KidsPeace

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

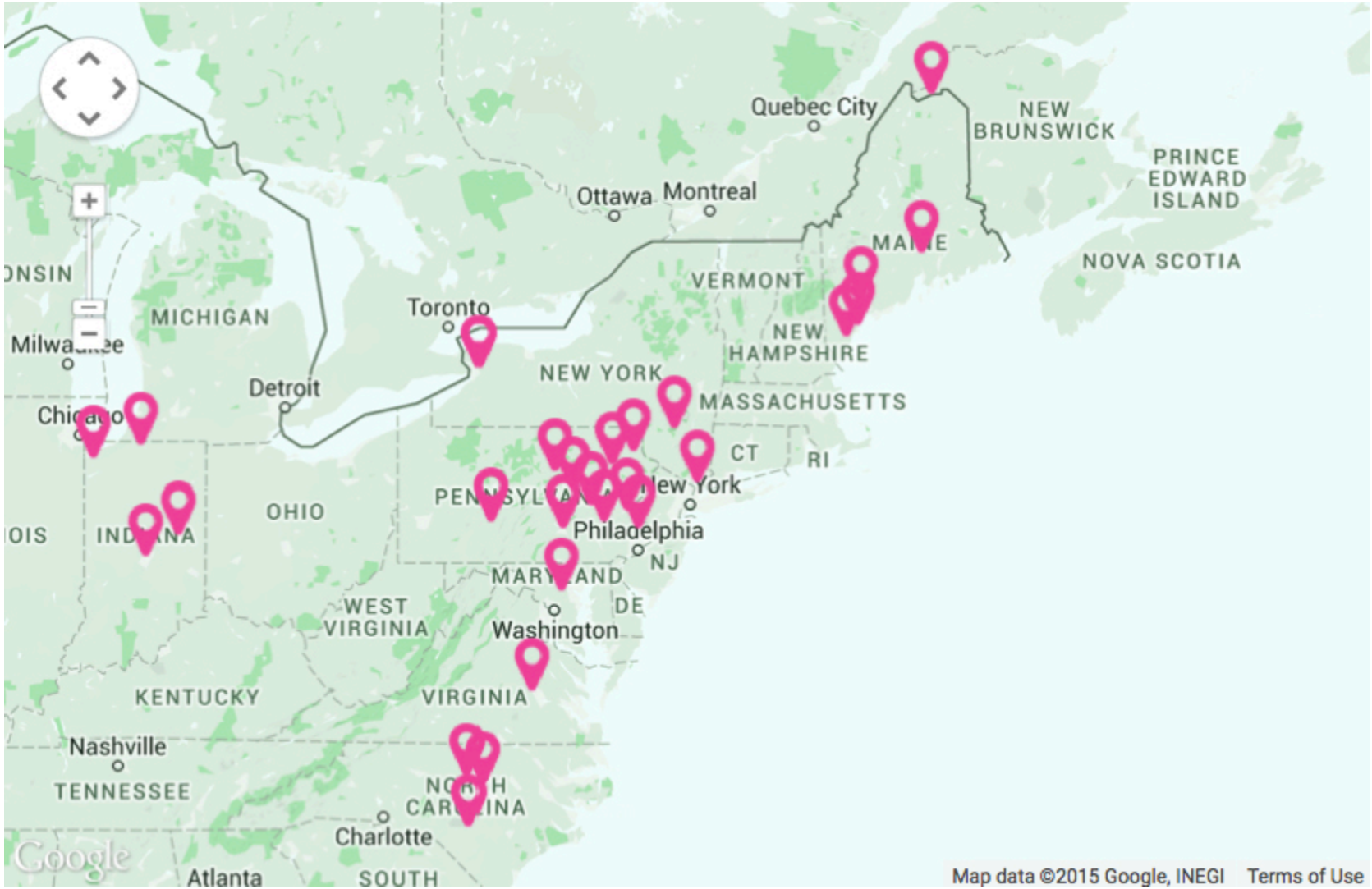
- What it means to be a "trauma informed agency" and why is this important?
- How the Trauma Informed Agency Assessment (TIAA) measures seven dimensions of trauma informed practice, sampling both clients and staff.
- How one agency used the TIAA to measure its commitment to the philosophy.
- How the results of the TIAA were used to improve trauma informed practices at each program/site.

KidsPeace®

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

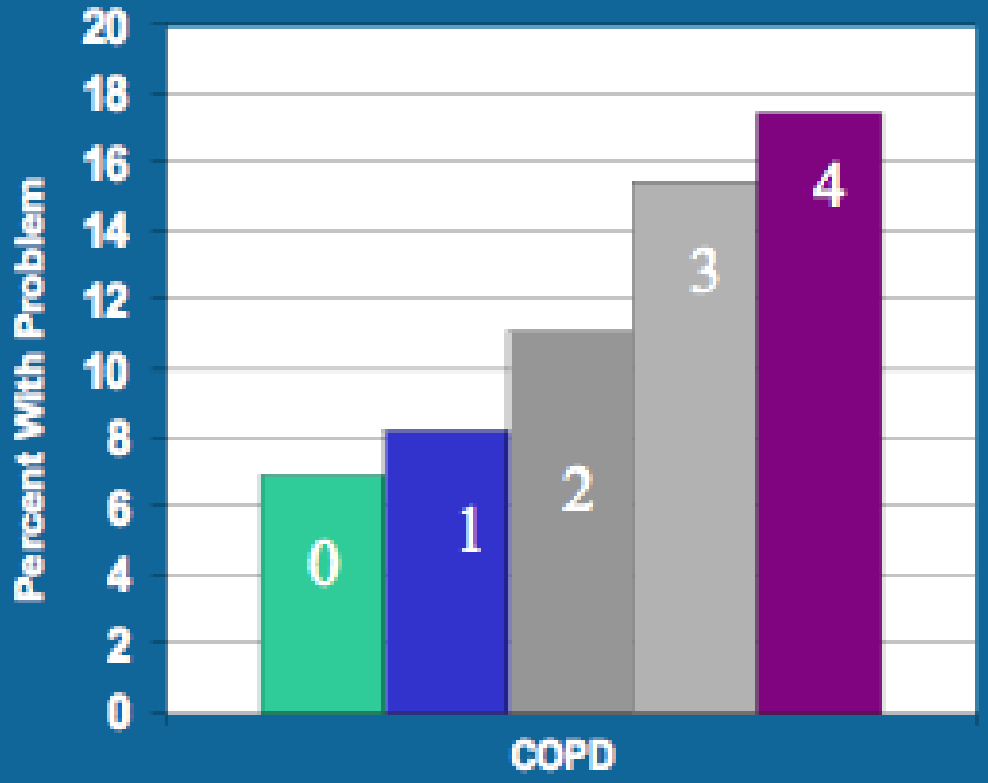
ACEs Study

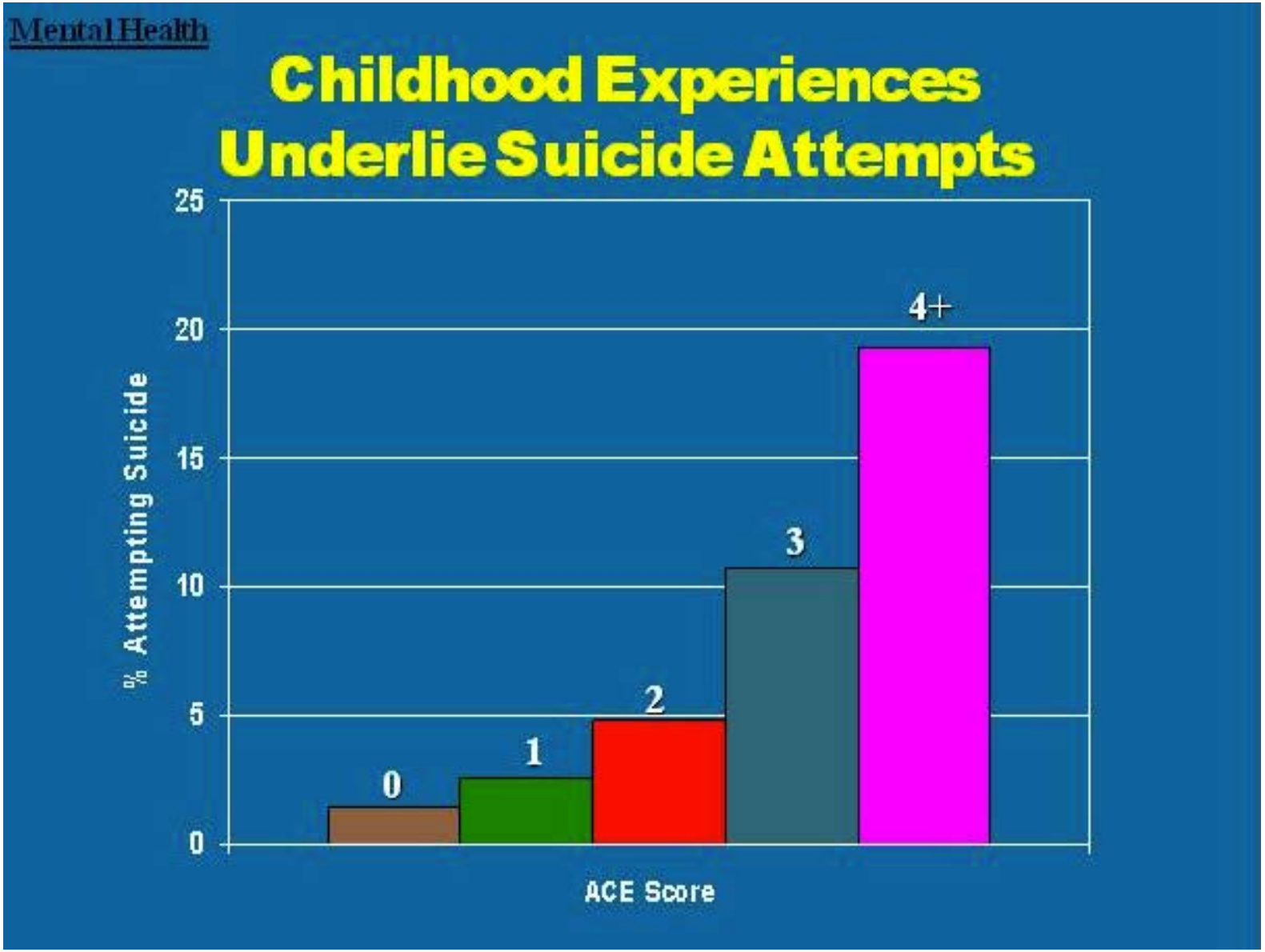
- Kaiser Permanente study of 17,000 insured adults (1998)
- Correlated 10 types of Adverse Childhood Experiences with adult health and social outcomes
- Found that ACEs were extremely common (two thirds of us have at least 1; 87% have more than 1)
- 1 in 10 have more than 5

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)

