Improving Fidelity to Trauma Informed Care Using the Trauma Informed Agency Assessment

NYSCCBHS Annual Staff Development Training Forum
November 28 – 29, 2017
Subtitle

And avoiding the tube sock approach to performance improvement initiatives.
Objectives

By the end of today’s training, participants will understand

• What it means to be a “trauma informed agency” and why is this important?

• How the Trauma Informed Agency Assessment (TIAA) measures seven dimensions of trauma informed practice, sampling both clients and staff.

• How one agency used the TIAA to measure its commitment to the philosophy.

• How the results of the TIAA were used to improve trauma informed practices at each program/site.
KidsPeace at a Glance

• 138 Years Old – PA HQ
• Large Service Array
  • Psychiatric hospital – kids
  • Residential Tx (behavioral, ASD)
  • Special Ed; Day Tx; PreK DD services
  • Therapeutic and Traditional Foster Care
  • Outpatient and Home-based counseling
  • Med Management
  • Adoption and reunification; Case Management
  • Family Group Decision Making
FCCP Locations
KidsPeace Clinical Model

• Resiliency: using risk and protective factors to establish treatment goals
• Together Facing the Challenge: Using evidence based (or evidence informed) interventions known to improve outcomes
• Trauma Informed Care: Providing all services with a deep understanding of the impact trauma has had on our clients, our staff and our organizations.
What’s so important about being trauma informed?

- Detrimental impact of re-traumatization
- Understanding health as well as social & vocational consequences of trauma
ACEs Study

• Kaiser Permanente study of 17,000 insured adults (1998)

• Correlated 10 types of Adverse Childhood Experiences with adult health and social outcomes

• Found that ACEs were extremely common (two thirds of us have at least 1; 87% have more than 1)

• 1 in 10 have more than 5
Health Outcomes and Childhood Trauma

- Increased risk of suicide
- Increased risk of heart disease
- Increased risk of cancer
- Increased risk of mental illness
- Increased risk of being a victim of violence
- Increased risk of being a perpetrator of domestic violence (men and women)
Mental Health

Childhood Experiences Underlie Suicide Attempts

% Attempting Suicide

ACE Score

0 1 2 3 4+

25 20 15 10 5 0
Longevity

Adults with 6 ACEs have, on average, a 20 year shorter lifespan
Early Death

Disease, Disability, and Social Problems

Adoption of Health-risk Behaviors

Social, Emotional, & Cognitive Impairment

Adverse Childhood Experiences

Conception

Death
ACE:
Adverse Childhood Experience

• Five personal — physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect.

• Five related to other family members: a parent who’s an alcoholic, a mother who’s a victim of domestic violence, a family member in jail, a family member diagnosed with a mental illness, and the disappearance of a parent through divorce, death or abandonment.
Neurobiology of Trauma: aka Toxic Stress

• Exposure causes release of stress hormones
• Chronic “fight or flight”
• If your hormones say “run from the lion” you’ll have a hard time learning algebra.
History of Trauma Focus in Child and Family Work

- Psychodynamic approach emphasized early trauma as underlying cause of emotional and behavioral dysregulation – treated with talk/process approaches.
- Devolved to alternatives: behavioral approaches and family systems (trauma history ignored)
- Evolved to cognitive behavioral approaches – reassessing “self-talk” as a model for facilitating change – the rise of “Resiliency” model
- Re-emphasis on impact of trauma – unconscious determinants of behavior; impact on clients, families AND those who work with them. New strategies to counteract trauma with protective factors.
Trauma Informed Basics

• Switch from “Why did you do that?”
• To: “What happened to you?”
RISK IS NOT DESTINY!!
Examples of Protective Factors

• Early development: easy temperament, first born, secure attachment
• Family/home: warm positive relationship with parent(s), stable employment, predictable rules/chores
• Child competencies: reading at grade level, extracurricular involvement
• Child social skills – humor, empathy
• Extra-family support – church, mentors
• Outlook – internal locus of control, realistic expectations for the future
Dimensions of Trauma Informed Care

I. Physical and Emotional Safety
II. **Youth** Empowerment, Choice and Control
III. **Family** Empowerment, Choice and Control
IV. Trauma Competence
V. Trustworthiness
VI. Commitment to Trauma-informed Philosophy
VII. Cultural Competency and Trauma
Physical and Emotional Safety

• Examples:
  – secure reception/waiting areas,
  – non-judgmental treatment
  – flexible scheduling,
  – Open conversation about how to promote sense of safety
Youth and Family Empowerment, Choice and Control

