Training Institute Curriculum
Trauma Informed Advocacy: Enhancing the Voluntary Services Model

Section 1 – Pre-Training

Materials Checklist:

- ✓ Trainer Packet
- ✓ Training Institute Trainer Tip sheet (located in trainer packet)
- ✓ Action Alliance branded documents (located in trainer packet)
- ✓ Packets for participants
- ✓ Handouts for participants
- ✓ Evaluations
- ✓ Certificates of completion
- ✓ Board or flipchart
- ✓ Markers
- ✓ Colored Pencils
- ✓ Pens
- ✓ Tape
- ✓ Index cards
- ✓ Internet access
- ✓ List of participants
- ✓ Links for videos cued and ready if not already embedded in PPT
- ✓ Sign in Sheets
- ✓ Name badges or plastic tents
- ✓ Computer
- ✓ LCD projector and screen
- ✓ Remote control for advancing slides
- ✓ Sound check of computer to ensure audio is heard

Training Methods:

- ➢ Presentation
- ➢ Video Clips
- ➢ Large group work and discussions
- ➢ Small group work and discussions
- ➢ Game

Section 2 – Welcome and Introductions

Time: 30 minutes (9:00 a.m. – 9:30 a.m.)

1. *SLIDE 1.*

2. Trainers introduce themselves.

3. Provide an overview of the Action Alliance (branded documents in trainer packet) and provide information on how to become a member.

4. *SLIDE 2.*

5. Housekeeping:
    a. Bathrooms
    b. Vibrate or silence cell phones
    c. Kitchen
    d. Note there will be small breaks throughout the day
    e. Lunch
    f. Be mindful of possible triggers – encourage participants to always take care of their needs and step out if they need to.

6. *SLIDE 3.*

7. Read the Learning Objectives:

    a. Overall objective: to increase awareness around the trauma informed advocacy model and how it is supported by the voluntary services model and to provide advocates with the tools and resources needed to adopt a trauma informed approach in their programs. There is an absolute wealth of information and research on trauma. It is not possible to cover all of this information in a day's training, but we will address the key areas in detail and you will walk away with plenty of resources and tools that will continue to guide you in your work every day. Today's learning objectives are:
    b. Understand trauma
    c. Define historical trauma
    d. Discuss cultural competency
    e. Review trauma research

f. Examine the physical and emotional impact of trauma on survivors
g. Define trauma informed care/services
h. Review characteristics of a trauma informed organization
i. Analyze sexual and domestic violence and trauma and trauma triggers
j. Examine how trauma informed care connects to the voluntary services model
k. Putting it into practice – strategies for working with trauma survivors

8. Explain that the first part of the training is at the macro-level but that we will move to the micro-level and the foundation being set will make sense as it relates to the question "But what does this mean for my program in my day to day work?" At the end of the day, you will leave with a "toolbox" of resources that you can use in your daily work of providing trauma informed services and supports. We encourage you to keep these resources in an easily accessible location so that you can always refer to them and keep the knowledge fresh in your minds.

9. Many of you might be thinking – we already do this – we already provide services through a lens of trauma. And that is great – but there is always more we can do and more we can learn. Even if you just sharpen the tools you already have, your time here is valuable.

10.  ***HANDOUT*** Self-Care and Trauma Work. This training may bring up some issues for you. If you need to step out, please do. The most important thing is to take care of yourself. While we don't have time today to dig into vicarious trauma, it is a critical aspect of providing trauma informed care and we provide you with several resources on this topic including strategies for taking care of yourself as an advocate. If you are not familiar with this term, vicarious trauma occurs when an individual who was not an immediate witness to the trauma absorbs and integrates disturbing aspects of the traumatic experience into their own functioning. And we do encourage you to read the handout we just provided and take time to focus on self-care every day.

Section 3 – Understanding Trauma

Time: 30 minutes (9:30 a.m. – 10:00 a.m.)

Learning Objective: To define and understand trauma.

11. *SLIDE 6.*

12.  **Activity (5 minutes) –** Tell the participants we will do a brief grounding exercise. Ask each participant to close or lower their eyes for 30 seconds or so. Then ask them to silently identify something they can 1. See. Repeat this instruction with the rest of the senses: 2. Smell, 3. Touch, 4. Hear, 5. Taste. Pause for a few moments and ask them to share some of the things they identified with their senses. Whenever you feel anxious, it is helpful to look around the place you are in and go through these five steps, focusing on each one and naming what you can identify. Often when we are anxious or fearful it is because we are thinking about or feeling something from the past and this exercise can be a useful tool to bring you to the present and help you stay there.

13. *SLIDE 5.*

14. Have people introduce themselves, their organizations, role, and preferred pronoun. Ask people to also share ONE thing they hope to get out of the day's training.

15. Reiterate that we will begin the day by establishing some basic concepts so that we all have the same foundation. This macro-level training might feel too theoretical and impractical, but it is what we will build from when we move to the micro-level, very practical sections of the training. We just want everyone to remember that every section of this training is a building block and that all the blocks are connected.

16. Let's talk about what we mean by trauma. We've all heard about post-traumatic stress disorder (PTSD) right? We hear it most often when talking about our armed service people returning from war. We are focusing today on more complex trauma – meaning that the trauma is repeated and ongoing. Layers up on layers of trauma.

17. With that in mind, we would like to hear from the group – what do you think of when you hear the word trauma? Or how would you define trauma? **[Write Answers on Flip Chart].**

18. Validate the answers that come from the group and then explain that there are variations of how that word is defined clinically, for example, but for our purposes today we mean an incident or event that is threatening or is *perceived* as threatening, and overwhelms a person's normal coping skills. Overwhelms is a key word here – these feelings of being overwhelmed are what is typical for a person who is traumatized. Trauma can take many

forms including emotional, physical, or sexual abuse; neglect; abandonment; natural disasters; assault; catastrophic injuries or illnesses.