ACE Score vs. COPD



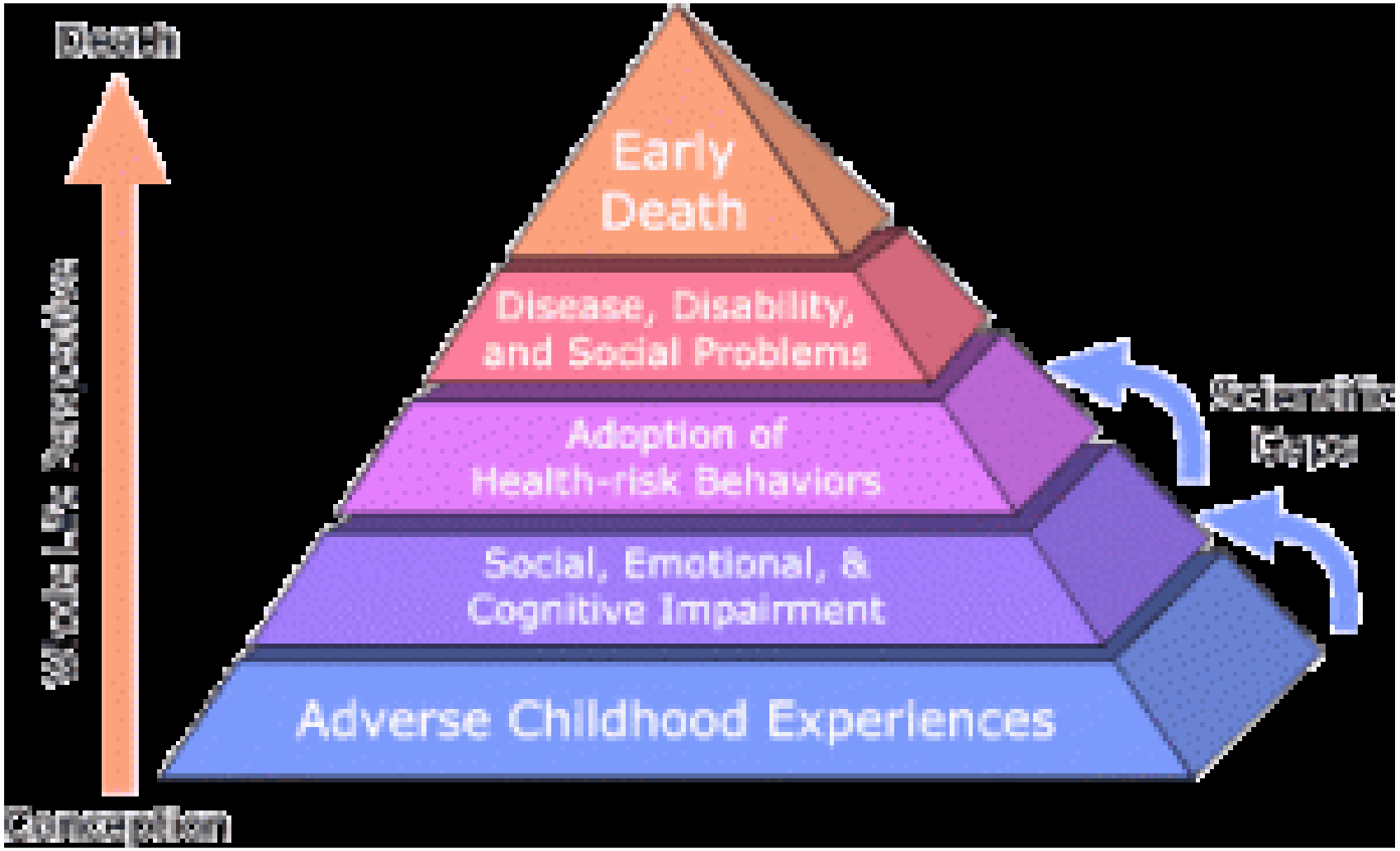

Mental Health
Childhood Experiences
Underlie Suicide Attempts
% Attempting Suicide
25
20
15
10
5
0
0
1
2
3
4+
ACE Score

Health Risks

Childhood Experiences vs. Adult Alcoholism

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

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)**

Indiana
- ☐ Foster Care (therapeutic and/or regular)
- ☐ Supervised Visitation
- ☐ Home-based Services
- ☐ Homemaker Services
- ☐ Adoption Preparation (child and/or adult)

Maryland
- ☐ Foster Care (therapeutic and/or regular)

Maine
- ☐ Therapeutic Foster Care
- ☐ HCT (Home and Community Treatment)
- ☐ TCM (Targeted Case Management)
- ☐ ARP (Alternative Response Program)
- ☐ Outpatient Therapy

