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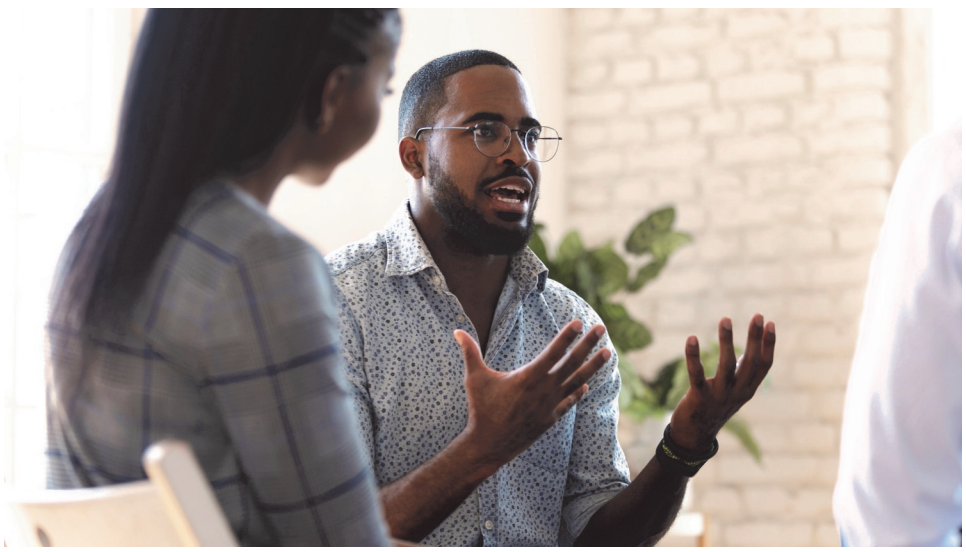
Trauma-Informed Care and Policy

Post-COVID Strategies to Achieve the Trauma-Informed Behavioral Health System We've Needed All Along

By Heidi Arthur, LMSW, Catherine Guerrero, MPA, Lawrence Fowler, and Mark Sasvary, PhD, LCSW



For decades, systemic racism has disproportionately routed Black and Brown children who have unmet behavioral health needs to congregate care and residential programs, and adults with these needs, to jails and prisons (Bronson & Berzofsky, 2017; National Conference of State Legislatures, 2021). Trauma is both a key driver and a compounding factor. Providers have grown accustomed to treating behavioral health needs that are both rooted in and buried by systemic disparities. Yet, many of those who have the greatest needs are not served by the delivery system we have today. We knew this before COVID further exposed the deep fissures in our systems.

The statistics are stark. Nearly 1 in 5 children and 1 out of 5 adults have a mental, emotional, or behavioral disorder, yet only about 20% of children who need services receive care from a specialized mental health care provider and only 65% of adults who have a serious mental illness receive mental health services (Centers for Medicare & Medicaid Services (CMS), 2018; Martini et al., 2012; National Institute of Mental Health, 2021; National Research Council and Institute of Medicine, 2009). Black and Brown populations face the most extreme barriers: Over 50% of Latinx young adults ages 18-25 who have a serious mental illness do not receive treatment (Mental Health America, n.d.; National Alliance on Mental Illness, n.d.). The rate is the same for Black and African American young adults ages 26-49 with a serious mental illness, but it climbs to 58.2% for those aged 18-25 (Artiga et al., 2020). In addition, a staggering 90% of Black and African Americans with a substance use disorder do not get care at all (Centers for Disease Control and Prevention (CDC), 2019). In 2018, 11.5 percent of Black and African Americans, versus 7.5 percent of White Americans, were still uninsured, despite the Affordable Care Act, and even those who can access services often receive treatment that is ineffective or inadequate (CDC, 2019; CMS, 2018; Frueh, 2009).

Trauma is a deep undercurrent. Children who experience trauma are at high risk for long term problems associated with mental health and physical health as well as problems related to socialization and quality of life (Hills et al., 2004). Experiencing trauma contributes to the development of severe mental illness (SMI) and individuals with SMI are at greater risk for PTSD and other negative impacts of traumatic experiences (Goodman et al., 2001). While targeted treatment, evidence-based practices, and social supports can contribute to positive outcomes, these services continue to be inaccessible to far too many people due disparities in the system.

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Utilizing Trauma-Informed Care to Address Trauma Reactions in Staff: Potential Impacts on Retention

By Crystal Taylor-Dietz, PsyD
National Director of Behavior Health Services, Devereux Advanced Behavioral Health

In our current sociocultural climate, we have been hearing the term "trauma" discussed more frequently, not only in healthcare, but in a variety of environments and social circles. This shift signifies a changing of the guard, as there is now a social and professional movement toward recognizing the many forms of trauma and its multi-systemic impacts.

According to the National Council for Behavioral Health, approximately 90 percent of individuals receiving behavioral health services have experienced trauma and, in the U.S., approximately 70 percent of adults have experienced at least one traumatic event in their lives. In addition, the National Council states that trauma is a risk factor for the development of various behavioral health and substance use disorders.

Adopting TIC models: The aforementioned statistics highlighted the need for the behavioral health industry to adopt Trauma-informed Care (TIC) models as best practice standards.

Organizations rooted in TIC focus on addressing trauma at every level, including the individuals receiving services and all staff. Focusing on one's trauma ensures proper interventions for individuals in care and helps prevent negative impacts on job performance and satisfaction among staff. Furthermore, research suggests a link between vicarious trauma and staff turnover, which likely contributes to workforce challenges and retention issues in human service organizations (Middleton and Potter, 2015).

Researching vicarious trauma in staff: While TIC models are highly researched, less attention has been dedicated to exploring how prevention, identification and management of trauma symptoms may impact staff retention.

Research on vicarious trauma in 1990, by McCann and Pearlman, was the start of focusing on the ways clinicians were psychologically impacted by working with trauma survivors (Edmonds, 2019). Vicarious trauma is defined as the unique transformation that takes place within the therapist who empathically engages an individual's traumatic experiences and their consequences (Branson, 2019; Pearlman & Mac Ian, 1995).

Today, vicarious trauma (VT) research has expanded to include other types of

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How the COVID-19 Pandemic Underscores the Need for Trauma-Informed Care

By Ann Sullivan, MD
Commissioner
NYS Office of Mental Health (OMH)

A traumatic experience can have long-lasting effects on a person's physical, mental and emotional health and well-being for decades afterwards; And the more traumatic events a person experiences, the more likely they'll have significant medical and emotional problems.

For the past 18 months, we've all shared in the trauma of the COVID-19 pandemic, which has disrupted our schools and daily lives, brought our economy to a halt, and taken the lives of friends, colleagues and loved ones.

Even before the pandemic, we'd seen an increase in awareness of how prevalent other types of trauma are, as well as the resultant psychological distress, mental illness, and substance abuse. Studies over the past two decades show that a vast majority of people seeking treatment for mental health issues and substance abuse disorders were exposed to significant emotional, physical, and or sexual abuse in childhood:

• The U.S Centers for Disease Control (CDC) report that one in four children experiences some sort of maltreatment – defined as physical, sexual, or emotional abuse;

• One in four women have experienced domestic violence; and,

• One in five women and one in 71 men have experienced rape at some point in their lives — 12 percent of these women and 30 percent of the men were younger than 10 years old when they were raped.

Dr. Ann Sullivan

Research has indicated that a majority of youth and young adults seeking help have experienced some level of trauma in their lives but have often been reluctant to talk about it. In addition, until recently, many models of care weren't prepared to address this issue.

After a traumatic event, one may experience shock or denial, which, in turn, can lead to sadness, anger, and guilt as the past intrudes into the present. People with trauma histories often use maladaptive coping mechanisms to help alleviate the psychic pain they are experiencing. Common examples are using drugs and alcohol, risk taking, over or undereating and engaging in self harm, such as cutting or burning. Survivors often express mixed feelings about dealing with trauma, even if they're fully aware of its impact. They may avoid revisiting their pasts or other potential therapy out of fear of experiencing distress again.

Trauma and the COVID Pandemic

Trauma has touched all our lives, in some manner, because of the pandemic. Many of us are still grieving the death of friends or family members and are experiencing the anger and sadness that can often accompany such loss. This trauma of losing a loved one is particularly difficult for children, many of whom are also struggling with how to handle the confusion, and uncertainty of returning to school after months of social isolation.

Recent research is confirming what every parent has suspected – and witnessed – during the last 18 months: that children and adolescents are probably more likely to experience high rates of depression and anxiety during and after social isolation. The research recommends that clinical services offer preventive support and early intervention where possible and be prepared for an increase in mental health problems.

Of course, isolation also affected older adults, who benefit greatly from social interaction but are often denied the opportunity to meet and talk with others under the best of circumstance. The pandemic made social interaction even more difficult, and potentially dangerous, for the elderly.

But no group was more traumatized by the virus than our first responders and health care personnel, many of whom experienced grief and despair as they lost patients and colleagues to the virus.

Respecting an Individual's Experience

The pandemic underscored the need for trauma-informed care, a system of practice that operates on the belief that services must be developed with the individual's perspective in mind. It recognizes that a survivor's perception of events plays a central role. This approach to care seeks to treat the whole person and address the past traumas that may have influenced an individual's sense of self and hindered their ability to connect with others and make use of support services.

Rather than applying a general approach to treatment, trauma-informed care focuses on each person as an individual. It recognizes that it is vital for each individual to participate in the development, delivery, and evaluation of services.

Precise care is taken to anticipate and avoid institutional processes and practices that could retraumatize a survivor. It shifts the focus from, "What is wrong with you?" to, "What has happened to you? What has worked for you?" Such use of language and choice of words can set the tone for recovery. Therefore, it encourages avoiding the term "victim" and using "survivor" instead.

Trauma-informed practice places importance on helping a survivor understand that their trauma is a normal reaction to a situation that was anything but. It helps them understand that their responses and behaviors often originate from a need to adapt as a means of coping.

More mental health practices are using

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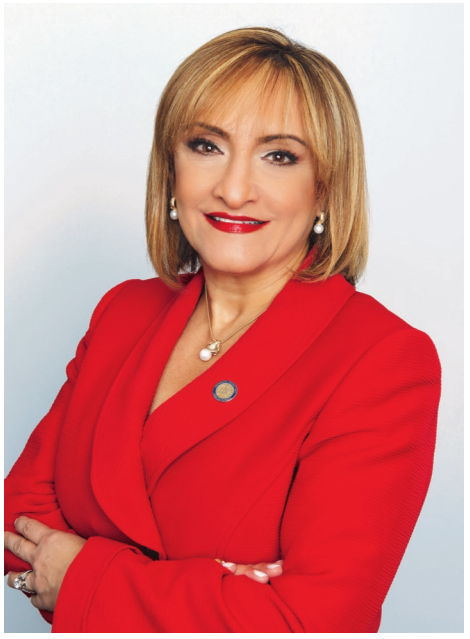
Facilitating Trauma-Informed Organizational Change: OASAS Trauma-Informed Care Champions

By Samantha P. Koury, LMSW, Susan A. Green, LCSW, and Maria L. Morris-Groves, MSEd

Last June of 2020, Arlene González-Sánchez, LMSW, Commissioner of the New York State Office of Addiction Services and Supports (OASAS) announced a partnership with the Institute on Trauma and Trauma-Informed Care (ITTIC) at the University at Buffalo School of Social Work. The goal of the partnership was to identify key leaders in the OASAS system to be "champions" of Trauma-Informed Care (TIC)." A total of 25 champions from 13 agencies across the state, and an additional 14 OASAS central office staff were selected to participate in a 7-month TIC learning collaborative. Recognizing the pervasive impact of trauma on individuals, families and communities, OASAS sought out the learning collaborative as means of paving the way for a trauma-informed approach which mirrors the model of using universal precaution. Universal precaution positions organizations to avoid unintentional re-traumatization (activation of trauma-related survival responses in the here and now) and therefore create opportunity for interactions and environments that can promote healing and growth.

With the coordination of an internal OASAS Team focus on Trauma and Trauma Informed Care, ITTIC facilitated the learning collaborative from June 2020 through January 2021 based on its Trauma-Informed Organizational Change Manual, which operationalizes planning, implementation, and sustainability of trauma-informed culture change (Koury & Green, 2020). In order to participate, the champions participated in an initial kick-off training, monthly full-team consultations, agency-specific coaching sessions and a wrap-up/graduation event all via Zoom. In between training and consults, the champions completed small assignments consisting of readings, videos and written reflection to begin making connections between their agency and the ten key development areas for trauma-informed change.



Arlene González-Sánchez, LMSW

The key development areas provide a flexible framework across three stages of implementation for organizations and systems to create their own tailored strategic plan that responds to unique strengths and areas for improvement. These key development areas (e.g., Leading and Communicating, Treating Trauma, Addressing the Impact of the Work, etc.) are based on synthesizing ITTIC's research and practice, the work of Dr. Sandra Bloom (2013), Maxine Harris and Roger Fallot (2001), as well as the 10 implementation domains that the Substance Abuse and Mental Health Services Administration (2014) recommends to guide trauma-informed organizations.

Trauma is universal and a growing public health concern that organizations and systems are increasingly recognizing the need to respond to. Trauma-Informed Care (TIC) is a system-wide paradigm shift that requires agencies and systems to acknowledge the high prevalence of trauma and align individual interactions and all levels of organizational functioning with the paradigm shift of "what happened to you" versus "what is wrong with you?" (Harris & Fallot, 2001). The trauma -informed approach is the overarching umbrella that provides the framework for all individuals, organizations and systems to engage in universal precaution: to assume that individual, systemic and historical trauma is likely to be present in any given individual's story, and thus responding to everyone in ways that prevent the possibility for re-traumatization.

"Being trauma-informed requires a commitment," says ITTIC Co-Director Susan Green. "Individuals need to commit to acknowledge how their self and world view influences their interpretation of present moments, and organizations need to commit resources to plan and facilitate an organizational strategy to maintain a basic understanding of trauma and adversity, consider workforce health and engage in trauma-informed practices."

The champions committed an average of 15-20 hours to learning how to use the guidelines and strategic plan for creating and ensuring a framework for trauma-informed approaches in their programs or agencies. Each month, the champions participated in learning, engaged in initial planning, and often implemented small action steps around two key development areas for trauma-informed change. The action steps in the agencies and programs represented in the collaborative often looked different.

"For example, one inpatient facility prioritized establishing a safe environment by completing a trauma-informed environment walk-through to identify possible triggers and make adjustments to create a more welcoming and safe physical space," explains Samantha Koury, the lead ITTIC trainer of the collaborative. "Another agency focused on reviewing policies and procedures by having intentional conversations about their intake and assessment processes and rules for the youth utilizing the services. Many focused on taking steps to train the workforce by incorporating resources shared in the collaborative in staff meetings, supervision and formal training sessions they facilitated. It was truly amazing to see so many champions not only make connections between the framework and their work, but also actually take small and large steps to realize it in their agencies."

One of the exciting things that has come out of the Collaborative is that participating providers have chosen to continue to meet and share resources and have scheduled and hosted the meetings on their own, inviting the OASAS Champions to participate, but not to facilitate the meetings. The ownership from the

see Champions on page 34

Trauma-Informed Care: Children in Crisis

By Amy E. Schmelz, MS, NCC
ICL

We know that most if not all of the people we serve at the Institute for Community Living (ICL) have experienced multiple traumas in the course of their lives. This is true for every ICL program, whether in behavioral health clinics and crisis services or housing for people living with mental illness and substance use or transitional shelters for almost 1,000 people experiencing homelessness.

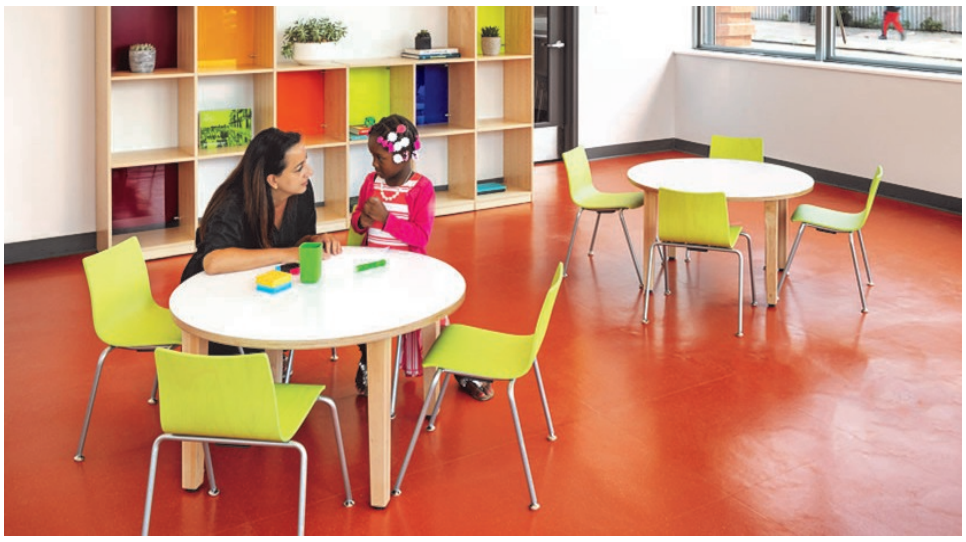
This article focuses on the use of trauma -informed care in treating children with serious mental health challenges who have lived through difficult social and emotional episodes throughout much of their lives. The combination of these factors impacts a child for the rest of their lives.

So how do we use trauma-responsive care and interventions with children, particularly in times of crisis and distress? We're looking here at two programs – the Family Resource Center (FRC) which uses a peer advocacy model and Livonia Residence which houses older youth and young adults who have lived in institutional care most of their lives and are working toward a more independent life.

Starting more than a decade ago, ICL incorporated trauma-informed care into all of its programs and services for children, youth and adults. We did so because we understood that a person's health and mental health are deeply affected by the complexity of their life experiences and those of generations before them. People we serve at ICL generally come from communities where poverty and lack of proper health care, nutritious food and adequate education (Social Determinants of Health) have led to serious, sometimes seemingly irreversible problems. Everything we do is aimed at trying to minimize the damage done and help people move toward a more fulfilling and healthy life.

What we see every day is the extent to which lives can be turned around through the use of trauma-informed care; that experience motivates us every day, no more so than in our work with children.

Whether participating in a clinical or housing program, our work starts with understanding what brought a family – and a child – to this point in their lives and addresses the combination of psychological, behavioral and educational factors we are able to uncover.



Working with children at the ICL East New York Health Hub

Generations of Struggles

"ACEs" -- Adverse Childhood Experiences – help to explain much of the reason a child or a family can benefit from trauma-informed care. These "adverse" experiences include physical, emotional, or sexual abuse and neglect, and household violence, as well as institutional or societal level of "abuse," such as racism or community violence, which contribute to serious and complex stress.

A trauma-responsive approach provides us with a range of interventions and supports for children living with "adverse experiences." The most effective way we can help children feel and do better is to reduce the sources of stress that so many of the families we work with are facing. This includes connecting them to resources that can help them meet basic needs – improved housing conditions, access to healthy food, educational support. At ICL, a whole health, whole-person approach to care also core to everything we do. Our focus on the physical health of families goes a long way in allowing them to address the emotional and mental health challenges their children may be facing.

When a child lives with multiple ACEs over time—particularly when they do not have supportive relationships with adults who provide protection—these experiences repeated over and over can lead to an extreme and long-lasting stress response. Over time the repetition can do great damage to one's health, resulting in physical problems (heart disease), social problems (poor academic achievement) and serious mental illness or substance abuse.

While trauma in children can have many causes, we commonly see it occur around loss, often unaddressed or untreated, whatever the cause of death may have been. Mary (not her real name), nine years old, came to ICL after she lost her mother to illness and had to relocate with her family to a new city, leaving close friends and other family behind. Helping Mary began with building rapport and trust with her and her family including acknowledging the way personal values and beliefs affect the way we provide care and how families do or don't accept care.

Mary worked with ICL's Family Resource Center which provides trauma-informed family support services to help caregivers meet the complex needs of children, adolescents and youth. These children have been identified as having emotional, behavioral, or mental health challenges affected by biological, psychological, or social factors, most often related to trauma.

Peer advocacy is key to FRC's support of caregivers and is also a critical part of our work with youth: Youth advocates are particularly effective working with peers who are living with the same kinds of serious mental health and emotional challenges they have faced. This sense of connection is so important in making trauma-informed care effective.

Mary's loss of a parent caused significant emotional and mental stressors. Leaving a comfortable and safe community of family and friends exacerbated these problems. When she first came to FRC, Mary struggled to open up and share her feelings. This led to isolation and withdrawal, which Mary's family feared would prevent her from managing her emotions and be able to cope with everyday demands like school and relationships with peers. Untreated trauma can make building healthy relationships with others difficult if not impossible.

When we met Mary, she had extremely low self-esteem and difficulty with social skills. All that she was going through was exacerbated by having to live with the pandemic. She told us how difficult it was not to be able to see friends because of COVID-19. This forced isolation reduced the already limited emotional sharing Mary had been doing and made her feel even sadder. The family was concerned Mary's situation would only get worse as the pandemic wore on.

Mary has made incredible strides in improving her mental health thanks to her being part of FRC programs, most importantly as a participant in youth support group and meeting regularly with her youth advocate and attending sessions with a trauma-informed therapist individually and with her family. Her family has shared that Mary's work with her therapist on her emotional regulation has been a huge part of her recovery. Her work with her youth advocate and peers have had a very positive impact on Mary's mental health and sense of well-being.

Today Mary talks about her love of art and music. She hopes one day to be a music therapist so that she can help other children who have struggled with so many difficulties in their young lives.

Addressing the Unique Challenges for Youth

Livonia is a residential setting that works with Transition Age Youth (TAY) 18 to 24 years old. We work to support their journey toward mental health recovery as well as build on their ability to live independently and successfully in the community. Like all other ICL programs, Livonia is grounded in a trauma-informed care, recognizing the population there as highly vulnerable and will benefit from an empirically supported approach that leads to safe and effective recovery.

Diana (not her real name) currently resides at Livonia. Diana has a long history of trauma and adverse experiences involving physical and emotional abuse and struggles with depression and bouts of self-harm and suicidal ideation. She has struggled with anger and believed she would never be able to control her impulses and urges. Diana often felt that "no one understood" what she was going through and how she was feeling.

Since working closely with her case manager at Livonia, as well as a youth advocate at the FRC, Diana says she is better able to connect with her peers and feels a greater sense of being heard and understood. She has reported that this is the first time that she has felt hopeful that she can grow and progress toward independence in the community.

Reducing a Lifetime of Stressors

For children whose lives have been seriously compromised by adverse life experiences, we see at both FRC and Livonia how the support of a mental health team as well as a peer advocate can have a very positive impact. Another way we approach children whose lives have been marked by trauma is to teach self-care activities including meditation and mindfulness, physical exercise and sports, and exposure to music and art. Pre-pandemic, an annual trip to see a holiday extravaganza at Madison Square Garden was something that parents, caregivers and kids alike loved to take part in. A break from the stress in their lives means a lot to those who participate and represents an indirect way to treat the effects of trauma.

Connecting families to other forms of trauma-informed care support for their children include making referrals to things like occupational, speech and language therapy, family therapy and less known but highly effective tools in trauma treatment such as Eye Movement Desensitization and Reprocessing Movement (EMDR), use of music and other forms of artistic and creative expression, and even animal-assisted therapies.

At FRC, we have built a large referral network of community supports who also recognize the importance of trauma-informed care. Brooklyn Creative Arts Therapy; Community Counseling and Mediation; Brooklyn Perinatal Network; and YAI are just a few of the exceptional resources we refer to regularly. Beyond connecting to vital clinical support grounded in understanding traumas our families have lived through, we work to help families build relationships with caring individuals in all parts of their lives – their family, community, and even their heritage.

While people of all ages and social strata have been affected by the pandemic, and the majority are suffering with mental health challenges as a result, the impact on children and youth has been most severe. Many believe the collective impact

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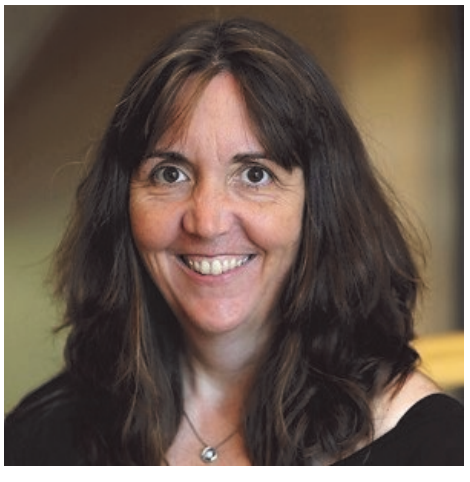
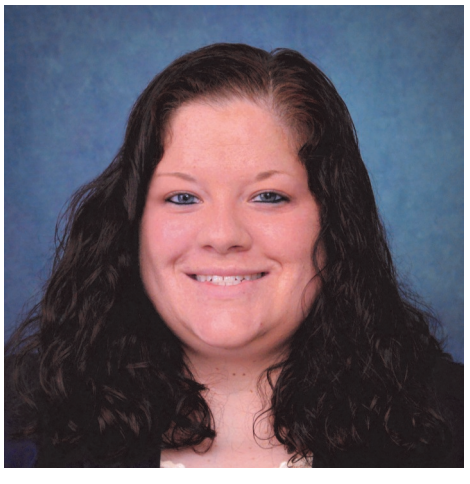
Integrating Trauma Informed Care into Organizations Serving Individuals with Intellectual Disabilities

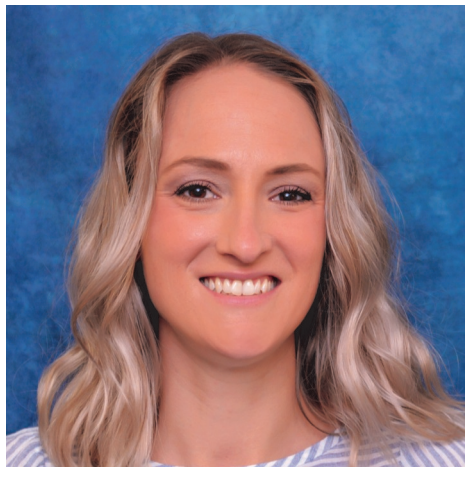
By Mary Jane Weiss, PhD, BCBA-D, LABA; Jennifer Mucellin, MA, BCBA, and Jennifer Ruane, MS, BCBA, LPC Melmark



Mary Jane Weiss, PhD, BCBA-D, LABA



Jennifer Mucellin, MA, BCBA



Jennifer Ruane, MS, BCBA, LPC

In recent years, there has been a large focus on understanding how trauma interacts with other factors to create unique vulnerabilities in people. Individuals who have experienced intense or frequent adverse childhood experiences (ACEs) exhibit more health and behavioral difficulties throughout their lives (e.g. Centers for Disease Control, 2016; Felitti, et al., 1998; American Psychiatric Association, 2013; Substance Abuse and Mental Health Services Administration, 2018). Traumatic events include: neglect, experiencing or witnessing physical, sexual, and/or emotional abuse, living with a family member with substance addiction or severe mental illness, and losing a family member to death, incarceration, or abandonment (ACES, 1997). Indeed, these events have been identified as being associated with traumatic risk, especially in the context of understanding the lingering effects of trauma across the lifetime. Those with a strong history of ACEs may have higher incidences of challenging behaviors in school, may have an increased risk for drug abuse in adulthood, and may be at high risk for negative health consequences and premature death (e.g. Szymanski & Conway, 2011; SAMHSA, 2018; CDC, 2016). Mental health professionals have been discussing the impact of ACES and of trauma on many different populations, including children. Many school and family counselors work to support individuals with these histories and with their families to support them safely (Hunt, Slack, & Berger, 2017).

This awareness has been extended to individuals with disabilities. There is an increased incidence of ACES in individuals with intellectual or developmental impairments. Indeed, the lifetime rate for these events among those with disabilities is three times that of the general population (Horner-Johnson & Drum, 2006). Underreporting is also likely, given the communicative deficits associated with disabilities (Horner-Johnson & Drum, 2006). So, individuals with autism and other developmental disabilities are at great risk for adverse events that can be traumatic, and for the long-term effects of trauma. This is a relatively new focus for most service providers who specialize in the treatment of individuals with autism.

A set of approaches known as trauma-informed care (TIC) has been proposed to address the unique needs of individuals who have this history. TIC advises taking past ACEs into consideration in assessment and treatment planning. TIC is a philosophy of care, leading to a cultural change in the delivery of intervention and the treatment of clients (SAMHSA, 2018). Professionals using TIC are encouraged to

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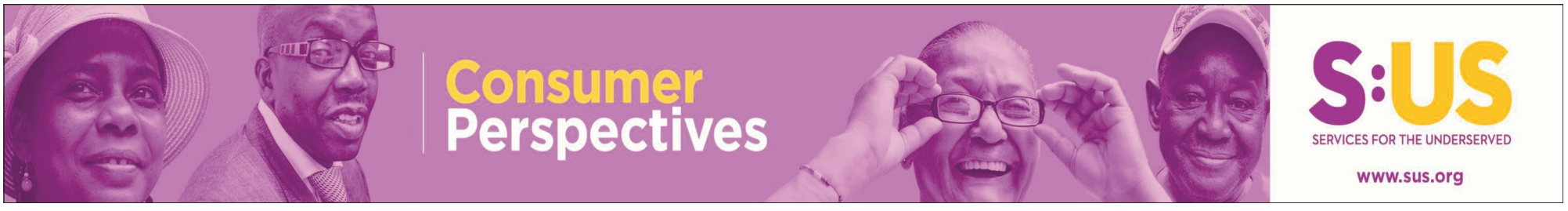

Housing and Mental Health Services Are Key to Recovering from Trauma

By Elfreda, Eugene, Larry, Raymond, and Timothy

This article is part of a quarterly series giving voice to the perspectives of individuals with lived experiences as they share their opinions on a particular topic. The authors are served by Services for the UnderServed (S:US), a New York City-based nonprofit that is committed to giving every New Yorker the tools that they can use to lead a life of purpose.

We are five New Yorkers who come from different backgrounds and have all experienced trauma in our lives. Most of us have mental illness, some of us are recovering from substance use or incarceration, some of us have been homeless and lived in shelters, and all of us have struggled over the past year because of the COVID-19 pandemic.

We all receive services from S:US -- ranging from housing to mental health support to employment assistance. S:US is a trauma-informed agency, whose services are designed to support people like us who experienced a crisis or trauma situation. That's clear in how S:US treats us, and in their high-quality person-centered services, and the safe housing and environments they provide for us.

Difficult Experiences

If you are experiencing trauma, the last thing you want is for a well-intentioned person who is trying to help you to actually make matters worse. No one is immune to the impact of trauma. It affects individuals, families and communities. It can disrupt healthy development and relationships, and lead to mental health issues including substance use, child abuse and domestic violence. Many individuals who have experienced trauma, like us, fail to get the help they need because their symptoms/behavior are misinterpreted, or their efforts to get help may fail when those seeking to help them are not sensitive to their trauma.

Hear Our Stories of Trauma on The Road to Recovery

"I recently contracted COVID-19. I lost my job because of that. I lost my father, my aunt and uncles, and my very close friends to COVID. I wasn't playing, I went and got vaccinated," Raymond shared.

"The pandemic reminds me of being incarcerated. I remember when we had the bird flu scare and 19 people died in the jail. I didn't come out, I stayed in my cell. I saw a lot of healthy young people die. That was a wake-up call. I would prefer my freedom over incarceration any day of the week. But if I have to stay inside my apartment, it's what I have to do. I can We've experienced trauma in the past and several of us found the pandemic to be devastating. The isolation reminded us of incarceration. We have experienced loss because of COVID-19. We've struggled with substance use and a few of us have experienced homelessness.

deal with that. Being away from society as a whole is devastating. You don't witness children growing up. You have to gradually re-integrate into life," Larry said.

"This pandemic has been a devastating experience. I never thought I'd have to be living like this. There were a lot of people I knew who didn't make it through the pandemic. Every day I wake up, I give thanks that I am here to see another day. It's a traumatic experience right now," Larry added.

"I have a one-and-a-half-year-old son I'm trying to take care of. With no job. Paying for daycare. We're just barely surviving on unemployment and food stamps. That's a traumatic experience every day. I only changed my life because of my son. I wouldn't be able to change my life if S:US didn't provide a roof over my head," said Raymond.

"I moved to New York when I was 14 to live with my father who I had never

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Promoting Post-Pandemic Growth

By Jenna Velez, LCSW
Vice President External Affairs
The Mental Health Association
of Westchester

Post-pandemic life is at the forefront of most people's minds right now. How could it not be when it reaches into every corner of our lives? Post-pandemic socialization, employment, childcare, recreation; the list goes on and on. It is not uncommon to hear people talking about a return to normal, often with wistfulness and a sense of relief. While many things will look and feel like they did two summers ago, let's not forget that things will never be quite the same. Having experienced the widespread trauma of a global pandemic and all the losses associated with that, amidst the spotlight that was shone upon the racial injustice in our country, we will not and should not return to the status quo.

Last year, in the Summer edition of *Behavioral Health News*, I wrote an article entitled Priming for Post-Traumatic Growth. In the midst of a crisis we will rightly focus on survival; it's what our bodies are designed to do. It is not the time to put pressure on ourselves to change our lives or start a self-improvement mission. The point of priming is to prepare ourselves to be in a position to do so. As we move into the post-pandemic phase, for many this will be the prime opportunity to

Jenna Velez, LCSW

start promoting post-traumatic growth. At the very least it is an opportunity to seize upon the lessons learned in the last year and a half. An opportunity to NOT return to normal.

Let me be clear here that the term post-pandemic does not suggest that it is all behind us. There is an accumulation of grief and loss that will be with us for some time to come. It has changed the way we think about our own lives, our perceptions of safety and control, and how we regard the world around us. However, it is just as valid to say that there is an accumulation of benefits and gains, which if capitalized upon can lead to new purpose and appreciation in our lives.

Post-traumatic growth as a concept was identified by psychologists Richard Tedeschi and Lawrence Calhoun in the 1990s and is defined as positive psychological change that some individuals experience after a life crisis or traumatic event. Their research pointed them to five domains of growth, including personal strength, greater appreciation for life, new possibilities, relationships with others, and spiritual change. The primary way this happens is through the process of creating a narrative around our thoughts and emotions. This does not mean "silver lining" those thoughts and emotions, but rather acknowledging the changes that have occurred in our mindset, embracing some of those as positive, while accepting that the negative can co-exist. Experiencing post-traumatic growth is an active process that requires our participation, so how can we go about promoting this in ourselves and others without unintentionally intimating that it should look the same for everyone?

In a trauma-informed organization there is attention and attunement to the ways in which trauma and adversity impact staff. The pandemic brought a shared and collective trauma with varying degrees of impact, and while we are not responsible for treating trauma in our staff, we can create environments that are responsive to it and prevent potential re-traumatization. Creating opportunities to engage and activate growth as an agency has the potential to positively impact both individuals and the collective organization. Since we know that storytelling and narrative development are keys to the growth process, there are simple ways to incorporate this into the work environment.

Engaging staff in conversations that lead to reflection on their thoughts, emotions and experiences in the last year is a simple strategy. Given that we know growth does not occur in the absence of adversity, these reflections need to include what has been most difficult or challenging, including the major losses that one might have experienced in the last year. Without moving too quickly through the negative impact, the conversation can then shift to acknowledging the good that emerged, including lessons learned and positive outcomes. Lastly, we want to encourage contemplation on the future, specifically how the future might look if we take our lessons learned with us versus leaving those lessons behind. Going through this process allows individuals to start shaping their narrative and envisioning how they want all that has happened to impact their futures. Continuing these conversations also allows for the narrative to evolve as learning becomes incorporated into each person's "new normal."

Creating an environment for narrative development does not have to be

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Implementing Trauma-Informed Care is a Journey, Not a Project

By Nadine Akinyemi, MHA, and Esther W. Y. Lok, MEd, MPA, PMP
Bridging Access to Care

Studies show that the prevalence of trauma is ubiquitous and can create adverse health outcomes for individuals. As the first HIV/AIDS organization in Brooklyn, New York, Bridging Access to Care (BAC) works with high-needs individuals in New York City who have trouble coordinating their healthcare. Established in 1986, BAC is a community-based organization providing an array of services to low-income individuals, families, and communities of color throughout New York City, including the homeless, substance users, mentally ill, and previously incarcerated.

Behavioral health organizations like BAC continue to address systemic challenges – homophobia, racial discrimination, stigma, and other social injustices – that persist and retraumatize the clients we serve. Although BAC has been adaptive and responsive to their varying needs through expanding our scope of services, BAC leaders recognize the effect of trauma on our clients' overall wellbeing and the struggle of our staff in reducing barriers as a result of trauma. Moreover, many staff and clients had trouble understanding how trauma-informed care connects to better health outcomes. These findings motivated BAC to embark on a

Nadine Akinyemi, MHA

Esther W. Y. Lok, MEd, MPA

remarkable journey in 2014 to reset the organizational culture through a trauma-informed care (TIC) lens.

Defining the Purpose and Plan

BAC's initial organizational culture change had the overarching goal of routinizing trauma-informed care using trauma -sensitive approaches to deliver daily service and augment care plans with trauma-specific objectives. BAC leaders determined that using the measurement-based care (MBC) approach would allow us to measure the realized value of health outcomes—How well the client is doing. MBC systematically uses standardized, validated symptom assessment tools and behavioral health functional rating scales to drive clinical decision-making (The Kennedy Forum, 2015). According to The Kennedy Forum, rating scales optimize the accuracy and efficiency of symptom assessment to improve the detection of patients or targeted populations not responding to the current clinical interventions.

Using the MBC framework, BAC began to connect the dots from symptoms, diagnosis, and function to the effects of the social determinants of health on individual wellness outcomes. MBC empowers providers to change or fine-tune treatment plans more quickly when patients are not improving. In addition, patients who regularly complete rating scales are more likely to increase their knowledge about their disorders, become attune to their symptoms, and be mindful of the warning signs of relapse or reoccurrence. Thus enabling them to better self-manage their symptoms or illnesses and seek treatment earlier.

Innovate, Test, and Evaluate

The implementation of TIC at BAC has required an enormous amount of research, testing, training, re-training, and evaluation. BAC leveraged technology to create a systematic approach. One of our desired outcomes was to develop a system for sharing information in real-time to facilitate access and retention in care. We also wanted to design a system that would enable trauma-informed care routinely across our agency.

Our strategy was to incorporate best practices and various screening and assessment tools in the electronic health record (EHR) system to help inform and guide staff in delivering trauma-sensitive activities. The EHR could capture specific data and trend changes in our clients' health outcomes. Specifically, BAC identified validated screening and assessment tools that were easy to use, have met industry standards, and were recognized by payors. In collaboration with our EHR

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Secondary Traumatic Stress: A Key Piece of the Conversation

By Amy Petersen, LCSW
Program Director of Children and Family Treatment and Support Services, Vibrant Emotional Health

The personal impact of being in the helping profession never crossed my mind when I was in graduate school on my way to becoming a social worker. My focus was on gleaning what I could from my professors and building what I hoped would be the most complete set of clinical skills. I was unaware at the time of how much of a toll the work would take on me.

Secondary traumatic stress is often mentioned as an afterthought and placed as the last item on the agenda if it makes it on at all. When it is discussed, the emphasis is often on individual practices of self-care and personal steps to be taken outside of working hours to avoid burnout. Graduate schools often overlook teaching students about the warning signs of secondary traumatic stress and miss the opportunity to highlight the impact that it can have on individuals, teams, and mental health organizations more broadly. In turn, the field has not yet understood the importance of secondary traumatic stress as a key part of strong clinical training. Yet, in order to foster resilience amongst providers and promote a healthy organizational culture, it is crucial to incorporate a robust discussion of secondary traumatic stress (STS).

Amy Petersen, LCSW

Just a few years after entering the field with excitement and optimism, I began to experience what I now know as the signs of STS. I saw these were signs not only in myself but in many of my colleagues and friends across the field. The daily weight of our work in hospitals, shelters, schools, or with survivors of abuse was starting to take its toll in both obvious and subtle ways. And yet, the impact that our line of work was having on us was rarely, if ever, discussed.

As I noticed my own warning signs - hypervigilance, anxiety, a sense of helplessness in the face of patients' suffering, just to name a few - I saw that my STS took a toll on my interactions with clients and colleagues, my personal relationships, and my own sense of well-being.

Everyone responds differently to STS. It can manifest itself cognitively (e.g. difficulty concentrating, preoccupation with traumatic content), emotionally (outbursts of anger, feelings of hopelessness, numbness), behaviorally (isolation, overactivation), or physiologically (sleep or appetite disruptions, frequent illnesses) (Administration for Children & Families, n.d.).

At an individual level, STS may be easy to spot. Much like a check engine light that signals to the driver of an underlying issue, certain clear signs may allow the person to recognize their own heightened stress. Alternatively, it may be difficult for the impacted person to recognize their own traumatic stress, more like a broken taillight that requires an external party to point out the concern to the driver. They may need a supervisor, friend, or family member to reflect back on their observations of how the person is being visibly impacted by the work.

Though I saw the signs, it took me some time to recognize these as symptomatic of secondary trauma. At first, I wondered what was so wrong with my friends outside of the field for not caring as deeply as I did about suicide prevention, why they did not scan the subway as cautiously as I did for people at risk of jumping onto the tracks, and why they did not feel an overwhelming sense of responsibility for the emotional well-being of their fellow subway riders during their morning commute. It was not until my friends and family highlighted the warning signs to me that I began to realize the degree to which it was impacting my daily life.

I took the steps I needed to recover; however, I could not help but look back and notice how little STS was talked about on the job. While my peers in the field often shared my experience of daily encounters with severe trauma and behavioral health crises, the daily exposure to trauma and suffering was no longer an exceptional event, rather a constant and repetitive one. In turn, our own chronic stress and the weight of patients' traumas were normal, perhaps even invisible, to us. Though we would eagerly advise our own patients to pause and reflect on their own experiences, needs, and well-being, we were often slow to do the same for ourselves.

Our field has a number of risk factors that make us prone to ignoring the signs and realities of secondary trauma - a preference for helping rather than being helped, tight budgets that make for few margins with our time or finances, and an increased demand for services as mental health needs grow globally.

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Five Lessons Learned in National Trauma-Informed Care Training

By Yael Lipton, MPH, MCHES, and Andrew Philip, PhD
Primary Care Development Corporation

Over decades of practice-informed research, clinical support, and advocacy, a gradual embrace of trauma-informed care as a fundamental component to quality health service delivery has emerged. Every patient has a story- a context, and a set of experiences- that impact their health and wellbeing, including their interactions in healthcare. When trauma, and particularly adverse childhood experiences, are a component of our patients' stories, we see a correlation with worse health outcomes and greater barriers to overall wellbeing. The healthcare delivery system must and can account for this awareness through provision of trauma-informed care.

Primary Care Development Corporation (PCDC), a national nonprofit based in New York, is dedicated to enhancing health equity through advocacy, investment, and technical assistance. After training hundreds of healthcare professionals across the country about addressing the impact of trauma on patients and communities, we have observed consistent patterns in what may help or hinder organizations as they become trauma-informed.

1. Trauma-informed care uniquely 'hits home' for healthcare staff. Like anyone,

Yael Lipton, MPH, MCHES

Andrew Philip, PhD

healthcare professionals may have experienced some form of trauma themselves. A key difference, however, lies in the frequency of responding to the needs of patients with trauma, and the significant potential for experiencing vicarious traumatization. This experience, be it in working with clients in processing traumatic memories or responding to medical emergencies amidst the anguishing circumstances of the COVID-19 pandemic, is uniquely persistent in healthcare service.

Calling out clinicians and other staff engaged in these experiences superheroes has perhaps ignored the humanness of being a caregiver, but there does seem to be value in recognizing staff experiences with trauma. For staff that bear witness to the impacts of trauma, understanding the phenomenon of trauma and appreciation for incorporating trauma-informed principles like safety and trustworthiness are almost innate. Most health professionals still need training and support in operationalizing trauma-informed care, but we have seen powerful motivation to implement trauma-informed principles activated when we recognize existing awareness of trauma. With this experience, however, it was not uncommon in both national webinars and in-person trainings, for care managers, therapists, nurses and others to acknowledge personal trauma during training discussions. While not the goal of trauma-informed care trainings, sharing revealed that many healthcare workers need and crave safe spaces to discuss their clinical cases, but also to process their own experiences including trauma.

2. Trauma-informed care begins with trauma-informed organizational practice. Trauma-informed care needs to flow from leadership and throughout the healthcare organization to consistently reach clients or patients. In even the most well-resourced organizations employing incredibly talented and dedicated staff, we have seen healthcare professionals that are burning out and struggling to stay afloat. Most often, this has not been due to a lack of self-care by employees, but a combination of demanding work with insufficient support.

It is unrealistic for organizations to expect their staff to practice trauma-informed care if they are not working in a trauma-informed organization where they experience emotional support, realistic

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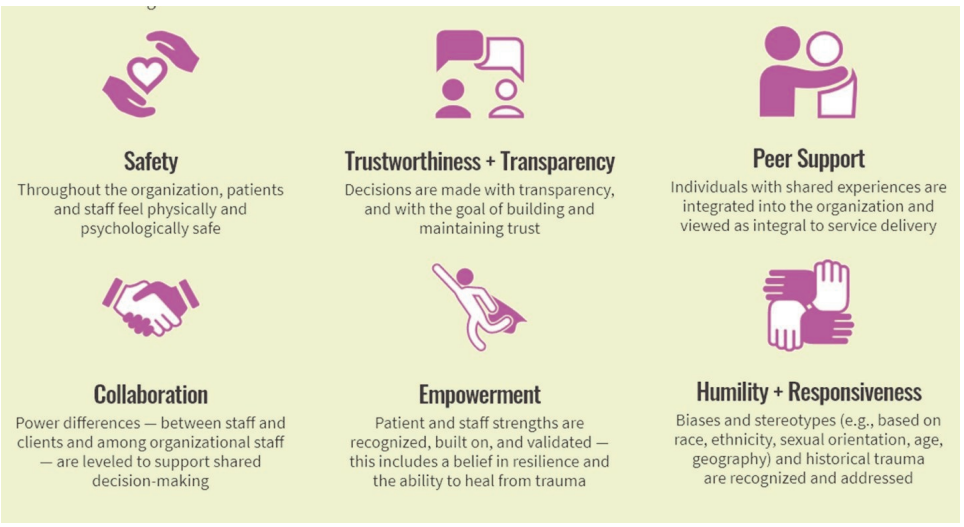
Trauma-Responsive Care: Beyond Mental Health

By Elizabeth Fitelson, MD, and Obianuju O. Berry, MD, MPH

In a disaster, the psychological 'footprint' greatly exceeds the size of the medical 'footprint' (J.M. Shultz, 2010).

While much of the United States is focused on "reopening" and going back to in-person work, school, and social activities, with images in the news of joyous reunions of families and friends, there is the shadow of yet another COVID-19 wave entering our awareness: the mental health impact of the pandemic and its individual, family, and community consequences. As the country and world come to terms with both the collective trauma of this pandemic and its inequitable outcomes, it is more important than ever for psychiatrists to understand the role of trauma in behavioral health disorders, and to work to mitigate its impact for our patients both in our clinics and beyond. The basic principles of trauma-informed care (TIC) should serve as a guide to rebuilding and reimagining our systems of care to meet the surging needs of Americans acutely affected by the pandemic, as well as those whose experiences of violence, abuse, neglect, bias, loss and poverty have long predisposed them to both mental health disorders and revictimization by the systems that are supposed to help. As psychiatrists, we have an understanding of trauma from a neurobiological and psychosocial perspective. This understanding can help us not only as we treat the mental health consequences on an individual level, but also in partnering with the organizations, groups, and institutions that our patients interact with outside the health care system.

SAMHSA defines traumatic experience as "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being." (SAMHSA 2014) This definition is intentionally broad; most Americans continue to be affected by some aspect of the public health, social and political upheaval of the last year that has been physically or emotionally harmful. Of course only a small minority of individuals will develop PTSD. But as the country moves on and the economy recovers, the people left behind are likely to be those most affected by the pandemic trauma – those with adverse childhood experiences, with prior mental illness, those affected by gender-based violence, the chronically discriminated against, those already living close to the edge of the cliff of good health . In other words, our patients.



Trauma-informed care demands that we recognize the widespread impact of trauma not just on our patients but also in their families, in our staff and colleagues, and in our own lives. As psychiatrists we also must understand that the paths for recovery do not always fall neatly into medical models of treatment that are prioritized in insurance-based payer structures. Our patients' struggles do not only present in our offices and clinics. We should seize the opportunity of this moment of rebuilding to re-think systems of care. What would care look like if it integrated the basic principles of TIC: safety, transparency and trustworthiness, collaboration, empowerment, humility and responsiveness, and peer support into all the institutions with which our patients interface? (see chart above - SAMHSA, 2014).

Psychiatry can have a positive role in advocating for trauma-informed services. Several years ago, we partnered with New York City to create a model of psychiatric care integrated into the five Family Justice Centers administered by the NYC Mayor's Office to End Domestic and Gender Based Violence (NYC ENDGBV) (Weiss 2017). These centers, adjacent to the District Attorney's offices, host social services, civil legal, counseling, and advocacy-based organizations and agencies dedicated to helping survivors of domestic violence and sex trafficking. Through this work we discovered that this type of partnership between mental health and service -oriented systems outside of health care not only reduces barriers to care for individuals but enhances the potential for positive impact of both psychiatric care and advocacy. For example, trauma-impacted clients frequently seek legal assistance at times of highest stress, when they are most vulnerable and emotional. In practice areas such as family law, immigration, child welfare, criminal law and others, by necessity, clients must share some of the most intimate and painful details of their lives at a time when the stakes are highest to a system that is likely to misinterpret the manifestations of traumatic stress as defects of character or admissions of guilt. Mental health practitioners know that working with patients who are survivors of interpersonal and sexual violence demands that we manage our own emotional reactions to confronting violence and its effects while at the same time offering sensitive and responsive care. We also learn how trauma impacts the nervous system, attachment models, and perceptions of safety and threat. Understanding of the role of transference and countertransference is an essential component of our training. However, our colleagues in the legal and criminal justice systems often do not have the advantage of this baseline understanding.

Earlier this year, our team partnered with the NYS Office for Victim Services as well as the New York Legal Assistance Group to provide a training series to legal professionals entitled "Trauma-Responsive Lawyering." The training covered the intersection of mental health and trauma, the neurobiology of trauma, revictimization, grounding tools, safety assessment, vicarious traumatization, and working with marginalized populations. Goals of the project included educating legal professionals to identify and define trauma, vicarious trauma, and trauma reactions; recognize and understand concrete strategies and practices for mitigating the impact of primary and secondary trauma; and comprehend and implement simple self-care practices and coping strategies while working with crime victims and their families. The sessions combined didactic instruction and interactive components ranging from polls, Q&A, discussion, and breakout sessions. Overall, 522 people registered for the course. It was clear based on participation levels of attendees and feedback following each session, that legal professionals are eager for continued trainings on these issues. This was one of the only trainings to our knowledge that was co-led by both mental

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A Trauma-Informed Community Approach to Bullying

By Jonathan Keigher, PhD
Vice President, Chief Clinical and Compliance Officer, New York Psychotherapy and Counseling Center

As the largest mental health clinic provider in the South Bronx, New York Psychotherapy and Counseling Center (NYPCC) therapists have witnessed an influx of traumatized children struggling with bullying in city schools. Indeed, New York State Education Department statistics show that bullying is a significant problem in NYC public schools. During the 2017-18 academic year, NYC public schools reported 5,875 incidents of harassment, discrimination and bullying and 1,242 incidents of cyberbullying. The most recent data available from the State Education Department confirms that bullying in NYC public schools is on the rise. In the 2019-20 academic year, there were a record-high 8,475 incidents of harassment, discrimination, and bullying, as well as 1,864 cyberbullying incidents (NYSED, 2020). These statistics may be an underrepresentation of the issue, as the National Center for Education Statistics (2021) reported that 22% of students aged 12-18 faced bullying at school during the 2019 school year.

Bullying involves unwanted, aggressive behavior among school-aged children (U.S. Department of Health and Human Services, n.d.). To be considered bullying, the behavior must be repeated, or have the potential to be repeated. The bullying must also involve a real or perceived power imbalance between the child who bullies and the child who is bullied. Bullying activities can include spreading rumors or embarrassing a child to hurt their reputation or social standing, making threats of violence, physical or verbal assaults, or purposely excluding a child from a group.

Bullying affects the physical and emotional well-being of both the targets of bullying and those who engage in bullying behavior. According to the Centers for

Jonathan Keigher, PhD

Disease Control and Prevention (2019), students who are bullied are at increased risk for social and emotional distress, self-harm, depression, anxiety, sleep problems, lower academic achievement, and dropping out of school. Bullied students have decreased academic performance and school participation. Students who bully are more likely to engage in violent or risky behaviors into adulthood. Markota et al. (2018) even found that ongoing bullying is significantly associated with increased rates of pediatric psychiatric rehospitalizations. Bullying also has long-lasting mental health outcomes. Many adults still experience the mental impact of having been bullied as a child, even decades after the bullying (Takizawa et al., 2014).

At NYPCC, clinicians approach bullying through a trauma-informed lens, recognizing that bullying impacts everyone involved in the bullying experience. During intake, therapists use evidence-based, culturally responsive assessments to evaluate all clients for traumatic exposure at the individual, family, and community levels. Therapists help the client establish physical and emotional safety and collaborate with family and community members to foster partnerships that are safe and supportive. Therapeutic interventions frequently focus on promoting social-emotional growth and building mental health supports to counter the isolation caused by bullying and other traumatic experiences. Therapists help build resiliency, empower clients to make thought out choices and instill hope. Self-regulation and social skills are practiced with an emphasis on empathy, assertiveness, and problem solving as the building blocks for bullying prevention.

NYPCC recognizes the complex impact trauma has on both patients and providers. All NYPCC therapists who treat bullying and other traumas do so under supervision that is based on the principles of recovery, mindfulness, and trauma-responsive care. Key elements of clinical supervision at NYPCC are ensuring workforce safety and promoting therapist resilience. Supervisors support clinicians to prevent re-traumatization by recognizing early signs of compassion fatigue and secondary traumatic stress. This maintains our workforce's effectiveness and helps retain the talent needed to care for the community.

Given the effectiveness of systems-level interventions and the need to target the social contexts of bullying to reduce bullying behaviors, NYPCC founded the Bronx Anti-Bullying Coalition to engage the community in anti-bullying education and prevention efforts using a trauma-informed approach. NYPCC established the Bronx Anti-Bullying Coalition in 2018 in conjunction with Bronx Legal Services, Union Community Health Center, Vibrant Emotional Health, and Destination Tomorrow. The Bronx Anti-Bullying Coalition was launched to create awareness of the signs of bullying, help children and parents learn strategies to deal with the problem, and connect families with support resources. NYPCC's community outreach team led group meetings and discussions with community partners to create a series of safe havens for children who have been bullied throughout NYC. Parents, educators, and clinicians learned how they could help raise awareness about the dangers of bullying and effectively intervene to stop bullying. NYPCC's outreach team utilized a trauma-informed framework to promote childhood trauma awareness and to increase understanding of how trauma affects children's learning and behavior. The outreach team helped to strengthen the resilience and protective factors within families, schools, and communities and pushed for meaningful collaboration across healthcare and school systems. NYPCC raised bullying awareness and streamlined access to resources on trauma exposure, its impact and treatment for teachers, principals, guidance counselors, clergy, parents, and community leaders. NYPCC's clinicians and outreach team identified bullying as a significant problem for our clients and for the larger community we serve. NYPCC's anti-bullying coalition responded with a trauma-informed approach to meet community needs with education, prevention, assessment, and treatment options.

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On Becoming Trauma-Informed: It Takes a Village

By Ashley Brody, MPA, CPRP
Chief Executive Officer
Search for Change, Inc.

Healthcare and social service providers who aim to promote optimal health and wellness among the populations they serve cannot achieve their objectives unless they address the impact of traumatic life events (both past and recurring) on vulnerable individuals. The landmark Adverse Childhood Experiences (ACE) study offered compelling evidence of this (Menschner & Maul, 2016), and it is consistent with other research findings that suggest Social Determinants of Health (SDoH), the conditions in which we live, learn, work, grow, and affiliate with others, are more determinative of health outcomes than traditional healthcare services (Bernazzani, 2016). Although the research literature treats trauma and SDoH separately for conceptual purposes their interrelationship is indisputable. That is, certain life conditions, such as poverty and economic distress, physical and emotional abuse or neglect, racism and other structural inequities, among many others, are inherently traumatizing for many and can produce or perpetuate behavioral health disturbances. Thus, providers must mitigate the effects of trauma on those entrusted to their care. Perhaps more importantly, they must avoid practices that are retraumatizing for service recipients or inflict vicarious trauma on their personnel.

Ashley Brody, MPA, CPRP

These are seemingly Herculean tasks for providers who face other significant obstacles to the fulfillment of their missions. Chronic underfunding and enduring human resource constraints (specifically related to the recruitment and retention of qualified personnel) have afflicted healthcare and social service providers long before the COVID-19 pandemic exacerbated these trends. Furthermore, the pandemic constitutes a collective trauma, the sequelae of which have yet to be fully reconciled, especially for individuals with preexisting histories of trauma for whom the pandemic poses unique challenges. In order for providers and the organizations in which they operate to optimize their service environments and to facilitate the recovery of vulnerable individuals, service interventions must not be limited to specific "treatments" or evidenced-based practices. Organizational structures, practices, physical configurations, and guiding missions and philosophies must be aligned in furtherance of trauma-informed principles (Substance Abuse and Mental Health Services Administration, 2014).

The development of a "trauma-informed" organization is an iterative process that is never fully completed. It requires sustained leadership, allocation of sufficient resources, and the "buy in" of all organizational personnel – not merely those charged with clinical tasks or the delivery of clinical or rehabilitative services (Bryson et al., 2017). These are important considerations for organizations whose representatives encounter current or prospective clients at various "touch points." Providers must consider how certain elements of the intake and assessment process, such as the physical configuration of its waiting areas, comportment of reception and front desk personnel, and the nature of questions posed during the assessment process might inadvertently undermine clients' feelings of safety or evoke associations with past traumatic events. Providers must similarly acknowledge attributes of their environments or service settings that would reinforce or perpetuate trauma, modifications of which might be beyond their control. For instance, operators of residential congregate care programs in which recipients must share living accommodations and cohabitate with individuals whose behaviors might be viewed as hostile or aggressive must consider how these environments could compromise the impact of trauma-informed interventions, however effective they might be if applied under more propitious circumstances. Notwithstanding such limitations, attention to key ingredients of trauma-informed practice can enable organizations to achieve considerable progress in creating and sustaining environments conducive to recovery in all its forms.

Organizational leadership must play an integral role in the pursuit of trauma-informed practice (Menschner & Maul, 2016). Unlike other interventions whose impacts might unfold within a clinician's office, classroom, or similarly circumscribed setting, trauma-informed care is all-encompassing and requires nothing less than a comprehensive review of the full environment and context in which care is delivered. This necessitates consistent commitment from organizational leadership and a commensurate allocation of resources. For example, the reconfiguration of a waiting area to reduce excessive noise and to enhance privacy and confidentiality necessitates the involvement of persons operating within different departments and at various levels of an organization's hierarchy whose efforts cannot be successful without the endorsement of its senior leadership. In addition, engaging service recipients in organizational planning and service delivery processes can prove especially beneficial to an organization's implementation of trauma-informed practices. Eliciting recipients' expressed needs, preferences, and concerns is inherently empowering, and it can alert providers to organizational practices that must be modified in order to align with guiding principles (Isobel & Edwards, 2016). Training all personnel in trauma-informed practice ensures its organizational activities are aligned with and reinforce critical policies and procedures (Bryson et al., 2017). Inasmuch as such training educates and alerts personnel to the potentially deleterious effects of trauma it can also mitigate the effects of secondary trauma, thereby enhancing the overall health and wellbeing of an organization's workforce (Substance Abuse and Mental Health Services Administration, 2014).

The foregoing practices, when implemented in an iterative and synergistic manner, enable organizations to become more "trauma-sensitive" in their orientation and to ameliorate the enduring effects of trauma and adverse life events on both individuals served and those charged to deliver services. These are seemingly lofty goals for organizations with limited resources, and partnerships that span organizational boundaries and service domains can provide essential support in the pursuit of common objectives (Keesler, Green, & Nochajski, 2017). For example, Coordinated Behavioral Health Services (CBHS), a prominent Independent Practice Association (IPA) comprised of health, behavioral health, and social welfare organizations operating throughout the Hudson Valley Region, has embarked on a Trauma-Informed Care initiative through which common standards and practices will be developed and disseminated to its participating providers. The IPA will also employ a Performance Enhancement Process to promote participants' fidelity to established standards and practices. This model is poised to enable implementation of trauma-informed care on a scale that exceeds the scope of an individual provider or service organization. In doing so, it promises to deliver this proven practice throughout our region and to promote the overall health and wellbeing of a sizable cohort of its population.

The author may be reached at (914) 428-5600 (x9228) or by email at abrody@searchforchange.org.

Want to Help Underserved Communities Succeed? Adopt a Trauma-Informed Model at Your CEO Table

By Lymaris Albors
Chief Operating Officer
Acacia Network

2020 was a year to remember. Not only did the United States –and the world– grapple with a pandemic of epic proportions, but our country was also forced to take a deeper, harder look at the pervasive and deadly impact of racial inequality and systemic discrimination, as the continued violence against Black Americans by police officers made the headlines time and time again. The murder of George Floyd was the last straw.

What 2020 also uncovered were the deep divides between those who have and those who have not: those who have access to steady income, stable housing, affordable health insurance, nutritious food, reliable technology, and otherwise dependable support networks, fare better, while those who do not have access to these lifelines are more susceptible to COVID-19 infection and mortality.

These divides were most evident in cities across America where racial and socio-economic segregation seem to be built into the urban fabric, such as New York City. The Bronx, home to some of the poorest Congressional Districts in the nation, consistently suffered the highest rates of infection and mortality throughout the COVID-19 pandemic (NYC Department of Health and Mental Hygiene, n.d.). In fact, all around the country, communities largely comprised of Black/African American and Hispanic/Latinx populations were disproportionately impacted by COVID-19.

What is the connection between race, poverty, and health? Why have we seen such stark differences among racial/ethnic groups when it comes to COVID-19 illness and likelihood of survival?

Trauma in the Underserved Communities

While the answer to the question above is multifactorial, it is necessary to take into account the incidence rate of Adverse Childhood Experiences (ACEs) among vulnerable populations, as well as the impact of critical social determinants of health.

The Centers for Disease Control and Prevention (CDC) describe Adverse Childhood Experiences (ACEs) as potentially traumatic events that occur during childhood, such as experiencing violence, abuse, or neglect, or witnessing violence in the home or community, among other experiences (CDC, n.d.). Environmental factors also contribute to a young person's sense of safety and stability, or lack thereof. For example, was the child exposed to substance use, alcoholism, and addiction within the household? Did any household members suffer from mental illness? Were there any other factors that contributed to ongoing instability and toxic stress, such as incarceration, homelessness, or poverty?

Community risk factors that contribute to the development of ACEs include growing up in neighborhoods with high rates of violence and crime, high rates of poverty and housing insecurity, limited educational and workforce development opportunities, easy access to drugs and alcohol, few community activities for young people and/or lack of afterschool supports, among other social and environmental challenges.

Lymaris Albors

ACEs can cause long-term consequences that reduce the quality-of-life for an individual, such as chronic physical and/or behavioral health conditions, substance use disorders, unemployment, loss of income, among other challenges. Meanwhile, factors associated with urban poverty have been shown to increase the risk that trauma will negatively impact family functioning (Collins, 2010).

This ripple effect is evident in communities of color across the South Bronx, which have been historically underfunded, under-resourced, and underrepresented. The barriers of structural inequality have not only led to chronic health, education, and socio-economic disparities while contributing to high incidences of mental health and substance use disorders, but they have also bred generational trauma.

While the public sector plays a key role in addressing these systemic challenges, nonprofit human services organizations are expected to fill the gaps, which are oftentimes enormous. Nonprofits like the one in which I run the operations – Acacia Network – play a key role in ensuring that vulnerable communities have access to the resources they need to overcome the barriers preventing them from leading healthy, successful lives.

In order to make transformative and lasting change, organizations must commit to adopting a trauma-informed model from the very top at the CEO level, to every single staff person in the frontlines: from social workers and primary care providers, to front desk personnel and security guards.

What is Trauma-Informed Care?

The American Psychological Association defines trauma as "any disturbing experience that results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have a long-lasting negative effect on a person's attitudes, behavior, and other aspects of functioning." (APA Dictionary, n.d.).

Trauma can affect anyone regardless of who they are or where they come from. Some people experience very few traumatic situations throughout their lifetime, while others may experience chronic or multiple traumatic events. Research tells us that for people experiencing homelessness and poverty, the rates of trauma are extraordinarily high.

According to the Substance Abuse and Mental Health Services Administration, "a trauma-informed approach […] includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. It involves viewing trauma through an ecological and cultural lens and recognizing that context plays a significant role in how individuals perceive and process traumatic events" (SAMHSA, 2014).

Organizations like Acacia Network, which are deeply embedded in vulnerable communities, must take into account the existence of prior and ongoing trauma when working with their clients. Experts argue that it is important to recognize the possible existence of a traumatic history in order to establish therapeutic environments that are physically and psychologically safe for the individuals served (Levenson, 2017).

Acknowledging trauma requires providers to take the necessary steps to promote the physical and emotional wellbeing of their clients, including the following:

• Ensuring that all spaces are welcoming, orderly, and have participants' rights visibly posted;

• Keeping participants informed about all aspects of their treatment so they feel involved in the decision-making processes regarding their care and gain a sense of empowerment;

• Adopting treatment interventions and designing care plans that are culturally responsive and take into account each participant's background.

Communities of color that have been systematically abused by the structures of power experience higher rates of hesitancy and mistrust when seeking care. More recently, we've seen this play out with COVID-19 vaccine hesitancy among

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Becoming an Adult During the Pandemic: Trauma and Resilience

By Michael B. Friedman, LMSW
Public Policy Analyst and
Mental Health Advocate

Studies tracking psychological distress during the pandemic show that young adults are more likely to be struggling emotionally than are older adults.

No wonder. Their lives have been disrupted just at a time in life when they are making the transition from the common turmoil of adolescence to the beginnings of personal stability.

For young adults, the fundamental developmental tasks are building intimate relationships and finding work that will enable them to support themselves and their families while hopefully also providing a source of meaning and self-esteem.

The pandemic made it far more difficult than normal to pursue relationships, complete education, and find work that is stable and has a future. So, it is little wonder that young adults are distressed. Little wonder, too, why many of them ignored public health warnings that they needed to live in isolation as much as possible.

But that is only part of the story. Here's another part.

Justine (a pseudonym) was a junior in college when the pandemic hit. She had to leave her school on the West Coast and

Michael B. Friedman, LMSW

return to live with her parents on the East Coast. She was not happy about it. She did not want to live with her parents, let alone to shelter-in-place with them. She missed her friends. She missed campus life. She missed being in class with other students. She missed partying. She was distressed about the uncertainty of her future. Sometimes she woke up in the middle of the night agitated and unable to get back to sleep.

But, despite her emotional distress, she got a summer job helping a social advocate prepare position papers. She volunteered with a local organization that helped homeless people. After the murder of George Floyd, she went on demonstrations, wearing a mask and trying to stay at a safe distance. She revived a relationship with a high school boyfriend. After a while, she got her own apartment with roommates who were also managing to make lives for themselves despite the pandemic.

Justine is just one of millions of young people who, at the same time they were dealing with emotional distress, found meaning and satisfaction in social and political activism (both on the left and on the right), work, volunteerism, online education, military service, virtual relationships, and so forth. They have found ways not just to cope but to make the best of their circumstances. They have had experiences that will contribute to the development of the skills, strengths, and relationships needed to grow into psychologically successful adults.

To say it again, it is also true that a great many young adults, including Justine and those like her, have experienced symptoms of psychological distress—more anxiety, more depression, more substance abuse, etc. And for some young people, the disruption of developmentally important experiences will have consequences that are troublesome later in life.

There is no doubt that this has been a particularly disturbing time for young people, especially those with pre-existing mental and/or substance use disorders, for those experiencing economic hardship who do not have the luxury of sheltering-in-place, for People of Color who have suffered from persistent health disparities and the overt re-emergence of racism, and for those who have experienced premature grief in response to premature death of people they love.

Many of the young adults who have significant symptoms of mental health conditions—excessive fears, morose moods, preference for isolation to interaction, substance abuse, suicidal behavior, and so forth—can benefit from professional help. And, sadly, there are not enough mental health services to go around. There were not enough before the pandemic and will certainly not be enough after the pandemic, despite improved access to care via tele-health.

Addressing the inadequacy of America's mental health system needs to become a social priority. It has to some extent. The American Rescue Plan includes $3 billion for expanded behavioral health services. Obviously, that's good news, but it is barely more than a 1% increase in

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Addressing Needs of Frontline Workers

By Barbara Bernstein, PhD, MPH
Chief Planning Officer, The Mental Health Association of Westchester

Throughout the past year, I have been struck by the degree to which attention to mental health and wellness, specifically of the impact of trauma on mental health, has entered mainstream discussion. "Frontline Workers" (FLW) who continued to show up for work despite personal risks have been heralded across the media. The concept of who constitutes a "Frontline Worker" expanded as we recognized our collective dependence on the individuals who keep shelves stocked, streets cleaned, children educated, transportation running, etc. Simultaneously, attention to the impact of trauma on communities at large as well as on "Frontline Workers" has entered the dialogue. Those who work in the behavioral health and increasingly in other sectors, have been steeped in principles of trauma-informed service delivery and staff support for quite some time. However, sensitivity to these issues has not been embedded in the workplace universally, nor do the practices of individual organizations create policy.

To highlight the needs of FLW and address the policy gap, in February 2021 NYS enacted legislation that directs the Commissioner of Mental Health to "convene a workgroup and report regarding frontline worker trauma informed care". The legislation, Chapter 33 of the Laws of New York 2021, outlines the following charge:

• Identify evidence-based tools to track the impact of COVID-19-associated collective trauma and the needs of frontline workers;

• Identify or develop training opportunities on how to support the mental health and wellness of their impacted employees for organizations that employ frontline workers;

• Identify evidenced-based trauma-informed support resources and learning opportunities for frontline workers;

• Identify or develop a mechanism to inform and refer impacted frontline workers experiencing symptoms associated with COVID-19 to behavioral health services and supports;

• Consult with any organization, government entity, agency, or person that the workgroup determines may be able to provide information and expertise on the development and implementation of trauma-informed care for frontline workers.

To meet these objectives, a Frontline Workers workgroup, (FLW) was convened by The NYS Office of Mental Health (OMH) in partnership with the Mental Health Association in NYS (MHANYS) and the NYS Trauma-Informed Network. The workgroup is co-led by Donna Bradbury, Associate Commissioner, OMH, and Glenn Liebman, CEO, MHANYS, and facilitated by Amy Scheel-Jones, Senior Consultant, Coordinated Care Services, Inc. It is comprised

Barbara Bernstein, PhD, MPH

of more than 30 members who bring viewpoints from health, education, human services and beyond. I am honored to serve on this workgroup. The task is wide-ranging and the time-frame relatively short. Satisfying our first requirement, in March 2021 we submitted an Interim Report which is available on the OMH website. The report includes key concepts in the areas of trauma, disaster recovery, disparity and related topics.

I would like to share some reflections on the work, as well as other impressions of the past year-plus. I will not address the workgroup's charges in their entirety, nor do I speak for the group or its leaders. First, it has been personally energizing to meet many smart, passionate, dedicated people working hard to mitigate the impact of the pandemic. Their work is accomplished through multiple avenues including direct services, advocacy (including advocacy that resulted in this legislation), attention to staff needs, and government actions. I believe that the critical thinking and degree of attention paid to these issues often does not reach public awareness. Next, policy is critically important. Policy is a statement of values. Policy helps us plan for the future. We expect that government policy will drive allocation of resources and stimulate new initiatives. But I am also aware that policy making is not a rapid process. Policy should be informed, thoughtful, and forward thinking. The work of this group will advance the understanding of the impact on FLW, define the need for ongoing services based on NY-specific data, and inform policy.

As we do this work, I find my thoughts "zooming in and zooming out" - focusing on needs at the individual level, at the organizational level, community level, and rippling out toward larger systems. One of the significant challenges of this work is to connect those levels – to improve the flow of information across and between levels and to use our resources efficiently. There are many good resources and tools available throughout NYS yet all too often information exists in pockets that are unknown to typical individuals and business owners. Connecting resources within and across levels is a challenge in many of the projects in which I am engaged – projects that focus on both prevention and mitigation of the impact of challenging life events from a public health perspective.

One of our workgroup objectives is to "identify or develop" training opportunities for organizations that employ FLW. We will inform ourselves about what already exists, for whom it exists and how those 'opportunities' are implemented. To identify gaps, we need to understand the need - i.e. what is the data about the impact of the pandemic on FLW. Only then can we develop training opportunities to address those gaps. And creating a database or clearinghouse of training opportunities will be meaningful if we also address mechanisms to connect impacted organizations with those opportunities. The knowledge of our group is critical in this endeavor. Collectively, we know of many resources across the state, and our knowledge will be augmented by research. There are existing initiatives that connect organizations and individuals to resources, upon which we can build. For example, The NYS Trauma Informed Network works to bring people and resources across NYS together, to disseminate information and to identify resources across the state. Another resource that connects individuals to resources in our most impacted communities is Project Hope. Our workgroup recently benefitted from a presentation by Project HOPE and virtually "toured" its website, which is rich in information. However, we should not underestimate the complexity of developing accessible pathways to supports and services given the vast size and diversity of the groups about whom we are concerned.

Despite the good work of the NYS Trauma Informed Network, Project HOPE (including MHA's Rockland team), support lines and other endeavors, in my experience those resources are not immediately known by the general community. Too often, individuals are challenged to find resources and, specifically to identify assistance that is a good fit for their situation. How can we best communicate what is available? During this past May, Mental Health Month, numerous community education events were held throughout Westchester. