Child Aware Approaches
Conference 2015

Developing an integrated trauma-informed service system

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“Failure to acknowledge the reality of trauma and abuse in the lives of children, and the long-term impact this can have in the lives of adults, is one of the most significant clinical and moral deficits of current mental health approaches.

Trauma survivors still experience stigma and discrimination and un-empathic systems of care. Clinicians and mental health workers need to be well informed about the current understanding of trauma and trauma-informed interventions”

Professor Louise Newman, Psychiatrist and Director, Centre for Developmental Psychiatry and Psychology, Monash University ASCA Practice Guidelines 2012
ASCA Practice Guidelines

The Last Frontier: Practice Guidelines for Treatment of Complex Trauma & Trauma Informed Care and Service Delivery

• Launched by Federal Minister for Mental Health (October 2012)

• Endorsed by national and international experts in the field

• Accepted clinical resource RACGP

• Download or purchase at www.asca.org.au/guidelines
What’s our starting point?

Why is trauma important?

What is complex trauma?

How does trauma affect people?
Reality of trauma

Multiple sectors and services: people, families, care-givers, children and young people affected by past and present trauma

Not only clients are affected. Many staff have own histories

A trauma-informed child welfare system is one in which all parties involved recognize and respond to the varying impact of traumatic stress on children, caregivers, families, and those who have contact with the system. Programs and organizations within the system infuse this knowledge, awareness, and skills into their organizational cultures, policies, and practices. They act in collaboration, using the best available science, to facilitate and support resiliency and recovery. CTISP National Advisory Committee 2010
Majority of people who seek/are referred to human service settings are survivors of multiple adverse and overwhelming life experiences (B van der Kolk, 2003)

Recent developments across health and human service systems - understanding of the impact of trauma – on individuals, families, and those who interact with them

Needs cross sectors - homelessness/housing, child protection, family services, mental health, disability, EDs, Corrective Services, law enforcement, education
Understanding traumatic stress

- Complex trauma – exposure to complex trauma – repeated, interpersonal, prolonged, often extreme
- Physical/emotional responses to perceived or real threat to self or others
- Overwhelms capacity to cope -> threatens sense of safety: terror, fear, helplessness, horror, confusion
- Children more vulnerable; impacts often greater
Trauma for child
- Events which brought them into system
- Removal/child protective and law enforcement services
- Placement/multiple placements; nature of placements
- Rejection/abandonment

Trauma for care-giver
- Removal of child
- Indigenous issues
- Ruptured family relationships

TI system helps care-givers work together to reduce conflict and create supportive collaborative environment
Trauma affects capacity of child to

- Master developmental tasks
- Build and maintain relationships with peers and caregivers
- Succeed in school
- Take advantage of opportunities
- Build resilience
- Lead productive fulfilling life
How might children present?
Difficulty with:
- emotional regulation
- maintaining attention
- reasoning under stress
- relationships

Can sometimes:
- Appear to `provoke’ chaos in order to make things feel predictable
- Exhibit dissociative responses
  (Perry, 2006:49, 55)
• Anxiety; depression; health problems (emotional and physical); disconnection & shame; isolation; confusion; being `spaced out’; fear of intimacy and new experiences

• Lifetime patterns of fear and lack of trust; long-term difficulties with emotional regulation/ stress; chronic feelings of helplessness; affects relationships with self, others, the world
How might adults present?
Adults can present with:

- deep feelings of insecurity; low self-esteem
- poor frustration tolerance; sensitivity to criticism
- hyper (physical or psychological agitation) or hypo-aroused (shut down – emotionally numb)
- substance abuse, self-harming, suicidal, risk-taking behaviours
Trauma and recovery

• Unresolved trauma impacts wellbeing

• Recovery from trauma is possible for everyone regardless of age – even severe early trauma

• Negative intergenerational effects can be intercepted.

• People can recover and their children can do well. Time for hope and optimism to build on strengths and resilience to facilitate recovery
Clients with trauma histories are vulnerable to destabilisation/re-traumatisation by policies, practices and systems which appear benign, but are not based on awareness about damaging effects of seemingly minor stressors on overloaded nervous systems.