New York
- ☐ Foster Care (therapeutic and/or regular)
- ☐ B2H (Bridges to Health)
- ☐ OMH Waiver (Respite)

North Carolina
- ☐ Foster Care (therapeutic or enhanced)

Virginia
- ☐ Foster Care (therapeutic or regular)

Pennsylvania FCCP: Clinical Services
- ☐ CRR HH (Community Residential Rehab Host Home)
- ☐ SITE (Sexual Issues Treatment and Education)
- ☐ BHRS (Behavioral Health Rehabilitation Services)

Pennsylvania FCCP: Non-clinical Services (child welfare)
- ☐ Foster Care
- ☐ Adoption services (SWAN or private)
- ☐ FGDM (Family Group Decision Making)

Pennsylvania Community Programs Outpatient
- ☐ Tobyhanna
- ☐ Green Street
- ☐ Sacred Heart
- ☐ Family Center

Pennsylvania Community Programs Day Programs
- ☐ Bethlehem
- ☐ Berks
- ☐ Advances

Pennsylvania Community Programs Autism
- ☐ After School
- ☐ Sarah's Smile
- ☐ BHRS (Behavioral Health Rehabilitation Services

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	Maine Results			Agency Results		
Trauma-informed Domain	Agency *(N =88)*	Family *(N =25)*	Youth *(N = 21)*	Agency *(N = 325)*	Family *(N = 132)*	Youth *(N = 83)*
I. Physical and Emotional Safety	83%	94%	80%	84%	90%	80%
II. Youth Empowerment, Choice and Control	79%	x	78%	80%	x	77%
II. Family Empowerment, Choice and Control	84%	91%	x	81%	84%	X
III. Trauma Competence	81%	92%	78%	78%	85%	79%
IV. Trustworthiness	87%	92%	77%	86%	87%	79%
V. Commitment to Trauma-informed Philosophy	79%	x	x	76%	X	X
VI. Cultural Competency and Trauma	79%	94%	85%	78%	88%	82%

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

2015 Report	Maryland Results			KidsPeace Results		
Trauma-informed Domain	Agency *(N =11)*	Family *(N =23)*	Youth *(N = 10)*	Agency *(N = 325)*	Family *(N = 132)*	Youth *(N = 83)*
I. Physical and Emotional Safety	75%	89%	82%	84%	90%	80%
II. Youth Empowerment, Choice and Control	84%	x	85%	80%	x	77%
II. Family Empowerment, Choice and Control	72%	86%	x	81%	84%	X
III. Trauma Competence	66%	84%	82%	78%	85%	79%
IV. Trustworthiness	77%	87%	82%	86%	87%	79%
V. Commitment to Trauma-informed Philosophy	60%	x	x	76%	X	X
VI. Cultural Competency and Trauma	65%	85%	86%	78%	88%	82%

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:

What do we want to change (Goals)?	Why did we choose this goal?	What steps will we need to take to meet these goals (Objectives)?	Who will be responsible?	When do we want to accomplish these objectives?	How will we know that we have accomplished our objectives?
When receiving more than one KPNE service, the second program will secure the biopsychosocial from the first program.	In order for families not to have to repeat their traumatic stories more than necessary, especially with staff they do not yet know.	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.	a)Program Supervisors b) Team leaders in each program	Target date for implementation in all programs – June 15, and continuing.	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.
More training for direct care, front line BHP/FSW staff.	To increase commitment to a trauma-informed approach, and to address multiple requests for more training.	a) Form small workgroup to address barriers, aka fishbone.	Training Supervisor and workgroup	Target date for implementation – November 1. Training will be ongoing.	a) TIAA scores will show increase in this area b) Every direct care staff will be trained.

What do we want to change (Goals)?	Why did we choose this goal?	What steps will we need to take to meet these goals (Objectives)?	Who will be responsible?	When do we want to accomplish these objectives?	How will we know that we have accomplished our objectives?
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 2. Program Manager and Team 3. Program Manager	1. May 4, 2016 2. April 12, 2017 3. April 12, 2017	1. Increased score on next staff TIAA. 2. Increased communication between team members.