19. For some people, the trauma is not a one-time event but is a threat that builds over time. According to Dr. Judith Lewis Herman, psychological trauma is characterized by feelings of: intense fear, helplessness, loss of control, and threat of annihilation.

20. There are different levels of exposure to traumatic events. **Acute Trauma** refers to a single traumatic event that is limited in time, such as an auto accident, a gang shooting, a parent's suicide, or a natural disaster. **Chronic Trauma** refers to repeated assaults on a person's mind and body, such as chronic sexual or physical abuse or exposure to ongoing domestic violence. **Complex Trauma** describes both exposure to multiple traumatic events, often of an invasive, interpersonal nature, and the wide-ranging, long-term impact of this exposure. These events are severe and pervasive, such as abuse or profound neglect.

21. As we talk about trauma throughout the day, it is critical to keep in mind that trauma is all about perception – what one person perceives as traumatic may not be perceived by another in the same way. The important thing to remember is that a person can become traumatized when their ability to respond to a perceived threat is overwhelmed. There is another equally important concept for us to understand about trauma: traumatic reactions are NORMAL reactions to ABNORMAL events. We'll dig into these concepts a bit later.

22. As advocates, we already know that survivors of sexual and domestic violence experience these feelings even if they don't name them as 'trauma.' When working with survivors our first concern is typically and necessarily immediate safety of the survivor and crisis intervention. The goal is to take care of these immediate needs but with a trauma informed perspective. It can be difficult to step back from the daily tasks and immediate needs facing advocates in order to apply a trauma informed lens to working with survivors. But we will be more effective and responsive to the needs of survivors if we understand and work within the context of trauma. And that's what we hope you will leave here with today – tools, resources and strategies for not only you working one on one with your clients, but also helping your organization learn how to become an trauma informed organization, or if your organization already is trauma informed, so enhance their perspective.

23. We also want to establish that while trauma service models have historically focused on the effects of trauma that occurred in the past, as we know, for many survivors the

trauma is ongoing and "symptoms" may reflect a response to ongoing danger and coercive control. We look at both the history and the present when working with our clients.

Section 4 – Defining Historical Trauma

Time: 30 minutes (10:00 a.m. – 10:30 a.m.)

Learning Objective: To define historical trauma.

24.  ***HANDOUT*** SAMHSA Social-ecological model

25. How many of you have heard of the Sociological Ecological Model or SEM?

26. The SEM is a framework that believes that individual behavior is shaped by factors at multiple levels, including institutional, community, and policy levels in addition to intrapersonal and interpersonal levels.

27. You have in front of you a picture of the social ecological model, but this one may be different from the one you are used to seeing. It is adapted for trauma.

28. The focus of this model is not only on negative attributes (risk factors) across each level, but also on positive ingredients (protective factors) that protect against or lessen the impact of trauma. This model also guides the inclusion of certain targeted interventions in this text, including selective and indicated prevention activities. In addition, culture, developmental processes (including the developmental stage or characteristics of the individual and/or community), and the specific era when the trauma(s) occurred can significantly influence how a trauma is perceived and processed, how an individual or community engages in help-seeking, and the degree of accessibility, acceptability, and availability of individual and community resources.

29. This model just provides context for us – trauma does not happen in a vacuum. You see in the model that the period of time in history is an influence.

30. Everything that we expect and believe about ourselves, about other people, and about the world that we live in – is learned through *experience.* Trauma is an experience that profoundly shapes how we see the world.

31. **Show embedded Lion King clip in Slide X. Then show the Color Purple clip embedded in Slide X.** {Click the black box a few times if the video doesn't show right away}.

32. **Get feedback from the group on the clips.** Discussion should yield points about history of trauma, learning to avoid and cope with trauma, that the past is never really gone, etc.

33. History - the past - matters. We know this on many levels, but it is especially so when we look at trauma and how we respond to trauma. Dr. Maria Yellow Horse Braveheart conceptualized historical trauma in the 1980's, as a way to develop stronger understanding of why life for many Native Americans is not fulfilling "the American Dream". Historical trauma is cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma. The effects of historical trauma include: unsettled emotional trauma, depression, high mortality rates, high rates of alcohol abuse, significant problems of child abuse and domestic violence.

34. Treatment of historical trauma works to repair connections with others, self-image, values and beliefs. Particular attention is given to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty.

35. When we are working with clients, it is important to keep historical trauma in mind. And cultural competency is directly related to historical trauma in that we need to work to understand cultural diversity, history, and the culture of our clients.

BREAK: 10:30-10:45 a.m.

Section 5 - Cultural Competency

Time: 15 minutes (10:45 a.m. – 11:00 a.m.)

Learning Objective: Discuss cultural competency and understand that it is relevant to trauma informed care.

36.  ***HANDOUT*** Cross-Cutting Factors of Culture Model

37. We have an entire curriculum devoted to cultural competency, so we will not spend much time on this, but it is critical that we at least touch on it.

38. Going back to our SEM model – survivors are influenced at many levels, and culture is one of them. An advocate cannot possibly know all the nuances of another culture, but being sensitive and willing to learn about another's culture will go a long way in providing trauma informed care.

39. Culture influences not only whether certain events are perceived as traumatic, but also how an individual interprets and assigns meaning to the trauma. In addition to shaping beliefs about acceptable forms of help-seeking behavior and healing practices, culture can provide a source of strength, unique coping strategies, and specific resources.

40. Respecting diversity, having a diverse workforce, and providing ongoing cultural competency training are also ways you can strengthen your trauma informed services.

41. We just gave out a document that will be useful to you – it is a model of cross cutting factors of culture. We encourage you to keep this tool handy and review it often.

42. With these concepts of trauma, historical trauma, and cultural competency in mind, let's move onto trauma research and how trauma impacts the physical and emotional health of survivors.