Re-traumatisation when exposed to triggers/systems that reflect aspects of prior trauma (secrets, betrayal, ‘power over’)

*Re-traumatisation by and within services and systems is highly prevalent. Trauma has often occurred in the service context itself*’ (Jennings, 2004:6; Bloom & Farragher, 2011; Davidson, 1997)
Trauma-informed practice

Asks us to consider what has happened to people

Not what’s wrong with people
Coping and survival strategies made sense at the time.
... early life experiences affect our ‘choices’ more than we realise
...victimisation (and survival) affects assessment of safety
For many people survival is still at stake. Until they achieve safety (safe relationships, safe environments, safe systems) can’t recognise what has happened, recuperate, and recover; Survival mechanisms may now cause problems

• “It’s their poor lifestyle choices”
• “They look for drama and difficulty”
• “They are used to it and don’t know any different”

Trauma-informed lens asks us to re-consider these ideas
Trauma-informed principles

Safety

Trustworthiness  Collaboration  Choice

Empowerment
Trauma-informed principles

What are core trauma-informed principles?

How can we put them into practice?

What benefits will we see?
Dimensions of safety

• unsafe in bodies – unable to control or predict thoughts, emotions (*intrapersonal safety*) *predict, understand, modify responses and behaviour*

• unsafe in relationships/interactions (*interpersonal safety*) *people can be trusted, can provide support*

• unsafe in surroundings – present triggers ‘past’ (*environmental safety*) *place free from harm; access to safe spaces, supports or exits*

• unsafe in systems and institutions (*Systemic/cultural safety*) *just, transparent, fair processes; respect for culture*
Supporting systemic safety

• **Asking ourselves** - Are our process fair, just, transparent?
• **Asking survivors** - Do they feel fair, just and transparent to you?
• Is there something you’d like to ask or know about what will happen next?
• Is there something you’d like to ask about why this is done this way?
Trustworthiness - choice

• How do we currently communicate that we are trustworthy?
• Can we develop/initiate any practices which enhance this?

• To what extent are choices for survivors and staff made clear and explicit?
• Are there any other ways we could maximise choice?
Collaboration in decision making recognises survivor expertise and judgement, without diminishing professional expertise and judgement.

In what ways do we collaborate with survivors regarding decisions and processes?

Are there any ways that decisions could be more collaborative? Abuse occurs in environments of coercion, control, terror and powerlessness.

Those assisting survivors need to avoid or minimise any ‘power over’ dynamics, and support survivors in the gaining of power.
Trauma informed responses

“Small things can make a big difference”

• Capacity of positive interactions to be *soothing* and *validating*, even in the most routine aspects of relating should not be underestimated

• This applies to all of us; especially important if trauma histories

• Prior experience of person is difficult – not person themselves

• Positive relational experiences promote wellbeing - make interactions more pleasant and assist healing
Trauma -informed practice

• **Need for Trauma-Informed Practice for people with past and present trauma**

• **Applicable to full spectrum of human services delivery**

• **Must be coordinated across service sectors and**

• **Recognises many conditions are trauma-related**
  (Perry, 2008; Ross & Halpern, 2009)

• **Minimises re-traumatisation**

• **‘Do no harm’ approach**

• **Cultural safety, competence, supervision**

• **Staff training and support**
Changes at service level

View trauma as a defining and organising experience that forms the core of an individual’s identity rather than a single discrete event (Jennings, 2004; Fallot & Harris, 2009)

- Understand client behaviours as adaptive attempts to cope
- ‘What happened to the person’ rather than ‘what is wrong with the person’ (Bloom, 2011; Fallot & Harris, 2009)
- Emphasis on resourcing and skill building
How do we implement change?
• Assess and modify every part of organisation, management, service delivery to ensure understanding of how trauma impacts people’s lives

• Staff training /education crucial - includes everyone—administrators, direct care staff, case managers, support staff

• Embrace paradigm cultural shift of trauma informed policy reform, embed into systems, services and practice

‘Incorporating knowledge about the traumatic experiences that underlie most of child and adult psychopathology is terribly threatening to the existing worldview and the mental models upon which human service-delivery is built’ (Bloom, 2011:126)
• Workforce development and training
• Full trauma history child/family; current/past trauma; culture
• Interventions which comprehensively address need and are specific to child and family and traumatic stress
• Minimise caregiver-child separation if possible; monitor safety
• Minimise separation-related distress
• Integrate trauma-informed approaches into child welfare practices
• Identify staff as trauma champions to impose ‘trauma lens’ on all activities
Implementation requires leadership for cross-Government collaboration and common vision across service systems; ways of promoting collaborative service/care coordination and enhanced workforce capacity.