• Example:
  – policies and practices empower clients through strength-based participation and/or community-based partnerships.
  – Client/family involved in organizational governance
  – Consumer voice
Trauma Competence

• The extent to which staff, policies, procedures, services and treatment serve the unique experiences and needs of trauma survivors

• Example: how often must a victim of trauma recount their trauma in the course of assessment and/or transition from one service modality to another?
Trustworthiness

• Factors such as consistency, accessibility of staff and interpersonal boundaries foster trust between the agency and consumer
Commitment to Trauma-informed Philosophy

• The extent to which all agency staff members with consumer contact integrate a trauma-informed philosophy in everything they do.

• As evidenced by training requirements, supervisory practices and “social norms” of behavior at the agency (including but not limited to agency executive leadership)
Cultural Competency and Trauma

• The extent to which staff, policies, procedures, services and treatment accommodate the cultures, traditions and beliefs of youth and family consumers.

• Including but not limited to training, supervision and agency norms.
The Multi-Site Multi-Program Problem:
How to be the rising tide that raises all boats?
1. What is the primary service that you receive (or have received) from this agency? (Pick one)

<table>
<thead>
<tr>
<th>State</th>
<th>Services Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indiana</td>
<td>Foster Care (therapeutic and/or regular), Supervised Visitation, Home-based Services, Homemaker Services, Adoption Preparation (child and/or adult)</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>FCCP: Clinical Services: CRR HH (Community Residential Rehab Host Home), SITE (Sexual Issues Treatment and Education), BHRS (Behavioral Health Rehabilitation Services)</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>FCCP: Non-clinical Services (child welfare): Foster Care, Adoption services (SWAN or private), FGDM (Family Group Decision Making)</td>
</tr>
<tr>
<td>Maryland</td>
<td>Foster Care (therapeutic and/or regular)</td>
</tr>
<tr>
<td>Maine</td>
<td>Therapeutic Foster Care, HCT (Home and Community Treatment), TCM (Targeted Case Management), ARP (Alternative Response Program), Outpatient Therapy</td>
</tr>
<tr>
<td>New York</td>
<td>Foster Care (therapeutic and/or regular), B2H (Bridges to Health), OMH Waiver (Respite)</td>
</tr>
<tr>
<td>North Carolina</td>
<td>Foster Care (therapeutic or enhanced)</td>
</tr>
<tr>
<td>Virginia</td>
<td>Foster Care (therapeutic or regular)</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>Community Programs Outpatient: Tobyhanna, Green Street, Sacred Heart, Family Center</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>Community Programs Day Programs: Bethlehem, Berks, Advances</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>Community Programs Autism: After School, Sarah’s Smile, BHRS (Behavioral Health Rehabilitation Services)</td>
</tr>
</tbody>
</table>
How to drive yourself crazy about trauma

Try to comply with expectations that care be trauma informed when different programs and different sites have

- Differential populations served (ASD, conduct, affective, reactive attachment)
- Differential staff skill and training (Master’s level trained vs. BA)
- Differential experience with trauma (child welfare vs. mental health)
- Differential philosophy and goals (overarching clinical models – residential vs. community based)
The KidsPeace Strategy
(remember that thing about the rising tides?)
First

• We knew we were all over the road – huge variability among states and offices
• We believe that effective treatment of childhood trauma improves outcomes.
• We wanted improvements in trauma informed care at all locations – not just to bring the least sophisticated up to the level of others
Our Solution

Trauma Informed Agency Assessment

• Developed in Maine – with consult from Roger Fallot. The Thrive Initiative
• Required of all Maine child behavioral health providers
• Measures seven dimensions that purport to describe a trauma informed agency
The Process

Agency staff, clients and family members complete a web-based assessment tool

- Web-portal is open for fixed period (3 weeks)
- Demographic info is service specific, not client specific
- Can be designed to be location specific
- Paper forms can be used
3 Versions of TIAA

• **Youth**
  – Example: “someone from this agency explained to me what trauma is and why it should matter”

• **Agency staff**
  – Example: “private conversations cannot be overheard”

• **Family**
  – Example: “staff members at this agency understand that my values, traditions and beliefs might be different from theirs”
Samples from Each Domain: Staff Survey

• Safety Plans
  – Agency promotes safety plans that minimize potential retraumatization (e.g., coercive hospitalization).
  – Plans required to include: triggers and coping techniques; youth and family preferences; community supports; clear outline of key components (if X happens, Y will occur); how plan will be shared, and with whom.
Youth and Family Empowerment

• Youth and family are meaningfully involved in setting service and treatment goals;
• youth and family may invite others to be involved in setting goals;
• conflicts between youth and family goals are resolved in a manner that respects all parties;
• youth and family have a way to monitor the progress and effectiveness of their own services on a routine basis.
Trauma Competence

• Training: All staff including non-service staff (e.g., frontline, administrative, janitorial, and translators) participate in required trauma competency training.