Section 6 – Trauma Research

 *Time:* 60 minutes (11:00 a.m. – 12:00 p.m.)

 *Learning Objective:* Review trauma research (ACEs Study)

43.  ***HANDOUT*** CDC What are ACEs Graphic

 ***HANDOUT*** ACE Study What Everyone Should Know

44. Ask participants to think about a time they felt victimized or traumatized by an event in their life. Ask them to think about what they did, how they felt, who they told, how it impacted them throughout their lives, and if it changed their lives in anyway. Give people a few minutes to think about this. Tell them to keep this exercise in the back of their minds – it will be relevant later.

45. Ask if anyone has heard of the ACEs study. Hopefully a few participants have. Explain that ACEs stands for Adverse Childhood Experiences and give the background: about 20 years ago in San Diego, public health practitioners were puzzled by constant patient drop out from obesity programs. They decided to investigate whether there were any shared underlying factors among those affected. They were shocked to find out that those who dropped out almost all had one thing in common: sexual abuse in childhood. This led them to another question - were there other areas of poor health in adulthood or social outcomes where the people affected had largely been victims of childhood adversity?

46. The result of this investigation was a longitudinal *Adverse Childhood Experiences Study* referred to as ACEs Study. This study involved more than 17,000-mostly middle-aged and middle-class West-coasters in the US, through a collaboration of Kaiser Permanente clinics and the Center for Disease Control in Atlanta.

47. Each study participant completed a confidential survey that contained questions about childhood maltreatment and family dysfunction, as well as items detailing their current health status and behaviors.

48. The findings of this study revealed a shocking prevalence of 10 classified types of ACEs which were broken down into three areas:

    1) Abuse: Sexual, physical, emotional;
    2) Neglect: Failure to meet basic physical needs, leaving a child uncared for, or unloved;
    3) Household dysfunction: Witnessing, addiction, crime, parent-to-parent violence, mental illness etc.

49. Respondents were given an "ACE Score" of 1 to 10. An overwhelming ***two-thirds*** of respondents had experienced at least one ACE and 12% of respondents had an Ace

Score of 4 or more. 20% had been victims of child sex abuse. People who identified as women were 50% more likely than people who identified as men to have a score of 5 or more.

50. Show clip of Dr. Nadine Burke Harris embedded in Slide X. **Show from time span 8:11 - 9:52.**

51. The ACE study found that repeated – again, that bear coming home every night - and severe trauma, if left untreated, leads to ongoing – we are talking about decades after the initial trauma - and serious and life altering problems including increased suicidal attempts and other mental health disorders, promiscuity, use of street drugs, heavy alcohol consumption, intractable smoking, and physical health problems such as diabetes, hypertension, obesity, strokes, heart disease, certain forms of cancer, chronic lung disease, and liver disease.

52. According to Dr. Nadine Burke Harris who you just saws in the clip, in California somebody who had experienced 7 of 10 forms of childhood adversity has a 20-year shorter life-expectancy than someone who has experienced none. The bottom line, the higher your ACE score, the worse your risk is for many problems, including the ones we just talked about like obesity and alcoholism.

53. Since the ACE study, several others have confirmed the findings (including addressing socioeconomic factors beyond middle class and suburban populations) making it impossible to ignore the impact of trauma on public health and how intervention and treatment services should be provided. In fact these additional studies found that ACEs are more prevalent in urban settings. In other words, the problem only worsens the more we examine it.

54. In your toolkit there is a link to an ACEs quiz that will give you and your clients a score. This can also be used as a trauma-screening tool or just as a way of educating your clients about ACEs.

55. Take-aways from this section are that trauma research tells a simple but powerful story:

    a. ACEs are common
    b. ACEs are highly interrelated
    c. ACEs pile up and have a cumulative impact
    d. ACEs account for a large percentage of health and social problems

e. The higher the ACE score, the higher the risk for health and social problems

LUNCH 12:00 – 1:00 p.m.

Section 7 – Physical and Emotional Impact of Trauma

Time: 60 minutes (1:00 p.m. – 2:00 p.m.)

Learning Objective: Understand the physical and emotional impact of trauma.

56. **Activity (5 minutes)** ***Time to stretch*** – Invite people to stand up if they would like to take a stretch break. Here is how the stretch works: Clasp the hands together and push the palms towards the ceiling, while pushing the shoulders down. Hold for 15 seconds. Re-clasp the hands with the opposite thumb on top and repeat. Now roll the shoulders forward 4 times and roll backwards 4 times. (Participants will feel that the upper body is more relaxed.)

57. Let's break down how trauma can show up. We've covered some of the ways trauma can manifest physically, but let's talk about it more. **Ask the group for examples of <u>physical</u> reactions to trauma, both initial reactions and ongoing. Write answers on flip chart.** Examples include headaches, stomach aches, heart palpitations, sweating, insomnia, diarrhea, constipation, easily startled, overeating, undereating.

58. Ok, now let's talk about **<u>emotional</u>** reactions. **Again, ask the group for feedback and write the answers on a flip chart.** Examples include shock, anxiety, depression, flashbacks, difficulty trusting people, shame, guilt, unwanted memories, difficulty concentrating, rage/anger, isolating themselves, detachment, numbing with sex, drugs, food, alcohol, irritability, sadness, crying frequently. We see that many times, diagnoses of 'mental health' issues are really just **normal reactions** to trauma. That's another reason why it is always important to think about a person's experiences of trauma when providing services to them. It is also when you are working with clients to stress over and over that how they are feeling is absolutely normal and not a "mental health" issue.

59. Fight, flight, and freeze – you heard Dr. Burke mention this and we've all heard of this concept. The brain's "fight or flight" response is activated through increased production

of the powerful hormone cortisol. While cortisol production can be protective in emergencies, in situations of chronic stress its level is toxic and can damage or kill neurons in critical regions of the brain.