Creating a trauma-informed system of care requires cross-system collaboration around information collection and sharing, training, a common vision across public and private systems, and the ability to blend funding in a way that creates a seamless system. It also requires leadership.

Laura Huot. 2011, Director of Children’s Community Mental Health and Deborah Willis, Director of Research and Evaluation, The Guidance Center, Wayne County, Michigan.
What difference will it make?

How will it help when seeing clients?

Who benefits?

How?
How trauma informed practice helps

Taking trauma dynamics into account when seeing clients:

• Avoids triggering trauma reactions
• Minimises re-traumatisation
• Means adjusting approach to best support individual’s coping strategy and foster empowerment
• Allows clients to gain maximum choice and control
• Builds trust and optimises safety
• Promotes self-care/ minimises vicarious traumatisation
“profound cultural shift in which consumers, their conditions and behaviours are viewed differently, staff respond differently, day-to-day service delivery is conducted differently' (Jennings, 2004)

- Improves client-staff interactions; benefits all parties; improved staff morale, fewer negative events

- Parallels requirements for job satisfaction; positive organisational outcomes; more effective service delivery

- Decrease symptoms; improves daily functioning

- Positive effect on housing stability; decrease crisis-based services; more collaboration within/outside agencies
Enhance family well-being and resilience

Trauma-informed evidence-based services and mental health supports to parents, many of who have unresolved trauma

Increases for child
• Resilience
• Wellbeing
• Permanency
• Safety

Assists parents to manage secondary trauma from supporting child with lived experience of trauma
Workers confront threats and violence daily
Experience secondary traumatic stress
Feelings of helplessness, anger, fear common

Trauma informed system must acknowledge primary and secondary traumatic stress on workforce and develop organisational strategies to minimise
Mismanagement of trauma

- reduces likelihood of reunification (Rubin, O’Reilly, Luan & Localio, 2007)
- increases placement instability (Hartnett, Leathers, Falconnier & Testa, 1999)
- results in the application of increasingly more restrictive placements (Pecora et al., 2005)
- increases the likelihood of administration of strong psychotropic medicines (Raghavan et al., 2005)
- increases the likelihood that the child will carry on an intergenerational cycle of abuse or neglect upon becoming a parent (Fang & Corso, 2007).
Stress experienced by staff negatively impacts clients

Staff sensitivities can be ignited in interactions with clients, particularly if staff have unresolved trauma

Vicarious trauma is the ‘negative transformation in the helper’ from exposure to traumatic material in the context of a helping relationship (Pearlman & Caringi, 2009)

Stress breeds stress and **attentiveness to wellbeing is the antidote**
Personal responses - VT

- Check own stress response/hyperarousal
- Stay in ‘here and now’
- Regular meals, exercise, sleep
- Take time out
- Maintain supportive relationships
- Don’t visualise or imagine events
- Watch your substance use
Organisational and interpersonal responses - VT

• Team culture – shared values, meaning, understanding
• Identify colleagues to whom you can signal distress
• Set and honour reasonable boundaries
• Promote collegial support, respect, safety
• Address strain between team members
• Explore impact of work e.g. How is this affecting you now?
**Vicarious Trauma/Secondary Traumatic Stress**

Seek help if:

- **fears about own (or family’s) safety,**
- **major disruption in relationships,**
- **loss of enjoyment usual activities,**
- **irritability,**
- ‘intrusion’, hyperarousal and avoidance

**Risk factors**

- Overwhelming exhaustion, cynicism, detachment.
- Affects work performance, absenteeism, withdrawal.
- Relative youth/inexperience
- Long work hours; exposure
- Low social support
- Work related stress
ASCA services

- Professional support line 1300 657 380
  Operates 9am-5pm Monday - Sunday EST

- Education and training workshops
  training@asca.org.au or 02 8920 3611

- Resources www.asca.org.au
  Factsheets, guidelines, videos, newsletters

- Advocacy and health promotion
Thank you

Dr. Cathy Kezelman
ckezelman@asca.org.au 0425 812 197