• Training covers: causes of trauma; impact on emotional development and behavior; ways to avoid re-traumatizing, recognizing potentially unsafe situations; and de-escalation techniques.
Trustworthiness

- Recognition of Power Dynamic: Formal policy and practice recognizes the power dynamic of the service provider over the youth and family, particularly those with trauma history; defines professional boundaries that all employees are expected to uphold, including availability/reachability; discusses consequences for failure to maintain proper boundaries or abuses of power.
Commitment to Trauma-informed Philosophy

• Trauma-informed Development Plan: Agency has written plan to develop, implement and support trauma-informed agenda. Agency has identified trauma champions and has high level staff trained in advanced trauma competencies.
Cultural Populations and Trauma

• Culture Considered in Service Planning: Agency considers the use of cultural, ethnic and faith-based organizations in service planning; works with families to develop and maintain cultural supports; supports and promotes cultural and trauma competence when working with other agencies.
How did we do? (2015)

As expected: significant variation from region to region…

Low of 54.4% (staff rating of commitment to trauma informed approach in one state)
Highs of 89.2% in both Safety and in Trustworthy (two different states)
## 2015 Report

<table>
<thead>
<tr>
<th>Trauma-informed Domain</th>
<th>Agency (N = 88)</th>
<th>Family (N = 25)</th>
<th>Youth (N = 21)</th>
<th>Agency (N = 325)</th>
<th>Family (N = 132)</th>
<th>Youth (N = 83)</th>
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<tbody>
<tr>
<td>I. Physical and Emotional Safety</td>
<td>83%</td>
<td>94%</td>
<td>80%</td>
<td>84%</td>
<td>90%</td>
<td>80%</td>
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<tr>
<td>II. Youth Empowerment, Choice and Control</td>
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<td>x</td>
<td>78%</td>
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<td>77%</td>
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<tr>
<td>II. Family Empowerment, Choice and Control</td>
<td>84%</td>
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<tr>
<td>III. Trauma Competence</td>
<td>81%</td>
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<td>78%</td>
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<td>IV. Trustworthiness</td>
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<tr>
<td>V. Commitment to Trauma-informed Philosophy</td>
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<td>76%</td>
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<tr>
<td>VI. Cultural Competency and Trauma</td>
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<td>82%</td>
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<tr>
<td>Trauma-informed Domain</td>
<td>2015 Report</td>
<td>Maryland Results</td>
<td>KidsPeace Results</td>
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<td></td>
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<td>Family (N = 23)</td>
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<td>Youth (N = 83)</td>
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<tr>
<td>I. Physical and Emotional Safety</td>
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<td>84%</td>
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<td>80%</td>
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</table>
Questions to Consider:

• In what area(s) is there the largest variance between agency responses and youth or family responses?

• In what area(s) does our state/region/program have the highest scores? The lowest? What about compared with the agency averages?

• What can we do to become more trauma-informed?

• Where do we need or want help? Technical assistance? Training?
# Maine Continuous Quality Improvement Plan:

<table>
<thead>
<tr>
<th>What do we want to change (Goals)?</th>
<th>Why did we choose this goal?</th>
<th>What steps will we need to take to meet these goals (Objectives)?</th>
<th>Who will be responsible?</th>
<th>When do we want to accomplish these objectives?</th>
<th>How will we know that we have accomplished our objectives?</th>
</tr>
</thead>
<tbody>
<tr>
<td>When receiving more than one KPNE service, the second program will secure the biopsychosocial from the first program.</td>
<td>In order for families not to have to repeat their traumatic stories more than necessary, especially with staff they do not yet know.</td>
<td>a) Communicate this expectation to program staff; b) Add “securing previous bios” to the case schedule; c) A Release of Info form will be done prior to the transition.</td>
<td>a) Program Supervisors b) Team leaders in each program</td>
<td>Target date for implementation in all programs – June 15, and continuing.</td>
<td>Bios will indicate (at top) where the information originated. The supervisor of the second service will indicate. Also, the release of info will be in the file.</td>
</tr>
<tr>
<td>More training for direct care, front line BHP/FSW staff.</td>
<td>To increase commitment to a trauma-informed approach, and to address multiple requests for more training.</td>
<td>a) Form small workgroup to address barriers, aka fishbone.</td>
<td>Training Supervisor and workgroup</td>
<td>Target date for implementation – November 1. Training will be ongoing.</td>
<td>a) TIAA scores will show increase in this area b) Every direct care staff will be trained.</td>
</tr>
<tr>
<td>What do we want to change (Goals)?</td>
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</tbody>
</table>
| 1. We want to increase our trustworthiness to at least 90%. | High performing teams are made up of team members that trust each other to work towards a shared vision/goal by completing assigned tasks and objectives respectfully and responsibly. | 1. Establish a working definition of the word trust.  
2. Each quarter we will have at least one team building activity. | 1. Team  
2. Program Manager and Team | 1. May 12, 2016  
2. April 12, 2017 | 1. Increased score on next staff TIAA.  
2. Increased productivity.  
3. Increased collaboration. |
| 2. We want to increase our trauma competency to at least 80%. | Our basic knowledge of trauma is reflected in how we relate to each other, our families, and our clients on a daily basis but especially during stressful situations. | 1. Training on the Who, what, when, where, & why of trauma.  
2. Create a trauma-informed resource center for staff and families (books, articles, trainings, etc)  
3. Create safe opportunities for staff to process trauma as a team. | 1. Ken Olsen Program Manager  
2. Program Manager  
2. April 12, 2017  
3. April 12, 2017 | 1. Increased score on next staff TIAA.  
2. Increased communication between team members. |
<table>
<thead>
<tr>
<th>3. We want to increase our commitment to the Trauma-Informed Philosophy to at least 80%.</th>
<th>By accomplishing the first two goals we should be able to perform as a competent team committed to the trauma-informed philosophy.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identify and repair unhealthy and/or nonproductive communication patterns with staff, families, and clients.</td>
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<tr>
<td>2. Provide a consistent message to staff, families, and clients.</td>
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<tr>
<td>3. Review and uphold model of care.</td>
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<td>4. Have a staff recommitment retreat.</td>
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<tr>
<td>1. Program Manager and Team</td>
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<td>4. Program Manager</td>
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</table>
2016 Results

Did the performance improvement plans result in KidsPeace FCCP becoming more trauma informed?
<table>
<thead>
<tr>
<th>Trauma-informed Domain</th>
<th>Agency (n=255)</th>
<th>2015*</th>
<th>Family (n=120)</th>
<th>Youth (n=75)</th>
<th>2016</th>
<th>Agency (n=232)</th>
<th>Family (n=133)</th>
<th>Youth (n=112)</th>
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</thead>
<tbody>
<tr>
<td>I. Physical and Emotional Safety</td>
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<tr>
<td>II. <em>Youth</em> Empowerment, Choice and Control</td>
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</tbody>
</table>

The symbol “x” means that the measure is not applicable.
The symbol “-“ signifies too few responses on which to base results.

* The 2015 results exclude surveys from those programs that were not surveyed in 2016, including those collected from the Pennsylvania Community Programs and Maine’s A Family For ME.
## Averages

<table>
<thead>
<tr>
<th></th>
<th>October 2015</th>
<th>November 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>80.1%</td>
<td>83.0%</td>
</tr>
<tr>
<td>Family</td>
<td>87.6%</td>
<td>88.4%</td>
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<tr>
<td>Youth</td>
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<tr>
<td>Trauma-informed Domain</td>
<td>2016 Report</td>
<td>Maine Results</td>
</tr>
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</tr>
<tr>
<td></td>
<td>Agency (n=91)</td>
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Distribute Handout

• If time: small group exercise in developing a PIP based on the Maine data.
<table>
<thead>
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<td>78</td>
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<td>81</td>
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Maine PIPs

2015
• Take steps to reduce need for families to repeat their traumatic stories.
• More staff training

2016
• Connect required trauma training to the associate’s specific job function – (in supervision)
• Supervisors directed to cover trauma issues for each client in supervision
• Sign off on these activities (trauma form)
• New annual training in trauma with consumer perspective.
What works? Lessons Learned

• No magic bullets
• Hawthorne effect
• Regional buy-in
• Organizational culture – theory of change
• More specifics in PIPs, more narrowly defined, and more frequently measured
• Focus on the basics: unconditional caring and predictability
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