3. We want to increase our commitment to the Trauma-Informed Philosophy to at least 80%.	By accomplishing the first two goals we should be able to perform as a competent team committed to the trauma-informed philosophy.	1. Identify and repair unhealthy and/or nonproductive communication patterns with staff, families, and clients. 2. Provide a consistent message to staff, families, and clients. 3. Review and uphold model of care. 4. Have a staff recommitment retreat.	1. Program Manager and Team 2. Program Manager and Team 3. Program Manager and Team 4. Program Manager	1. April 12, 2017 2. April 12, 2017 3. April 12, 2017 4. April 12, 2017	1. Increased score on next staff TIAA.

2016 Results

Did the performance improvement plans result in KidsPeace FCCP becoming more trauma informed?

Organization-wide Report Trauma-informed Domain	2015*			2016		
	Agency *(n=255)*	Family *(n=120)*	Youth *(n=75)*	Agency *(n=232)*	Family *(n=133)*	Youth *(n=112)*
I. Physical and Emotional Safety	84%	91%	80%	87%	91%	84%
II. *Youth* Empowerment, Choice and Control	80%	x	78%	82%	x	81%
II. *Family* Empowerment, Choice and Control	81%	85%	x	83%	86%	x
III. Trauma Competence	78%	86%	80%	81%	88%	83%
IV. Trustworthiness	86%	88%	80%	89%	88%	81%
V. Commitment to Trauma-informed Philosophy	75%	x	x	79%	x	x
VI. Cultural Competency and Trauma	77%	88%	82%	80%	89%	85%

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

	October 2015	November 2016
Agency =	80.1%	83.0%
Family =	87.6%	88.4%
Youth =	80.0%	82.8%

2016 Report Trauma-informed Domain	Maine Results			Organization-wide Results		
	Agency *(n=91)*	Family *(n=31)*	Youth *(n=10)*	Agency *(n=232)*	Family *(n=133)*	Youth *(n=112)*
I. Physical and Emotional Safety	85%	92%	86%	87%	91%	84%
II. *Youth* Empowerment, Choice and Control	81%	x	81%	82%	x	81%
II. *Family* Empowerment, Choice and Control	85%	88%	x	83%	86%	x
III. Trauma Competence	83%	90%	85%	81%	88%	83%
IV. Trustworthiness	90%	90%	85%	89%	88%	81%
V. Commitment to Trauma-informed Philosophy	80%	x	x	79%	x	x
VI. Cultural Competency and Trauma	81%	93%	87%	80%	89%	85%

The symbol "x" means that the measure is not applicable.
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Distribute Handout

- If time: small group exercise in developing a PIP based on the Maine data.

TIAA Report for Maine	2017										
	2016				2017				Change		
Trauma-informed Domain	Agency	Family	Youth		Agency	Family	Youth		Agency	Family	Youth
I. Physical and Emotional Safety	83	94	80		85	92	86		2	(2)	6
II. Youth Empowerment, Choice and Control	79	x	78		81	x	81		2	x	3
II. Family Empowerment, Choice and Control	84	91	x		85	88	x		1	(3)	x
III. Trauma Competence	81	92	78		83	90	85		2	(2)	7
IV. Trustworthiness	87	92	77		90	90	85		3	(2)	8
V. Commitment to Trauma-informed Philosophy	79	x	x		80	x	x		1	x	x
VI. Cultural Competency and Trauma	79	94	85		81	93	87		2	(1)	2
			1433				1462				29
n	88	25	21		91	31	10		3	6	(11)

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

- Credits:
  - The TIAA is owned by the Maine Department of Health and Human Services: can be used with permission: jay.yoe@maine.gov
  - Web hosting and data analysis by Hornby Zeller Associates: hhornby@hornbyzeller.com

KidsPeace

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