60. Fight/flight/freeze are all automatic survival responses and are complex limbic/autonomic nervous system responses and generally are not chosen with a thought or foresight – they are automatic and instinctive. This is important information to have when you are talking with your clients – many times a person can feel guilty for freezing or "going dead" and not "fighting back." It is critical that your clients have the information that such reactions are complex, instantaneous reactions to an abnormal event. We wouldn't blame an animal in the wild for freezing when a predator threatened that animal.

61. Remind participants that all of these reactions are NORMAL – they are in response to an ABNORMAL incident.

62. Let's talk about the lasting impact of trauma on the brain. People exposed to chronic trauma can fluctuate between hyperarousal, intrusion, and constriction.

63. Hyperarousal is the body's way of remaining prepared. It is characterized by sleep disturbances, muscle tension, and a lower threshold for startle responses and can persist years after trauma occurs. It is also one of the primary diagnostic criteria for PTSD.

64. Intrusion happens when past traumatic events continue to invade the present – in the form of memories, flashbacks and body memories, for example. They often come without warning, often called flooding, and can sometimes leave the survivor unable to stay present in the moment. As a coping strategy, survivors sometimes will do anything to avoid this flooding of memories, sometimes called constriction.

65. Constriction can happen at the time of the trauma, or become an ongoing coping mechanism. It can take the form of feeling numbed, distorted perceptions, out of body feelings, or an altered sense of time, for example a feeling of slow motion.

66. Research shows that hyperarousal and intrusion are the main responses to initial trauma but that over time, constriction becomes the dominant coping mechanism.

67. As we said before, not everyone experiences trauma in the same way. **Ask the group to talk about examples of how trauma can show up in the people they work with.** If you need to prompt, examples include a survivor who:

    a. Is cool and detached
    b. Is sensitive and has their feelings easily hurt
    c. Is suspicious/not trusting
    d. Has trouble describing what happened to them
    e. Doesn't seem to notice what is happening around them
    f. Needs some time alone
    g. Not want to say what they need
    h. Not feeling safe
    i. Feels to overwhelmed to think there is any "way out"
    j. Feels guilty
    k. Is combative

68. After we talk about trauma informed services and organizations, we'll come back to this and talk about strategies for responding to survivors.

69. Take-aways from this section of the training are that the brain has an AUTOMATIC response to initial trauma and that the impact of trauma can be long lasting and take many forms, including physical and emotional.

BREAK 2:00 – 2:15 p.m.

Section 8 – Define Trauma Informed Services/Care

Time: 60 minutes (2:15-3:15 p.m.)

Learning Objective: Define trauma informed services/care.

70. **Slide X.** The image you see here is a cross-section of a tree. It reveals its story as told by the pattern of growth rings, reflecting the climatic conditions in which the tree grew year by year, and documenting injuries sustained throughout its life. Much in the same way,

we experience periods of trauma and resilience over the course of our lifespans. A trauma-informed approach seeks to understand the ways in which these experiences shape us.

71. A trauma aware and trauma informed approach seeks to change the paradigm from one that asks, "what's wrong with you?" to one that asks, "what happened to you?"

72. The term trauma-informed is used to describe organizations and practices that incorporate an understanding of the pervasiveness and impact of trauma and that are designed to reduce re-traumatization, support healing and resiliency, and address the root causes of abuse and violence (NCDVTMH 2013, adapted from Harris and Fallot 2001). Put a bit more simply, it can be described as an intervention and organizational approach that focuses on how trauma may affect an individual's life and their response to services from prevention through treatment.

73. Trauma-informed services are not specific types of services. Instead they promote healing environments and share a set of core trauma-informed principles: safety, trust, collaboration, choice and empowerment.

74. Let's think about some characteristics of a trauma informed services. **Get feedback from the group and write answers on flip chart.** Examples could include:

    l. Asking about context – history of violence, abuse, victimization
    m. Asking about the person's health
    n. Being respectful, sensitive
    o. Being keenly aware of possible triggers and avoiding them
    p. Being culturally competent and sensitive
    q. Focusing on building trust
    r. Focusing on providing trauma-informed resources and tools to the survivor
    s. Focusing on promoting the health and resiliency of the survivor
    t. Emphasizing the positive/strengths/skills of the survivor
    u. Ensuring physical safety
    v. Collaborating with others – e.g. faith community, neighbors, schools, animal shelters if pets are involved, friends, allied professionals, etc.
    w. Community education – educating the public and peers about trauma and working to provide an integrated, cross-systems approach to services.

75. Trauma informed services begin with the **first contact** a person has with an agency; it requires *all* staff members from administrative assistants, to program staff, to directors,

all the way up to board members) to recognize that the individual's experience of trauma can greatly influence his or her receptivity to and engagement with services, interactions with staff and clients, and responsiveness to program guidelines, practices, and interventions. It includes program policies, procedures, and practices to protect the vulnerabilities of those who have experienced trauma and those who provide trauma-related services. Trauma informed care is created through a supportive environment and by redesigning organizational practices, with consumer participation, to prevent practices that could be re-traumatizing - we'll be discussing this more later. (Harris & Fallot, 2001c; Hopper et al., 2010).

76.  ***HANDOUT*** The National Center on Family Homelessness has developed eight foundational principles that represent the core values of trauma-informed services – this is one of your handouts. Read the principles.

- **Understanding Trauma and Its Impact**: Understanding trauma and its impacts on survivors and recognizing that many behaviors that seem maladaptive in the present are actually adaptive responses to traumatic experiences in the past.
- **Promoting Safety:** Establishing a safe environment in which basic needs are met, safety measures are in place, and service provider responses are consistent and respectful.
- **Ensuring Cultural Competence:** Understanding how cultural context influences each survivor's perception of and response to traumatic experiences and the recovery process; respecting diversity within the program, providing opportunities for survivors to participate in cultural practices, and designing interventions that respect and are specific to cultural backgrounds.
- **Supporting Survivor Control, Choice, and Autonomy:** Helping survivors regain a sense of control over their lives; informing survivors about all aspects of the system, outlining expectations, and providing them with opportunities to make decisions and create personal goals; and maintaining an awareness of and respect for basic human rights and freedoms.
- **Sharing Power and Governance:** Promoting equalization of the power differentials across the program; sharing power and decision-making across all levels of the organization, including in the review and creation of policies and procedures.
- **Integrating Care:** Maintaining a holistic view of survivors and their process of healing and facilitating communication within and among service providers and systems.

- **Healing Happens in Relationships:** Believing that development of safe, genuine, and healthy relationships can be restorative to survivors of trauma.
- **Recovery is Possible:** Understanding that recovery is possible for everyone; instilling hope by providing opportunities for involvement at all levels to program participants and former program participants, and facilitating peer support, focusing on strength and resiliency and establishing future-oriented goals.

77. Ask if there is any feedback on these 8 principles.

78. Take-aways from this section: trauma informed services ask 'what happened to you' and focus on promoting equality between program staff and the survivor as well as the survivor's strengths and capability for resiliency.

Activity (5 minutes) ***Time to stretch*** (feel free to play music) – Invite people to stand up if they would like to take a stretch break. Tell participants to stand up, turn right and walk around the perimeter of the room three times and then sit down. (Make sure the room is clear of obstructions).

Section 9 – Characteristics of a Trauma Informed Organization

Time:

Learning Objective: Review characteristics of a trauma informed organization.

79. Now let's talk about characteristics of a trauma informed *organization.* Creating a trauma-informed organization is a fluid, ongoing process – there is no end to this work and each person in your agency contributes to the success of these efforts. The ultimate goal for an organization is to make trauma informed care **consistent**, in line with **best practices**, and **integrated** across service systems.

80. The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) has a good definition of what it means to be a trauma informed organization: "A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for healing; recognizes the signs and symptoms

of trauma in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings."(SAMHSA)

81. SAMHSA further identifies stages that form the basis of creating a trauma-informed organization:

- Commit to creating a trauma-informed agency.
- Create an initial infrastructure to initiate, support, and guide changes
- Involve key stakeholders, including consumers who have histories of trauma.
- Assess whether and to what extent the organization's current policies, procedures, and operations either support trauma informed care or interfere with the development of a trauma-informed approach.
- Develop an organizational plan to implement and support the delivery of trauma informed care within the agency.
- Create collaborations between providers and consumers and among service providers and various community agencies.
- Put the organizational plan into action.
- Reassess the implementation of the plan and its ability to meet the needs of consumers and to provide consistent trauma informed care on an ongoing basis.
- Implement quality improvement measures as needs and problem areas are identified.
- Institute practices that support sustainability, such as ongoing training, clinical supervision, consumer participation and feedback, and resource allocation.

82.  ***HANDOUT*** The National Council for Community Behavioral Healthcare has developed Seven Domains for Being a Trauma Informed Organization, which is one of your handouts. We won't dig into each principle, but the 7 domains are **(just read bolded text):**

- **Domain 1. Early Screening and Comprehensive Assessment of Trauma** Developing a respectful screening and assessment process that is routine, competently done and culturally relevant and sensitive and revisited over time.
- **Domain 2. Consumer Driven Care and Services** Involving and engaging people who are or have been recipients of our services to play numerous roles (e.g., paid employee, volunteer, members of decision making committees, peer specialists) and meaningfully participate in planning, implementing and evaluating our improvement efforts.

- **Domain 3. Trauma-Informed, Educated and Responsive Workforce** Increasing the awareness, knowledge and skills of the entire workforce to deliver services that are effective, efficient, timely, respectful and person centered taking into consideration that service providers also have histories of trauma.
- **Domain 4. Provision of Trauma-Informed, Evidence Based and Emerging Best Practices** Increase the awareness, knowledge and skills of the clinical workforce in delivering research informed treatment services designed to address the cognitive, emotional, behavioral, substance use and physical problems associated with trauma.
- **Domain 5. Create a Safe and Secure Environment** Increase the awareness, knowledge and skills of the workforce to create a safe, trusting and healing environment as well as examining and changing policies, procedures and practices that may unintentionally cause distress and may re-traumatize (cause harm) those we serve.
- **Domain 6. Engage in Community Outreach and Partnership Building** Recognize that the people we serve may be part of and affected by a larger service system including housing, corrections, courts, primary health, emergency care, social services, education and treatment environments such as substance use programs. We have an opportunity to engage and increase the awareness of these other service providers to the principles and practices of trauma-informed care. In this way, our efforts are less likely to be undermined by other parts of the system.
- **Domain 7. Ongoing Performance Improvement and Evaluation** The organization values a systematic approach to measuring performance on each of the core trauma-informed domains. Data is used to track, measure and analyze performance improvement in order to inform leadership and its core implementation team on areas needing improvement as well as guiding the process of sustainable change.

83. Get feedback from the group on the 7 domains.

84.  ***HANDOUT*** Creating Accessible, Culturally Relevant, Domestic Violence- and Trauma Informed Agencies A Self Reflection Tool

 ***HANDOUT*** Agency Self-Assessment for Trauma-Informed Care

 ***HANDOUT*** National Center on Domestic Violence, Trauma & Mental Health: Trauma Informed Practice Checklist

85. Take-aways from this section: a trauma informed organization has a plan to implement trauma informed care and continually re-assesses this plan. There are concrete steps and processes that your organization can take to ensure that it is trauma informed, starting with a self-assessment. This handout is an example of a self-assessment your organization can adapt for its own needs.

Section 10 – Sexual Violence, Domestic Violence and Trauma and Triggers

 *Time:*

 *Learning Objective:* Review SV/DV and trauma and triggers.

86.  ***HANDOUT*** National Center on Domestic Violence, Trauma & Mental Health TipSheet A Trauma-Informed Approach to Domestic Violence Advocacy

87. Let's dig in now to our specific work – sexual and domestic violence. But before we do, we want to acknowledge that while we know that statistically, people who identify as women are at greater risk for interpersonal violence, we all know that doesn't mean that people who identify as men aren't subject to interpersonal violence and the same goes for people who identify as transgendered. So while the statistics bear out the prevalence of violence against people who identify as female, and we tend to speak in generalities, please understand that we acknowledge and are acutely aware of the violence against all genders.

88. The principle "first, do no harm," is one of the tenants of trauma informed care and one that we as advocates are very familiar with. Essentially, this frames all of our work.

89. Remember the exercise we did earlier where we asked you to think about a personal experience with trauma? Think back to that and think about what you needed after the traumatic incident – what did you need immediately after and what did you need long term to help you heal, if you did heal? If you did not heal, what do you think might help

you heal? Did you ever experience being 'triggered' – having something happen that brought to the surface the feelings you experienced after the initial trauma? Without revealing the specific event, **ask if anyone feels comfortable sharing the answers to those questions and validate the responses.**

90. Now let's think about the people we serve. They have experienced domestic and/or sexual violence. They are coming to you for help and they are coming to you with a history of trauma. Your first concern is often for their immediate need, and that's okay. But what we want you to take away today more than anything is to understand that they are coming to you with a history of trauma and to avoid re-traumatizing them. Even when addressing their immediate needs, use a trauma informed lens.

91. There are things about sexual and domestic violence that make it unique from other types of trauma. Ask the group: **can you think of some characteristics of this type of violence that makes it different from other types of trauma, say a natural disaster, car accident, etc?** If you aren't getting answers, you can explain that with domestic abuse, as we know, there is a pattern – it is chronic by definition. Sexual abuse can be chronic, but it can also be a one-time event. So the chronic nature of the trauma is one example. Also when we're talking about domestic violence, and many times sexual violence, the perpetrator is often someone the survivor knows and probably even loves. Experiencing triggers of the trauma is also common and can be a distinct characteristic of sv/dv. Another example - consequences of "leaving" the chronic trauma are significant – family, children, need for safety planning, etc. These aspects of sv/dv bring a whole other set of issues to the trauma informed care paradigm.

92. **Hopefully someone will mention the unique aspect of survivors often needing to be sheltered. If not, state this example, but don't dwell on it. We will cover it in the next section.**

93. We mentioned triggers as a unique characteristic of sexual and domestic violence. Ask the group, what does the word trigger mean to them? Validate their responses.

94. Traumatic triggers come in many forms. A trigger is a reminder of past traumatizing events. Many things can be a possible trigger for someone. For example, what seems like an "ordinary" request such as, "Make sure the children are ready for school on time," can be a trigger for a survivor whose abusive partner terrorized and punished her if the children were late for school. As you know, we ALL have triggers and we as advocates need to be mindful not only of our own triggers, but the ever present reality that

anything we do or anything in our environment might be a trigger for the survivor.

95. It is important to note that there will always be trauma triggers that we cannot anticipate and cannot avoid. But it is as equally important to note that there are triggers that we can avoid. The service system often re-traumatizes survivors. We know that intake can be traumatizing, for example. So can individual or group counseling. A survivor who feels they are not believed or empathized with can be re-traumatized.

96. Trauma informed care makes a conscious effort to eliminate or reduce every possible chance of re-traumatizing survivors. An organization's culture, policies, practices, and procedures must all be analyzed through this trauma lens.

97. Take-aways from this section: sexual and domestic violence presents unique challenges and impact how trauma informed services are provided, including being aware of triggers and re-traumatization of survivors.

Section 11 – Trauma & the Voluntary Services Model

Time:

Learning Objective: Understand how trauma informed care connects directly to the voluntary services model.

98. Tell the group we will watch a brief clip developed by our peer organization the Washington State Coalition Against Domestic Violence. **Show clip embedded in Slide X. [You may have to click a few times in the black box to get the video to work.]**

99. Keep this Teresa and Joe video in mind, we will revisit it later.

100. *GROUP* Break participants into small groups. **(20 minutes)**

101. SLIDE X: Ask the group to discuss the following questions about their programs:
- Does your program have any rules?
- Give examples of these rules.

- Does this rule mirror an abuser's control?
- What problem are we trying to solve with this rule? Is this the least burdensome way to address this issue?
- Is this rule consistent with your mission and core values regarding your shelter work?
- If we think we have to have the rule because of the Administrative Code/Health Code/Fire Code, have we double checked lately? Is there a less oppressive way to meet requirements?
- Do these rules (and the need to enforce them) create the kind of environment we want to create?
- Is it possible to enforce the rule? If not, what purpose does it serve?
- Does this rule actually accomplish its purpose? For example, does it actually create safety or does it just create an illusion of safety?

102. After about 20 minutes, or sooner if the discussion has organically stopped, state that we know that abusers often impose many rules on their partners, and that a primary harm of domestic violence is being robbed of one's autonomy. We want to create environments where survivors can reclaim their autonomy, and feel secure without excessive rules and punitive systems that echo the abuser's rules. A survivor whose abuser made and enforced "rules" in the house may feel anxious or frightened even by the words "shelter rules." Living in a shelter in and of itself can be traumatic. **Go back to the clip we showed of Teresa and Joe – ask the group to talk about how shelter rules connect to what was depicted.**

103. Then ask for feedback from each group about what they discussed about rules, what they were surprised to learn. Validate the responses and thank them for sharing.

104. Ask for a show of hands – how many people are familiar with the voluntary services model?

105. We won't dwell on defining this model too long – the Department of Social Services, Office of Family Violence presented detailed training on this fairly recently and we include a link to that training in your toolbox. But we do want to spend some time on the basics and the implications of the model for trauma informed services.

106. In a nutshell: OFV now requires all programs funded through the Domestic Violence Prevention and Services Grant to shift to the voluntary services model as of January 1, 2014. This is a federal requirement of the Family Violence Prevention Services Act grant

(part of your VDSS grant dollars).

107. The voluntary services model is based on the idea that participating in services should be voluntary and not a condition of receiving shelter or other services. Voluntary services, sometimes referred to as the reduced-rules model, emphasizes client-driven services. The voluntary services model is based on the belief that adult survivors are competent, capable and should have right to make their own decisions. The focus is on empowerment-based advocacy rather than compliance-driven services.

108. When I gave that brief summary about the VSM, was the connection to trauma informed care clear in your minds? The principles are the same and the VSM is just a practical aspect of providing trauma informed care. I hope that connection is clear or that it will be as we move through this section of the training.

109. Let's talk about some real life examples. We know that among our own members, there is tremendous variation in how far programs are taking the voluntary services model. Some programs simply call their rules something else, but they are still rules. Some programs really have done away with rules but have a real struggle with things like getting their clients to see case managers, which is not necessarily good for the clients or for the outcomes data that funders look at. So what is the balance when there are very real practical considerations for programs? Let's break into groups and use some real life examples and see what we come up with.

110.  *GROUP* Break participants into small groups. **(10-15 minutes)**

111. Give out the printed scenarios in the Trainer Materials and instruct the group to come to a consensus on how the program should handle the situations described in the scenario(s) assigned to their group. The goal is to come up with a response that reflects the voluntary services model if possible. **If the groups are small, give each group 2-3 scenarios.**

- Scenario 1: A shelter resident leaves her 16 year old daughter overnight, alone, to go see her boyfriend and asks the daughter to cover for her by lying to shelter staff about her whereabouts. The boyfriend is not the perpetrator.
- Scenario 2: Shelter residents frequently argue about other residents who will not clean any common areas.

- Scenario 3: A shelter resident uses the common computer to get on Facebook to stay in touch with her abuser.
- Scenario 4: A shelter resident refuses to see a case manager for weekly appointments.
- Scenario 5: A shelter resident stays away for 2-3 nights without letting anyone know where they are and comes back and expects their bed to be vacant.
- Scenario 6: A shelter resident is caught with heroin that was left out in the open where children could have accessed it.
- Scenario 7: A shelter resident comes in at 1 am without telling anyone they will be late and set off the alarm.

112. Have one person read the scenario from each group, and then ask them to provide the 'solution' they came up with. Listen to the responses and provide constructive feedback if any responses given are too punitive. **Remember: there are no right or wrong answers, but there are responses that can be modified to align more closely with the VSM.**

113. Possible alternative responses to the scenarios if the group discussion is not in line with the VSM:

- Discuss with the group cleaning habits. Offer the suggestion that they develop their own cleaning schedule. Encourage the group to come up with their own solutions. Hire a part time cleaning person or ask a volunteer to do the cleaning. Note: typically a few residents take on the cleaning of communal areas while others do little to nothing. This is common in all group living settings – even if the shelter did have a 'rule' about cleaning, chances are, it would be very difficult to enforce.
- Restricting a person from social media is not going to keep them from their abuser if they really want contact, and it only serves to further restrict and isolate them.
- In your rules and responsibilities document, use language like: *You have the right to work with staff to plan strategies and goals toward independent living. Staff are available by appointment to provide information and resources in a non-judgmental and respectful manner. It is your responsibility to attend appointments made with the case manager to work on those strategies and goals.*
- Acknowledge there are practical considerations a shelter must take into account such as the health and safety of other residents. For example, in the scenarios where the daughter is left alone, heroin is left out, and a bed remains vacant for several days, the resident may need to be asked to not repeat the behavior and

that removal of the shelter for the next time that happens may be a natural consequence of that behavior for the health and safety of others. For drug abuse, ask if the person wants treatment. Help the person get into treatment if that is what they want.

- Consider disabling the alarm or empowering the resident who comes in late to know how to do so. Consider hiring an all-night staff person.

114. Suggested steps to complying with the VSM, which an extension of a trauma informed perspective:

 ***HANDOUT*** General Recommendations Regarding Shelter Rules & Model Rights and Responsibilities

 ***HANDOUT*** Making Minimal Rules Work

 ***HANDOUT*** How We Gave Up a Curfew

 ***HANDOUT*** Rethinking Punitive Approaches

 ***HANDOUT*** Critical Questions About Shelter Rules

- Train all of your staff on the voluntary services model and trauma informed care
- Engage in a meaningful discussion with your staff about their concerns and feedback regarding both topics
- Inventory *all* of your rules
- Analyze your rules – what can be removed? What can be modified to reflect the VSM and principles of trauma informed care?
- Develop new documents (we recommend using the Making Minimal Rules Work Checklist handout to help you do this) to replace your shelter rules – call it Rights and Responsibilities or something that feels right for your program.
- Get feedback from your clients on this document
- Take conflicts as they arise – modify your documents as necessary, but always involve your staff and clients in discussions before issuing any changes

- Consult with your peers or membership organizations – we can help each other

115. Take-aways of this section: Complying with the voluntary services model is not optional and so we have to find ways of making it work effectively. It is an ongoing process and real life is not perfect – there will be conflicts but there will also be amazing new ways of doing things that you will discover. Recognize that shelter life in and of itself can be traumatic. Using the model is an extension of trauma informed care and will only enhance your services and will empower your clients. Focus on natural consequences instead of punishment and take conflicts on a case by case basis. Give residents the tools and resources when group conflicts arise and let them come up with the solutions. Be a resource, not a rule maker.

Section 12 – Putting it Into Practice – Strategies for Working with Trauma Survivors

Time:

Learning Objective: Learn how to put the strategies and tools for trauma informed care into practice.

116. ***HANDOUT*** Survivor Reactions and Advocate Interventions

HANDOUT Tools for Coping with Traumatic Stress

HANDOUT Tips for Creating a Welcoming Environment

HANDOUT Survivor Reactions and Advocate Interventions

 ***HANDOUT*** Screening & Assessment

117. Let's talk about practical strategies and general principles to use when working with trauma survivors. Keep in mind all of the things we have talked about today – this section will build on that and that was our foundation.

118. When you are working with a trauma survivor, it is important to be mindful of your body language, tone of voice, your own triggers, and your environment. Sometimes a person's story can make us uncomfortable. Our peer organization in Ohio has developed a very helpful Survivor Reactions and Advocate Interventions table that we just passed out. This outlines a specific survivor reaction accompanied by how a survivor can react. We encourage you to use this tool in your own work.

119. Essentially, we can break down the strategies and principles for responding to survivors into these steps:

a. Create a safe, welcoming environment
b. Acknowledge that shelter life can be difficult; explain the voluntary services model and offer supportive strategies.
c. Screen and assess trauma
d. Educate survivors about the traumatic effects of abuse
e. Provide survivors with resources and tools needed to deal with the effects of trauma
f. Focus on holistic health
g. Enhance social support and integration

120. Creating a safe, welcoming environment can seem like common sense, but it is an essential piece of trauma informed care. We provide resources on this in your toolbox.

121. One of the most important things you can do for a survivor is to let them know that what they feel after experiencing a trauma is normal. Just letting them in on that piece of information can be very comforting and empowering. You may even want to give them information about ACEs, including the ACEs quiz that is included in your toolbox.

122. We don't have time to dig into screening and assessment, but we provide you with tools and resources so that you can complete these necessary processes with a trauma informed perspective.

123. Let the survivor know what to expect: they may alternate between feelings of intense anxiety or re-experiencing the event and depression and withdrawal.

124. Talk to the survivor about triggers and that again, this is normal.

125. Discuss that healing is a process and that being patient with one's self is very important.

126. Emphasize that the survivor is a strong and courageous person and has already survived – they will continue to survive and in fact heal and thrive.

127. As advocates, our role is both to affirm and validate the coping mechanisms that trauma survivors use and also to support survivors in developing new ways to cope with the impact of trauma. One of your handouts really gets into the meat of what to keep in mind when discussing positive coping strategies with survivors but what are some strategies you can think of? Write answers on flip chart. Validate responses. Examples include:

- Crying
- Exercise
- Hugging a pet
- Art
- Journaling
- Hot bath
- Music
- Volunteering for a cause they care about
- Humor
- Prayer
- Meditation
- Counseling
- Good nutrition
- Adequate sleep
- Reading

128. A key part of a survivor's overall healing process is to promote their resilience. Always keep this in mind. What we mean by resilience is the maintenance of healthy/successful functioning or adaptation within the context of a significant adversity or threat. It is our ability to bounce back when faced with a variety of challenges. Focusing on the person's strengths is an intervention that builds on the individual's existing resources and views them as a resourceful, resilient survivor.

129. Resilience is a protective factor – those of you familiar with prevention terminology will recognize that term and we talked about it earlier in the section on historical trauma. Protective factors are individual or environmental characteristics, conditions, or behaviors that reduce the effects of stressful life events. Validate that your client has already survived – they have tremendous strength and they can build on that to heal from the trauma they experienced. We want to build survivors up. And we can. YOU can! All of the work you do with survivors builds up resilience, which every one of us has.

130. A practical strategy in focusing on resilience is to use "strength-based" questions in your conversations with survivors. For example, these questions or statements might include:

- The history that you provided suggests that you've accomplished a great deal since the trauma.
- What are some of the accomplishments that give you the most pride?
- What would you say are your strengths?
- How do you manage your stress today?
- What behaviors have helped you survive your traumatic experiences (during and afterward)?
- What are some of the creative ways that you deal with painful feelings?
- You have survived trauma. What characteristics have helped you manage these experiences and the challenges that they have created in your life?
- If we were to ask someone in your life, who knew your history and experience with trauma, to name two positive characteristics that help you survive, what would they be?
- What coping tools have you learned from your _____ (fill in: cultural history, spiritual practices, athletic pursuits, etc.)?

131. Part of trauma informed care is to always be thinking about healing and resilience, and these strength-based questions are just an example of how you can do that in your everyday work.

132.  **Closing Activities: (15 mins) Play game, reflect, poster activity. Need index cards, markers, and 3 sheets of poster board.**

133. In your toolkit is a website called resiliencetrumpsaces.org. We could spend a day just on this topic. Since we don't have time for that today, we are giving you the information and strongly encourage you to get on that website. They have fun and practical tools you can use, even games. We are going to close our training today with one of these games, to end on a positive and resilient note!

134. Give instructions for playing the game.

135. **Give each person an index card** and ask them to write down the 2 most important things they learned today. Then ask them to write down how they plan to implement what they learned, and to circle which one they will do first. Then break them into a pair and have participants take just ONE minute to tell a partner what they've learned and how they will use it.

136.  *GROUP* Now break people into either 2 or 3 groups, depending on the size of the training. Give each group several markers and colored pencils and one sheet of paper from a flip chart. Explain that the task is to design a poster that summarizes the key points they've learned. There are rules: only pictures can be used, which includes graphics, symbols, icons, or diagrams but not words, letters or numbers; it has to be a joint effort, meaning that all team members should contribute; and the time limit is 5 minutes. 7)

137. Evaluations

138. Certificates

139. Thank participants!

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