recognition Beginning

Massachusetts' Imprint on Trauma Recognition:

- **1994: "Dare to Vision" landmark conference** focused on the mental health needs of abused women and the traumatic effects of some psychiatric practices, particularly R/S. Keynote address by **Pat Deegan, PhD:** *"Before We Dare to Vision, We Must Be Willing to See"*
- **1995: Advocates raised serious concerns** with DMH Commissioner Elias about the experiences of women in psychiatric settings. Consumers described how coercive intervention, especially RS **recapitulated earlier traumatic experiences**. A Task Force was appointed to study the issue. Their report followed in 1996.

Massachusetts Department of Mental Health

Task Force on the Restraint and Seclusion of Persons who have been Physically or Sexually Abused

Report and Recommendations

January 25, 1996

Prepared by the Task Force

Elaine Carmen, M. D. (Chair)

Bill Crane, J. D. (Co-chair)

Margaret Dunnicliff, Ph. D.

Steve Holochuck, B. S.

Laura Prescott, B. A.

Patricia Perri Rieker, Ph. D.

Susan Stefan, J. D.

Nan Stromberg, R. N., C. S.

DMH's Trauma Recognition Beginning

- 1998: Two years after the Task Force's work, DMH revised its restraint and seclusion regulations. The new regulations required that **trauma assessments be conducted at admission for all consumers**. For those who had abuse histories, **individual crisis prevention planning was also mandated**. These regulations applied to all DMH state hospitals and private sector psychiatric facilities.

Task Force Concerned with Restraint/Seclusion of Persons who have been Physically and/or Sexually Abused
Restraint Reduction Form for DMH Facilities/Vendors

This form is a guide to gathering information with clients for the development of strategies to de-escalate agitation and distress so that restraint and seclusion can be averted. It should be used in conjunction with the Trauma Assessment Form. It is recommended for use in all acute care facilities, such as acute inpatient units, crisis stabilization and other diversion units, and psychiatric emergency rooms, when clinically indicated. Indications include a past history or likelihood of loss of control of aggressive impulses. The information obtained should be incorporated into the treatment plan for this client.

1. It is helpful for us to be aware of the things that can help you feel better when you're having a hard time. Have any of the following ever worked for you? We may not be able to offer all these alternatives but I'd like us to work together to figure out how we can best help you while you're here.

voluntary time out in your room		listening to music	
voluntary time out in quiet room		reading a newspaper/book	
sitting by the nurses station		watching TV	
talking with another consumer		pacing the halls	
talking with staff		calling a friend	
having your hand held		calling your therapist	
having a hug		pounding some clay	
punching a pillow		exercise	
writing in a diary/journal		using ice on your body	
deep breathing exercises		putting hands under cold water	
going for a walk with staff		lying down with cold facecloth	
taking a hot shower		other? (please list)	
wrapping up in a blanket			

2. Is there a person who has been helpful to you when you're upset? (Y/N) Would you like them to come and visit you? (Y/N) Can we assist in this process? (Y/N)
If you are in a position where you are not able to give us information to further your treatment, do we have your permission to call and speak to _____(name) _____(phone)? (Y/N) If you agree that we can call to get information, sign below:
Client signature _____ Witness _____ Date _____

3. What are some of the things that make it more difficult for you when you're already upset? Are there particular "triggers" that you know will cause you to escalate?

being touched		being isolated	
bedroom door open		people in uniform	
particular time of day (when?)		time of the year (when?)	
loud noise		yelling	
not having control/input (explain)		other (please list)	

4. Have you ever been restrained in a hospital or other setting, for example, in a crisis stabilization unit or at home?

	physically/mechanically?	chemically?
when?		
where?		
what happened?		

5. If you are escalating or in danger of hurting yourself or someone else, we may need to use a physical, mechanical or chemical restraint. We may not be able to offer you all of these alternatives, but if it becomes necessary, we'd like to know your preferences.

quiet room	seclusion	
physical hold	safety coat	papoose board
3-point restraint	face up?	face down?
4- point restraint with legs together	face up?	face down?
chemical restraint		

6. Do you have a preference regarding the gender of staff assigned to you during and immediately after a restraint? Women staff ____ Men staff ____ No preference ____

7. Is there anything that would be helpful to you during a restraint? Please describe.

_____

_____

8. We may be required to administer medication if physical restraints aren't calming you down. In this case, we would like to know what medications have been especially helpful to you? Please describe.

_____

_____

9. IF FACILITY DOES ROOM CHECKS: We do room checks here to make sure you are okay at night. We are trying to make these room checks as nonintrusive as possible. Is there anything that would make room checks more comfortable for you?

_____

_____

Please incorporate the information obtained in the restraint reduction form into the treatment plan for this client

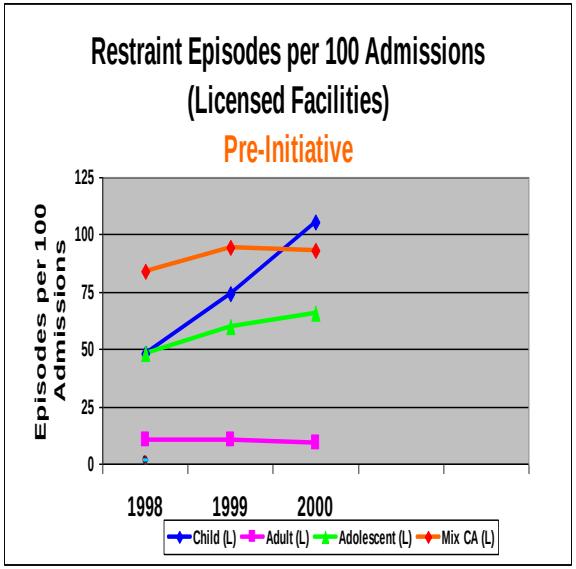
rswinf/dmhtrauma/112095

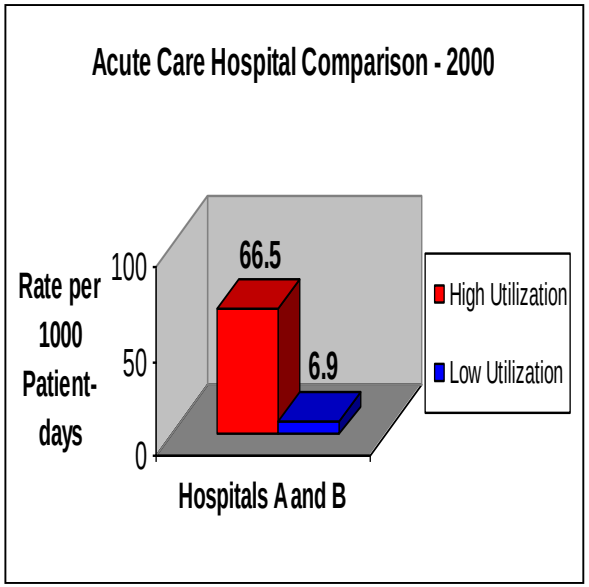
Evolution of DMH Raising Trauma Awareness / Practice Expectations

- 2000 Commissioner Sudder's Directive
- 2001 RS Prevention Initiative Kickoff
- 2004 Philosophy Statement
- 2004 SAMHSA Grant
- 2006 New RS Prevention Regulations &
  RS Forms & Debriefing with apology
- 2009 Interagency RS Prevention Initiative
- 2009 DMH Forensic Services grant with DOC results in MCI-Framingham's 1st major trauma training for correctional officers
- 2010 New RS Policy
- 2012 Joint Procurement: ***Caring Together***

Recognizing Trauma Underlying RS Use

- Providers: *"It's the kids …"*
- Medical records:
  - trauma 87% (2001)
  - trauma 98% (2008)
- The forms: reactive *Restraint Recipe*





C/A Restraint/Seclusion Prevention Effort

- Teaching about trauma & retraumatization with RS use (workforce, youth & families)

- Janina Fisher x 23 (Sensory-Motor) ~ 03/20
- Jake Lukas (Relational Health) ~ 10/19
- Glenn Saxe (Trauma Systems)
- Ross Greene (CPS)
- Laura Prescott (consumer experience)
- Kevin Huckshorn (Six Core Strategies)
- Tina Champagne (sensory-integration)
- Maggie Bennington-Davis (Engagement)
- Laurie Leitch (*TI is not enough*) ~ TBD

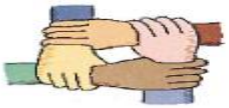
C/A Restraint/Seclusion Prevention Effort

- Asking about trauma (assessment & crisis prevention/safety/soothing planning)
- Doing something about trauma (sensory integration/sensory modulation, recreation/ExYo & skill development)
- Studying the impact of RS on treatment/operations: The Business Case

What makes you feel upset?

(Circle all that make you feel sad, mad, scared or other feelings)

Touch



Being touched

Too many people

See

Darkness

Hear

Loud noises

Yelling

Thunderstorms

Other

Missing someone

Being left alone

Being surprised

Having a fight with a friend

Not having visitors

Being hungry

Being tired

Someone being mean

Being sick

Certain time of year

Certain time of day/night

Having my bedroom door open

Anything else that makes you feel upset? _____

NOTE: The following are general triggers for people
Being told what to do rather than asked;
Being told no rather than being given choices.

Warning Sign Tool

What happens to my body when I am angry, scared or upset?

(Circle all that apply)

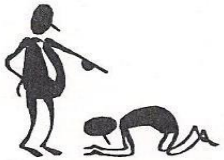

Cry


Clench teeth


Loud voice


Red/hot face


Laughing/giggling


Being mean or rude

Swearing


Racing heart


Breathing hard


Wringing hands


Clenched fists


Upset stomach


shaking or tapping


Jumping up and down or stamping feet


Rocking


Hyper


Running or pacing

What helps you feel better?

(Circle all that help you)

Touch


Writing


Fidget tools


Games


Toys or Blocks


Bath or Shower


Stress ball or clay


Special blanket or cloth

Any other objects you touch or hold that help you feel better? _____

See


Reading


Watching TV


Looking at pictures


Using a computer

Any other objects you like to look at that help you feel better? _____

Movement


Using a rocking chair


Swinging


Dancing


Sports
(kickball, basketball, soccer, etc)

Any other movements you like that help you feel better? _____

Hear


Talking on the telephone


Listening to music


Singing or humming

Quiet place


Counting to ten

Do you prefer music that is: ☐ Loud or ☐ Soft

What type of music do you prefer: _____

Any other sounds or noises that help you feel better? _____

Pressure touch


Hugging a stuffed animal


Sitting in a bean bag chair


Using a weighted blanket


Climbing on a jungle gym


Exercise


Sitting on a therapy ball


Getting a hug

Any other activities that help you feel better? _____
(Examples: blowing bubbles, deep breathing, etc.)

Smell

Any smells that help you feel better? _____
(Examples: peppermint, popcorn, cookies, flowers, etc.)

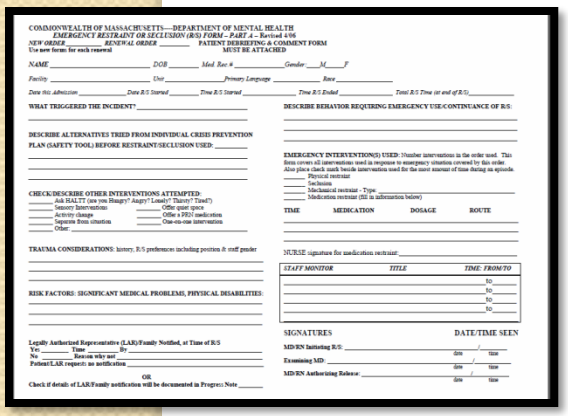
Taste

Any certain tastes that help you feel better? _____
(Examples: chewy, crunchy, salty, sour, spicy, etc.)

Raising Awareness Improving Practice

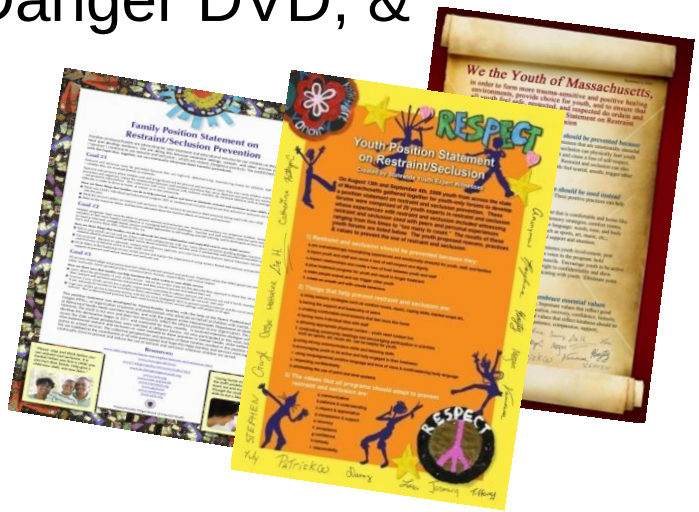
Creating Tangible Legacies

- Standards / Regulations
- RS Forms
- Resource Guides
- Licensing expectations
- Contract language & Performance Indicators
- Y&F Position Statements; Real Danger DVD; & 13RTF


COMMONWEALTH OF MASSACHUSETTS—DEPARTMENT OF MENTAL HEALTH
EMERGENCY RESTRAINT OR SECLUSION (R/S) FORM – PART A – Revised 4/06
NEW ORDER _____ RENEWAL ORDER _____ PATIENT DERIVATIVE & COMMENT FORM
Use new forms for each renewal MUST BE ATTACHED

NAME _____ DOB _____ Med. Rec # _____ Gender: ___M ___F
Facility: _____ Unit: _____ Primary Language _____ Race _____
Date this Admission _____ Date R/S Started _____ Time R/S Started _____ Time R/S Ended _____ Total R/S Time (at end of R/S) _____

WHAT TRIGGERED THE INCIDENT? _____
DESCRIBE BEHAVIOR REQUIRING EMERGENCY USE/CONTINUANCE OF R/S:
DESCRIBE ALTERNATIVES TRIED FROM INDIVIDUAL CRISIS PREVENTION PLAN (SAFETY TOOL) BEFORE RESTRAINT/SECLUSION USED: _____
EMERGENCY INTERVENTION(S) USED: Number interventions in the order used. This form covers all interventions used in response to emergency situation covered by this order. Also place check mark beside intervention used for the most amount of time during an episode.
_____ Physical restraint
_____ Seclusion
_____ Mechanical restraint - Type _____
_____ Medication restraint (fill in information below)
CHECK/DESCRIBE OTHER INTERVENTIONS ATTEMPTED:
_____ Ask HALTT (are you Hungry? Angry? Lonely? Thirsty? Tired?)
_____ Sensory Intervention: _____ Offer quiet space
_____ Activity change _____ Offer a PRN medication
_____ Separate from situation _____ One-on-one intervention
_____ Other: _____
TIME MEDICATION DOSAGE ROUTE
TRAUMA CONSIDERATIONS: history, R/S preferences including position & staff gender
NURSE signature for medication restraint: _____
RISK FACTORS: SIGNIFICANT MEDICAL PROBLEMS, PHYSICAL DISABILITIES:
STAFF MONITOR TITLE TIME: FROM/TO
SIGNATURES DATE/TIME SEEN
Legally Authorized Representative (LAR)/Family Notified, at Time of R/S
Yes _____ Time _____ By _____
No _____ Reason why not _____
Patient/LAR request: no notification _____
OR
Check if details of LAR/Family notification will be documented in Progress Note _____
MD/RN Initiating R/S: _____ date _____ time
Examining MD: _____ date _____ time
MD/RN Authorizing Release: _____ date _____ time



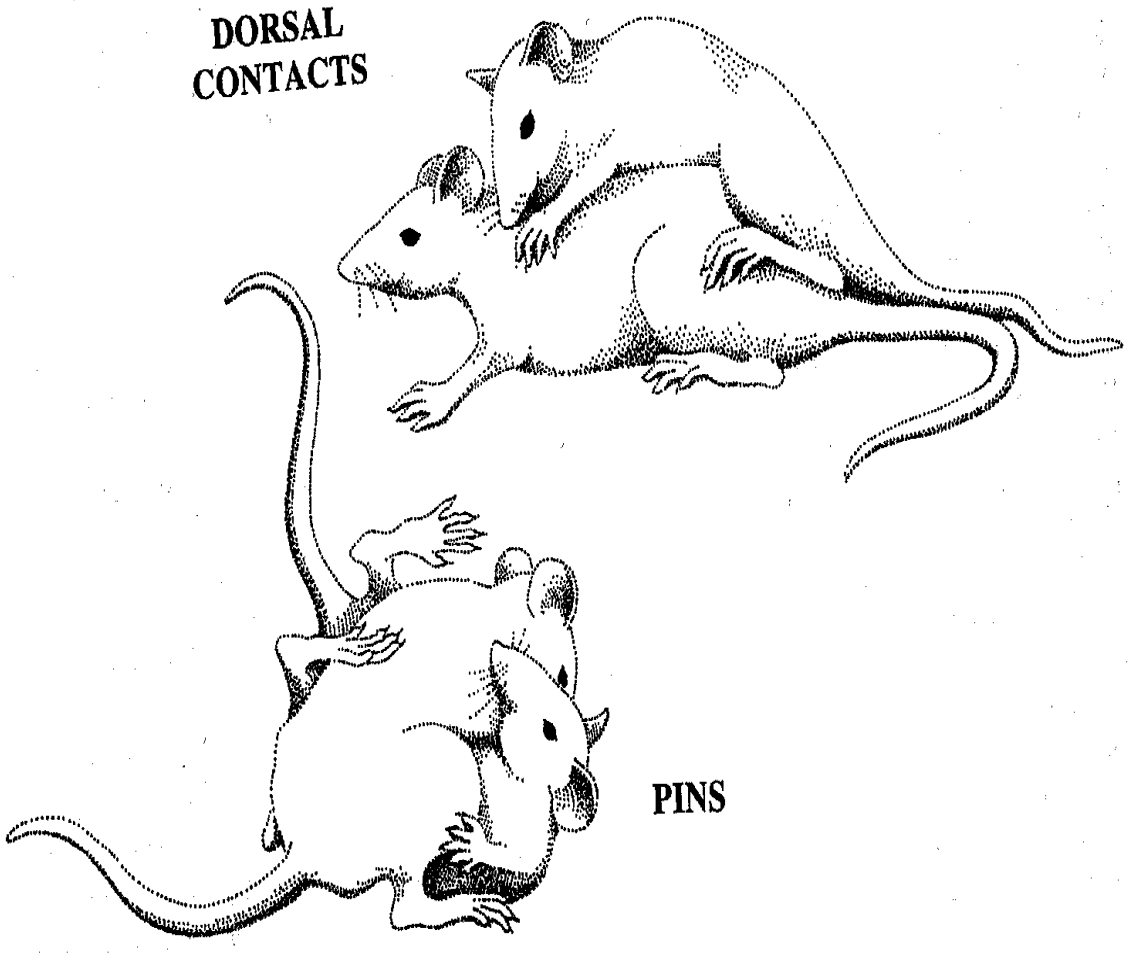
Youth Create their own Position Statement: RS are “devastatingly traumatic”

Creating New Treatment Modalities:
Practicing Pleasure & Experiencing Joy

Teach sensorimotor integration:

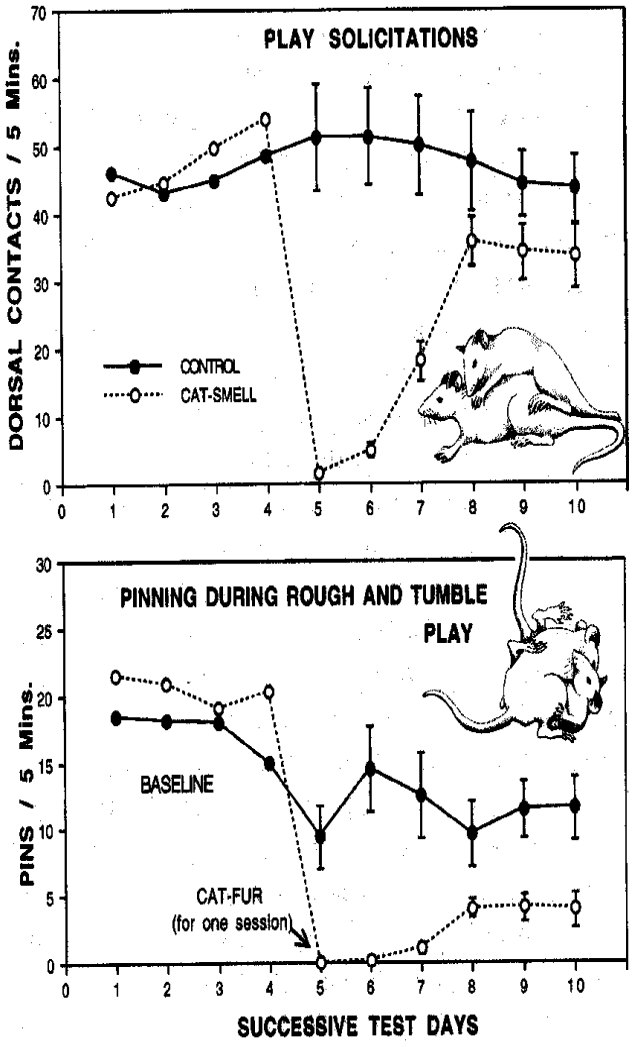
Healing the
brain, the mind, and
the body through
proprioception,
vestibular input,
movement, exercise,
dance, & more

Play



(Panksepp, 1998)

Play and Fear



(Panksepp, 1998)

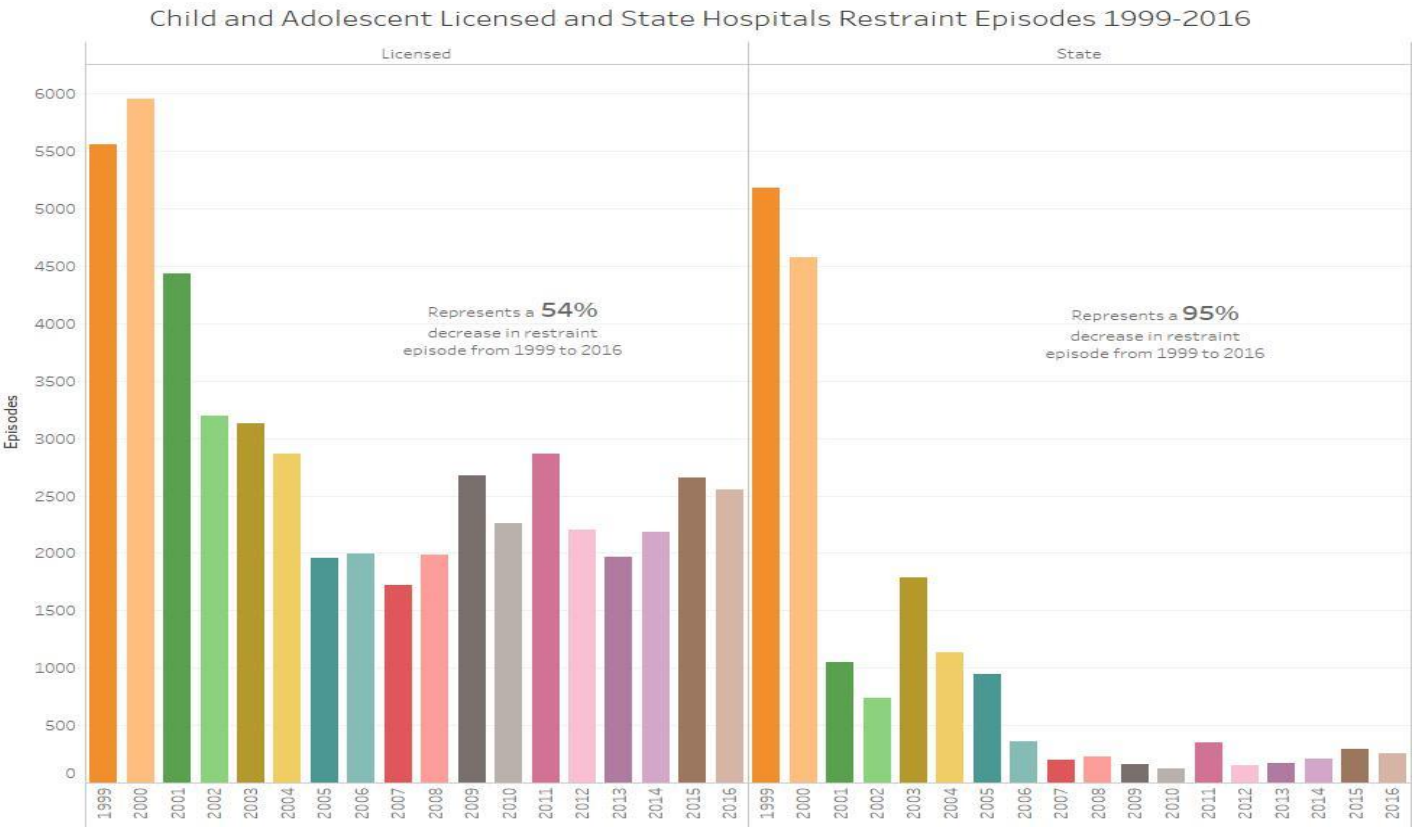
Creating New Treatment Modalities:
Practicing Pleasure & Experiencing Joy

Changing Practice

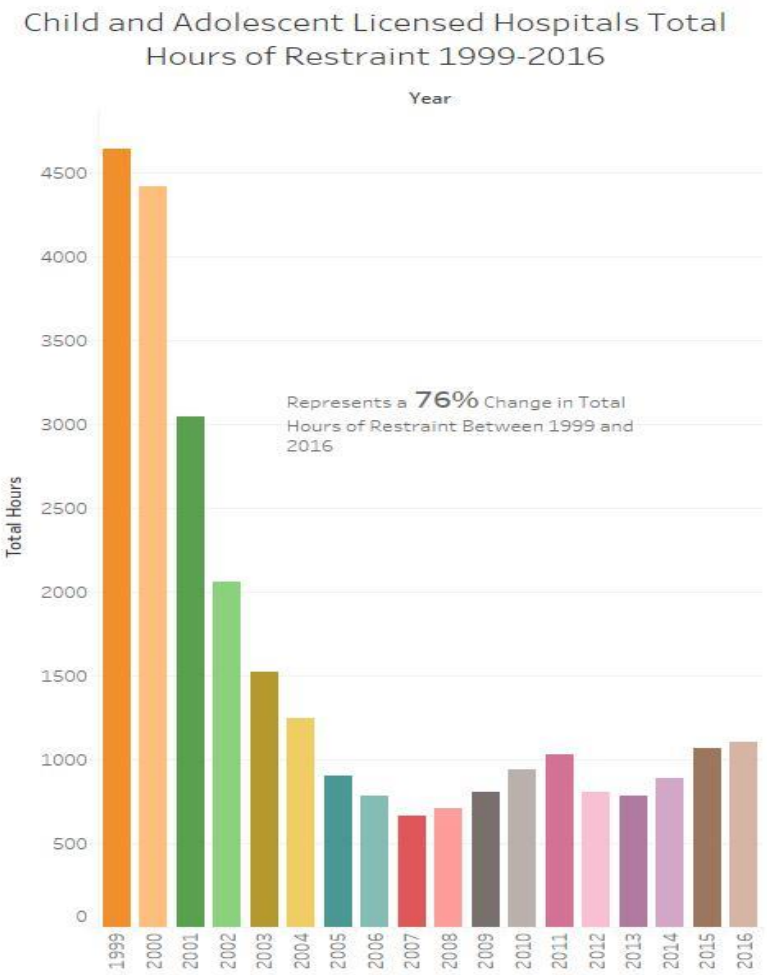
- Restraint & Seclusion Room

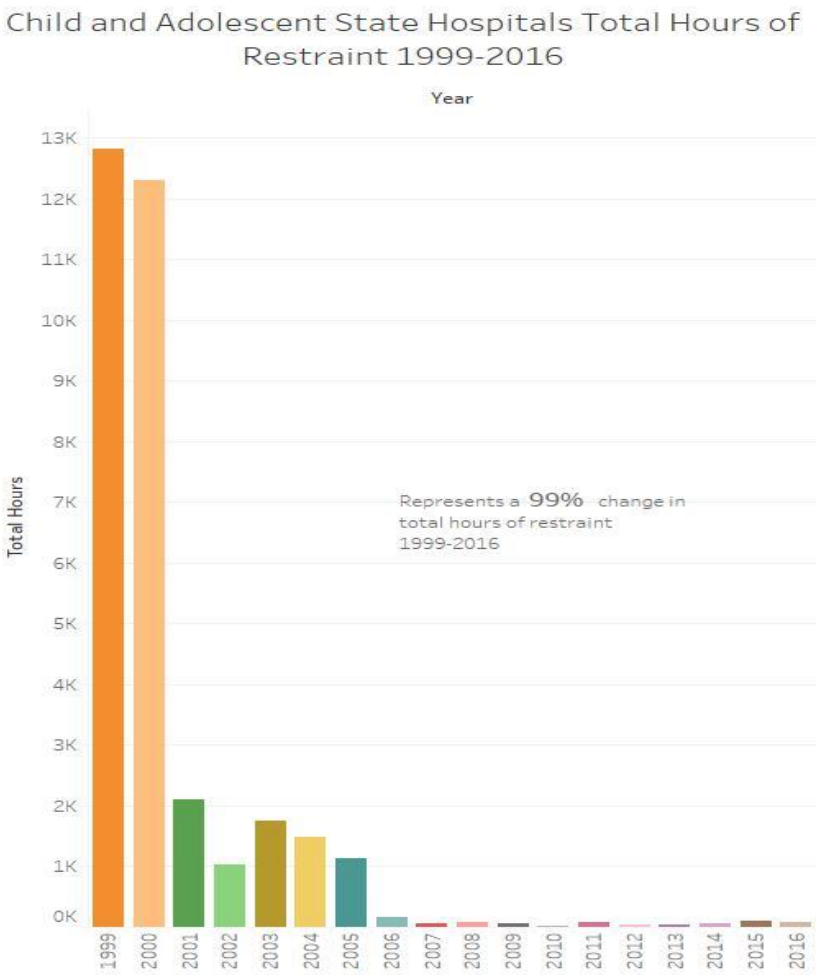
- Sensory & Play Room

Child/Adolescent Services: Episodes



Child/Adolescent Services: Duration





DMH Regulations

- 104 CMR 27.05(4) Admission examination: assessment of trauma/trauma history;
- 104 CMR 27.12(2): Assessment of trauma, trauma impact on persons served & staff;
- 104 CMR 27.12(3): Staff training on the impact of trauma, including sexual and physical abuse and witnessing of violence, on both patients and staff;
- 104 CMR 27.12(4b): incorporation of trauma history into crisis prevention plan/planning

A Shared Approach

Interagency RS Prevention effort is organized with a Vision, Guiding Principles and a trauma platform

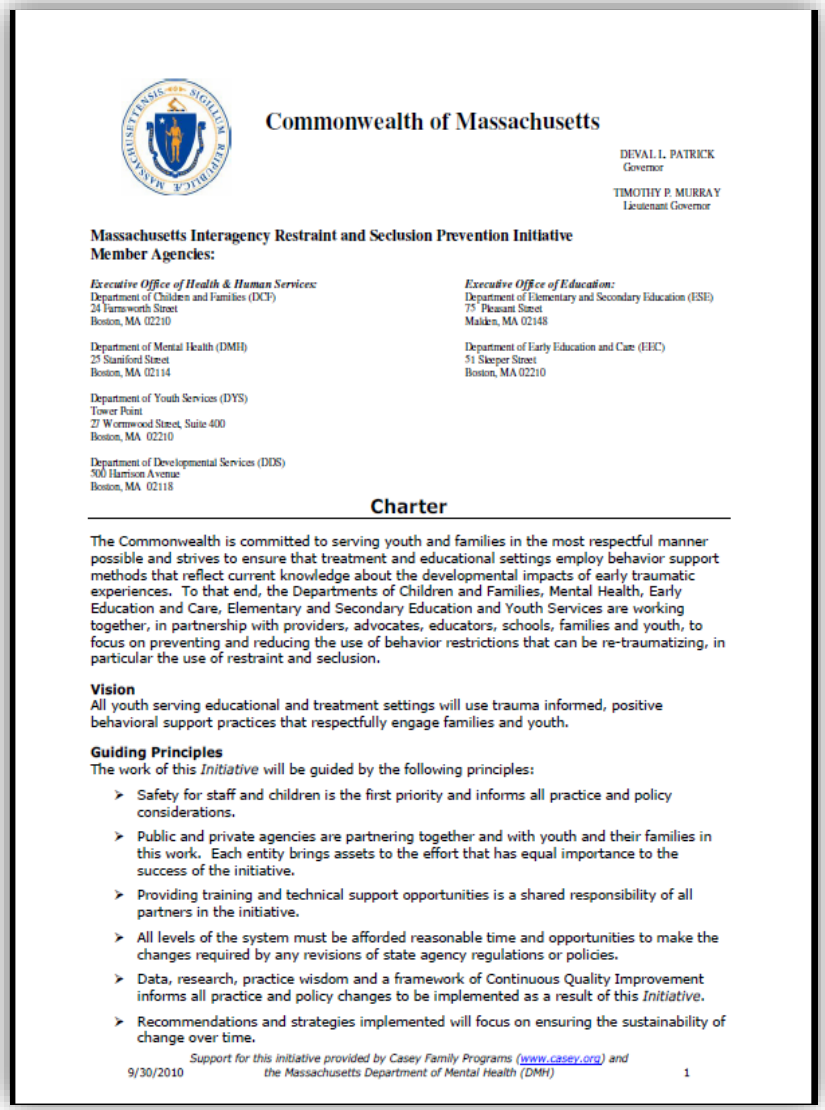
Initial work was:

- Guided by a national scan funded by Casey Family Services
- Co-Chaired by DMH & DCF
- Staffed by Amy Kershaw, Project Manager
- Conducted by 3 subcommittees:

1) Data Analysis & Reporting

2) Training & Technical Support

3) Policy & Regulation Reform



Commonwealth of Massachusetts

DEVAL L. PATRICK
Governor

TIMOTHY P. MURRAY
Lieutenant Governor

Massachusetts Interagency Restraint and Seclusion Prevention Initiative
Member Agencies:

Executive Office of Health & Human Services:
Department of Children and Families (DCF)
24 Farnsworth Street
Boston, MA 02210

Department of Mental Health (DMH)
25 Staniford Street
Boston, MA 02114

Department of Youth Services (DYS)
Tower Point
27 Wormwood Street, Suite 400
Boston, MA 02210

Department of Developmental Services (DDS)
500 Harrison Avenue
Boston, MA 02118

Executive Office of Education:
Department of Elementary and Secondary Education (ESE)
75 Pleasant Street
Malden, MA 02148

Department of Early Education and Care (EEC)
51 Sleeper Street
Boston, MA 02210

Charter

The Commonwealth is committed to serving youth and families in the most respectful manner possible and strives to ensure that treatment and educational settings employ behavior support methods that reflect current knowledge about the developmental impacts of early traumatic experiences. To that end, the Departments of Children and Families, Mental Health, Early Education and Care, Elementary and Secondary Education and Youth Services are working together, in partnership with providers, advocates, educators, schools, families and youth, to focus on preventing and reducing the use of behavior restrictions that can be re-traumatizing, in particular the use of restraint and seclusion.

Vision
All youth serving educational and treatment settings will use trauma informed, positive behavioral support practices that respectfully engage families and youth.

Guiding Principles
The work of this *Initiative* will be guided by the following principles:

- Safety for staff and children is the first priority and informs all practice and policy considerations.
- Public and private agencies are partnering together and with youth and their families in this work. Each entity brings assets to the effort that has equal importance to the success of the initiative.
- Providing training and technical support opportunities is a shared responsibility of all partners in the initiative.
- All levels of the system must be afforded reasonable time and opportunities to make the changes required by any revisions of state agency regulations or policies.
- Data, research, practice wisdom and a framework of Continuous Quality Improvement informs all practice and policy changes to be implemented as a result of this *Initiative*.
- Recommendations and strategies implemented will focus on ensuring the sustainability of change over time.

Support for this initiative provided by Casey Family Programs (www.casey.org) and the Massachusetts Department of Mental Health (DMH)

9/30/2010 1

Important Systemic Movement

- 2009: EEC licensed programs aggregate restraint total:

  > 65,000 episodes.

- 2017: EEC licensed program aggregate restraint total:

  > 17,000 episodes.

- Even with a reduction in beds ... this is >48,000 episodes that did not happen and roughly 74% statewide reduction.

Caring Together (2012): New Expectations

DCF & DMH RFR Performance Standards

Restraint/Seclusion Prevention:

The Agencies are committed to serving youth and families in the most respectful manner possible and preventing and reducing these coercive practices by ensuring that treatment and educational settings use trauma informed, positive behavioral support practices and methods that reflect current knowledge about the effects of trauma.

Caring Together (2012): New Expectations

DCF & DMH RFR Performance Standards

Clinical Model:

The Agencies require the use of evidence based and promising practices which support trauma informed, strength-based, individualized, family driven/youth guided and community focused care clinical approaches which are consistent with the **Building Bridges Initiative (see http://www.buildingbridges4youth.org/)**. While the Agencies do not mandate a specific clinical model for services under this RFR, a Contractor must utilize a coherent and organized therapeutic model that: ….. Is consistent with trauma-informed care

Caring Together (2012): New Expectations

DCF & DMH RFR Evaluation Tool & Proposal

Trauma-Informed, Trauma-Sensitive Care	**6. Describe the policies and practices you have implemented, or will implement, to strengthen trauma-informed care.** **7. How will you ensure staff provide trauma-informed/ trauma-sensitive care?**	**Section 2.06, 2.07** **Section 2.08** **Section 4.21**

Selection:

- **Evaluation scoring anchored by trauma-informed practice indicators**
- New consumer roles in services: Peer Mentors, Family Partners / Leaders
- New funding methodologies
- New QI approach to trauma-focused service implementation & monitoring
- Consumer inclusion in service design & selection

Teaching about the Effect on Health, Longevity & More

Adverse Childhood Experiences (ACE) have serious health consequences

- Adoption of health risk behaviors as coping mechanisms
  - eating disorders, smoking, substance abuse, self harm, sexual promiscuity
- Severe medical conditions: heart disease, pulmonary disease, liver disease, STDs, GYN cancer
- Early Death

(NASMHPD, 2015; Felitti et al, 1998)

Morbidity & Mortality Study

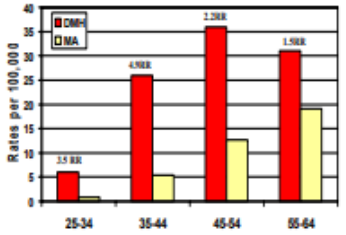
(NASMHPD Technical Report: Parks, Svendsen, Singer, & Foti, 2006)

2. Massachusetts Study

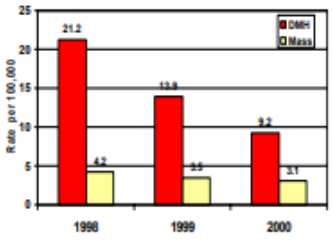
The Massachusetts Department of Mental Health (DMH) first conducted and presented the results of a study that led to the Sixteen State Mortality Study as well as other states' surveillance studies. Of note are the ***increased rates of death from heart disease, particularly in DMH populations under 55. In 1998 – 2000, among persons 25 to 44, cardiovascular mortality was 6.6 times higher among DMH clients than the general population.***

Age and selected disease specific rate comparisons are illustrated in the accompanying graphs. The DMH deceased population was younger, less educated, and had a higher proportion of African Americans than the general population.[v]

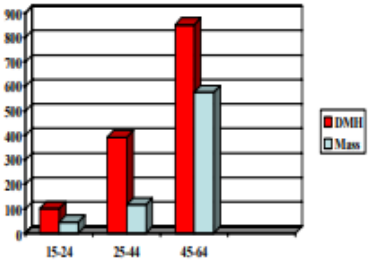
Massachusetts Study: Deaths from Heart Disease by age group/DMH Enrollees with SMI compared to Massachusetts 1998-2000



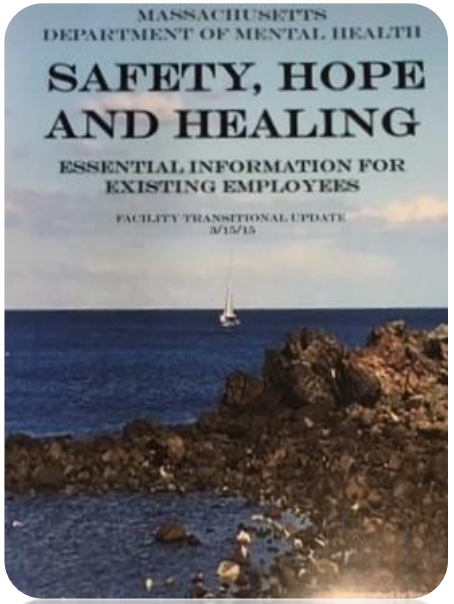
Massachusetts Study: Mortality from Pneumonia/Influenza
DMH clients, ages 25-64



1998-99 Age Specific Death Rates
DMH compared to Massachusetts



DMH Education

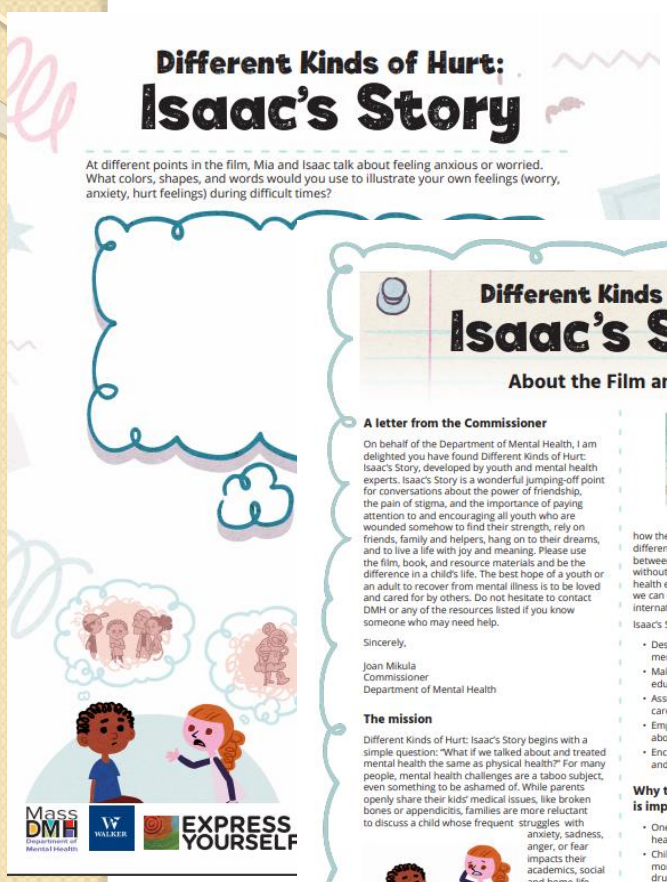


Safety Hope & Healing

- Trauma & Culture
- Trauma & the Brain
- What being Trauma Informed means
- Trauma: defined Big Ts and little Ts
- Effects of Trauma
- Trauma Informed Approach
- Trauma Assessment
- Challenging Behaviors in Context

Isaac's Story

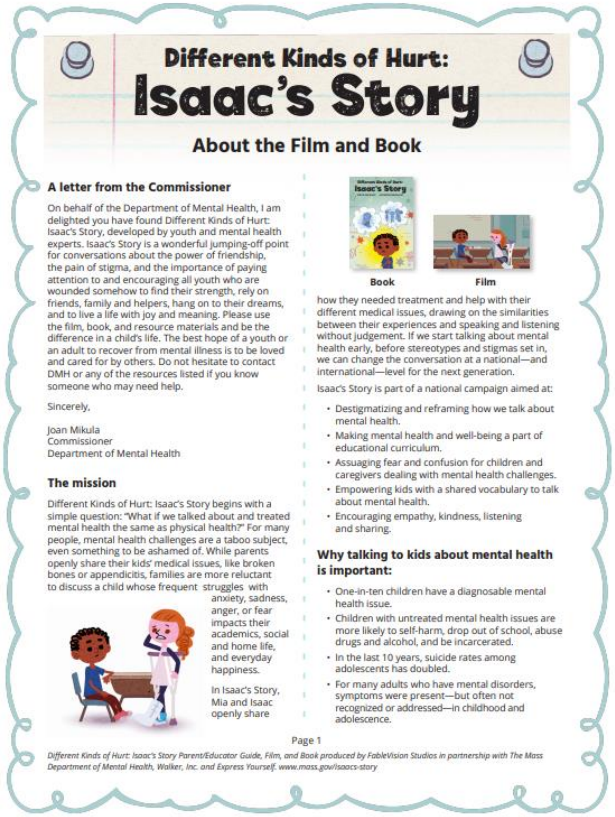
Trauma-implicit



Different Kinds of Hurt:
Isaac's Story

At different points in the film, Mia and Isaac talk about feeling anxious or worried. What colors, shapes, and words would you use to illustrate your own feelings (worry, anxiety, hurt feelings) during difficult times?

Mass DMH Department of Mental Health | Walker | EXPRESS YOURSELF



Different Kinds of Hurt:
Isaac's Story

About the Film and Book

A letter from the Commissioner

On behalf of the Department of Mental Health, I am delighted you have found Different Kinds of Hurt: Isaac's Story, developed by youth and mental health experts. Isaac's Story is a wonderful jumping-off point for conversations about the power of friendship, the pain of stigma, and the importance of paying attention to and encouraging all youth who are wounded somehow to find their strength, rely on friends, family and helpers, hang on to their dreams, and to live a life with joy and meaning. Please use the film, book, and resource materials and be the difference in a child's life. The best hope of a youth or an adult to recover from mental illness is to be loved and cared for by others. Do not hesitate to contact DMH or any of the resources listed if you know someone who may need help.

Sincerely,

Joan Mikula
Commissioner
Department of Mental Health

The mission

Different Kinds of Hurt: Isaac's Story begins with a simple question: "What if we talked about and treated mental health the same as physical health?" For many people, mental health challenges are a taboo subject, even something to be ashamed of. While parents openly share their kids' medical issues, like broken bones or appendicitis, families are more reluctant to discuss a child whose frequent struggles with anxiety, sadness, anger, or fear impacts their academics, social and home life, and everyday happiness.

In Isaac's Story, Mia and Isaac openly share how they needed treatment and help with their different medical issues, drawing on the similarities between their experiences and speaking and listening without judgement. If we start talking about mental health early, before stereotypes and stigmas set in, we can change the conversation at a national—and international—level for the next generation.

Book Film

Isaac's Story is part of a national campaign aimed at:

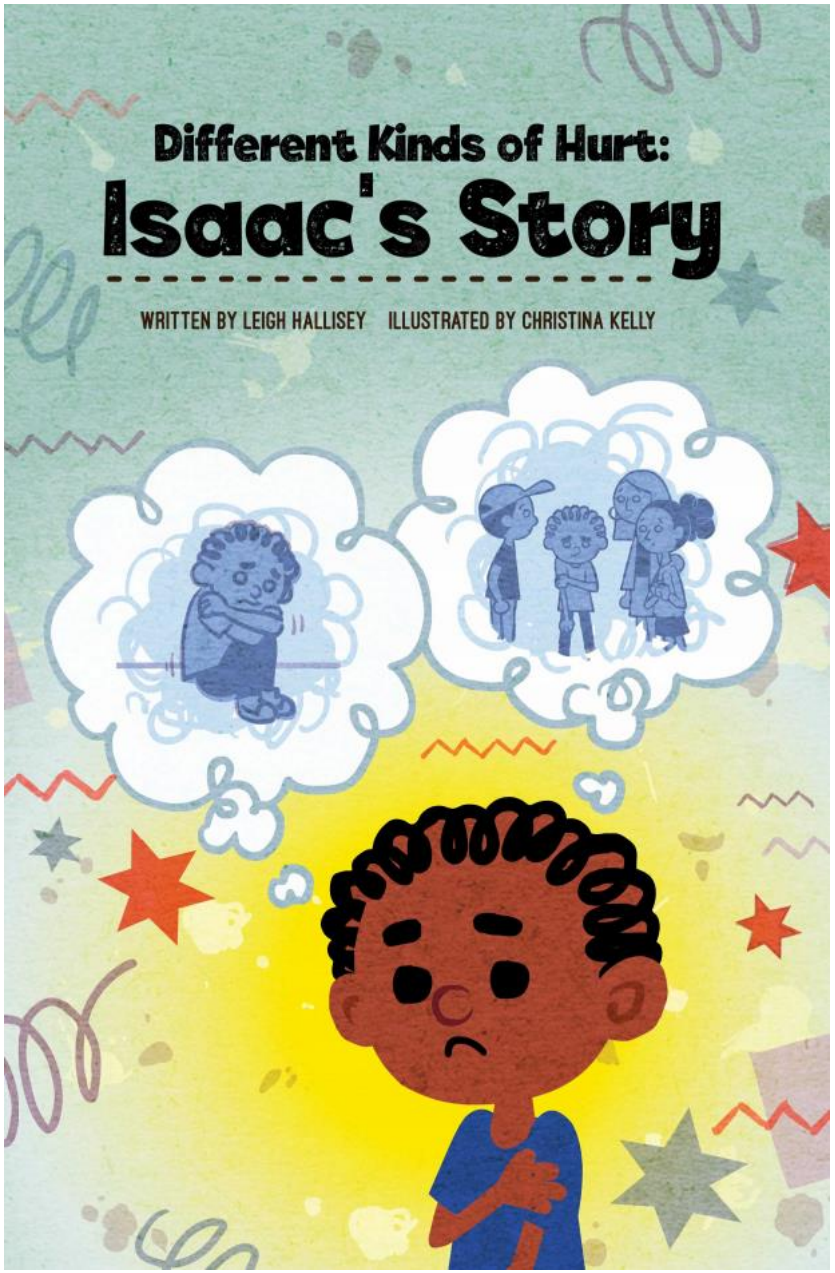
- Destigmatizing and reframing how we talk about mental health.
- Making mental health and well-being a part of educational curriculum.
- Assuaging fear and confusion for children and caregivers dealing with mental health challenges.
- Empowering kids with a shared vocabulary to talk about mental health.
- Encouraging empathy, kindness, listening and sharing.

Why talking to kids about mental health is important:

- One-in-ten children have a diagnosable mental health issue.
- Children with untreated mental health issues are more likely to self-harm, drop out of school, abuse drugs and alcohol, and be incarcerated.
- In the last 10 years, suicide rates among adolescents has doubled.
- For many adults who have mental disorders, symptoms were present—but often not recognized or addressed—in childhood and adolescence.

Page 1

Different Kinds of Hurt: Isaac's Story Parent/Educator Guide, Film, and Book produced by FableVision Studios in partnership with The Mass Department of Mental Health, Walker, Inc. and Express Yourself. www.mass.gov/isaacs-story



Other DMH Area Efforts

- Central MA Area: met with every school district in their Area and educated them on SAMHSA's *"Building a Trauma Informed Nation"* and discussed ways that school districts can be more trauma informed in their programming and response to student behavior.

DMH Adult System

- Motivational Interviewing: person-centered practice is rolling out system wide
- Substance Use Treatment framework – rolling out with 3 strands of focus: 1) 12-step; 2) Cognitive Behavioral; 3) Trauma-Informed

Advancing Knowledge & Understanding

- Pre-Trauma Recognition 1995
  - No Trauma Education
  - No Trauma Assessment
  - No Crisis Prevention / Soothing Planning
  - No Sensory Alternatives
  - High R/S Use
  - Prevalence of Point/Level System Use
  - No Consumer Inclusion / Roles
  - No Consumer Education / Empowerment
- Post-Trauma Recognition 2019
  - Trauma Education
  - Trauma Assessment for all
  - Crisis Prevention / Soothing Planning for All
  - Sensory Infusion
  - Decreasing RS Use & Some elimination
  - Point/Level System Sunset
  - Concerted Consumer Inclusion & many new Roles Developed
  - Gift Training & Core Elements

New Face of DMH Leadership: Consumer Mobilization

Fully include persons-served

- *Facts tell, stories sell*
- Self-advocacy
  - Laura Prescott

(Prescott photo credit: mindfreedom.org)

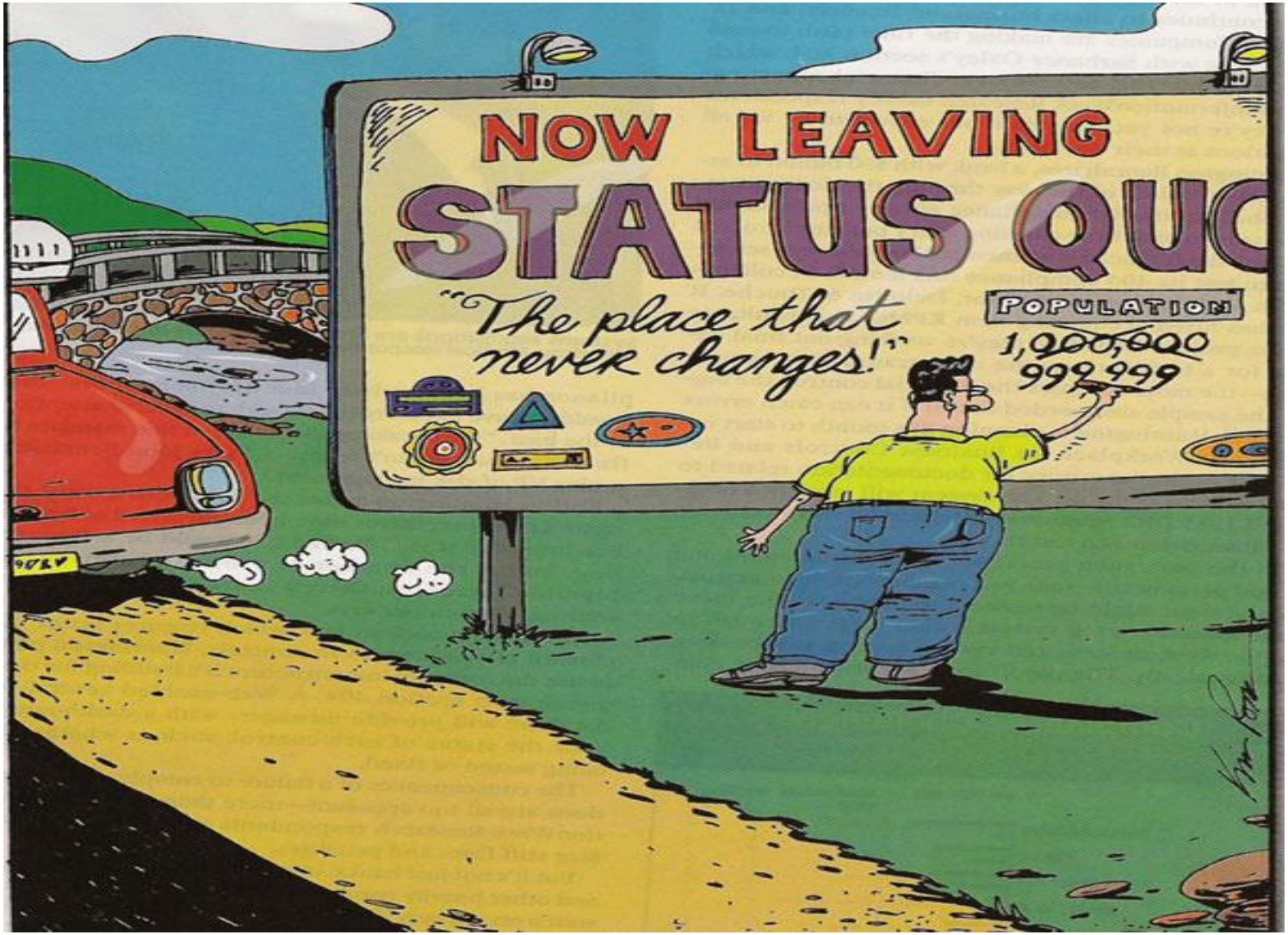
Parting Thoughts

- Being trauma informed is not enough:
  - Overly focused on problems/deficits/negative symptoms
  - Focus on positive and protective factors
  - Promote neurogenesis/neuroplasticity through self-directed attention practices (e.g. meditation, yoga, etc.) and movement (sports, rec.)
  - Teach practical skills of self-regulation (social skills)

(Leitch et al., 2017)

Parting Thoughts

- To make trauma-informed care/approach real:
  - Identify the problem and goal from the perspective of those you serve
  - Be pragmatic: take good care of the youth/family first and prepare to answer the ***"So What?"*** question
  - Organize the leadership/team/coalition & include persons-served
  - Publically commit to a direction – in writing with deliverables
  - Stay current with new knowledge & raise the practice bar with new written expectations & standards


NOW LEAVING
STATUS QUO
"The place that never changes!"
POPULATION
1,000,000
999,999

CREATING GUIDELINES FOR TRAUMA-INFORMED PRACTICE IN MASSACHUSETTS

Trauma Guidelines Purpose

- Purpose: Promote greater (and more consistent) adoption of trauma-informed practices in child-serving organizations in Massachusetts
  - We want systems & services to be trauma-informed
  - We want "trauma-informed" to mean something
  - We want to help systems/organizations get there

- Questions:
  - How will creation of guidelines move us closer to purpose?
  - How do we want guidelines to be used?
  - Who are these written for? (Audience)

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Trauma Guidelines Use

- Define, in an accessible way, what it means to be “trauma-informed”
  - Clear, easy to understand, context-specific examples

- Help organizations assess themselves:
  - Strengths of their approach
  - Opportunities for improvement

- Direct organizations to resources for more information about key elements of trauma-informed practices (e.g. staff training, role of leadership, safety planning, etc.)

- Are there opportunities for alignment with state RFPs/service procurement?

- Could these guidelines form basis for additional work (e.g. technical assistance, training, certification)?

- Other?

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Trauma Guidelines Audience

- State child-serving agencies
- Community-based providers
- Public and private schools
- Healthcare organizations (community health centers, hospitals, pediatric care)
- Law enforcement
- Judiciary
- Others?

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Trauma Informed Frameworks

- SAMHSA (2014)
- National Center for Child Traumatic Stress (2012, 2013, 2018)
- Trauma & Learning Policy Initiative (2005, 2013)
- OJJDP (2006, 2007, 2013)
- American Institutes for Research (2014)

- Are there existing agency-specific guidelines/frameworks in MA that we should know about/incorporate?

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Defining Trauma-Informed

- SAMSHA uses trauma-informed care and trauma-informed approach interchangeably.

- An organization/system is trauma-informed if the following conditions are met:
  - All people at all levels of the organization/system "have a basic **realization** about trauma" and understand how trauma can affect the behavior of individuals, families, groups, organizations, and communities.
  - People in the organization/system know how to **recognize** signs of trauma.
  - The organization or system **responds** by applying principles of trauma-informed approach
    - Staff training
    - Policies and procedures
    - Environment
  - The organization/system resists **re-traumatization** of children, youth, and staff members.

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Things an org needs to **KNOW**

Things an org needs to **DO/NOT DO**

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Defining Trauma-Informed

CTTF Needs to Define/Further Explain

CTTF May Want to ADD

- An organization/system is trauma-informed if the following conditions are met:
  - All people at all levels of the organization/system "have a basic **realization** about trauma" and understand how trauma can affect the behavior of individuals, families, groups, organizations, and communities.
  - People in the organization/system know how to **recognize** signs of trauma.
  - The organization or system **responds** by applying principles of trauma-informed approach
    - Staff training
    - Policies and procedures
    - Environment (Physical & Emotional Safety)
    - Staff Support (Addressing Secondary Trauma)
    - Organizational Leadership
    - Evaluation & Continuous Quality Improvement
  - The organization/system resists **re-traumatization** of children, youth, and staff members.

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Principles of Trauma-Informed Approach

- Organizational Leadership
- Staff Training
- Environment (Physical & Emotional Safety)
- Policies and Procedures
- Staff Support (Addressing Secondary Trauma)
- Evaluation & Continuous Quality Improvement

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Organizational Leadership

- Establishing a trauma-informed approach as part of the organization's mission/vision statement, manual, and policies
- Aligning resources to support implementation of a trauma-informed approach
- Promoting an organizational culture based on resiliency and recovery
- Other?
- Examples of what this may look like in different settings

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Staff Training

- Who should receive training?
- How frequently?
- Training intensity (length of time)
  - Differentiated by staff role?
- Training Content/Learning Objectives
  - Basic understanding of trauma, signs of trauma, and impact trauma can have on behavior
  - Vital role staff play in lives of traumatized children & impact (positive or negative) that staff can have
  - Helping traumatized children modulate their emotions and gain social and academic competence
  - Identifying & using outside supports (context specific)
  - Other?

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Environment (Creating Physical & Emotional Safety)

- What does it mean to provide physical & emotional safety for children?

- Examples may include:
  - Safety planning with child: what helps this youth calm down/regain control?
  - Establishing routines and predictability
  - Modifications to physical space
  - Avoiding re-traumatization
  - Other?

- Examples of what this may look like in different settings

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Policies & Procedures

- Will vary dramatically across audience types

- Examples of what adhering to the definition of “trauma-informed” looks like in different settings
  - Things to do
  - Things not to do/to avoid

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Staff Support (Secondary Trauma)

- What does it mean to provide physical and emotional safety for staff members?
    - Training on self-care and secondary trauma
    - Supporting open communication
    - Providing mentoring
    - Supporting continuing education and wellness activities
    - Encouraging use of vacation time
    - Providing good mental health care coverage in benefits package
    - Other?

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Evaluation & CQI

- What are the key data elements that should be collected?
- How might this differ based on organization type?
- How should an organization incorporate evaluation and CQI with regards to trauma-informed practice?
- Other?

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Next Steps

- OCA will develop guidelines draft based on this conversation

- Will need CTTF members support in:
  - Providing context-specific examples
  - Reviewing draft

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Next Meeting

TBD

(Please fill out Doodle!)

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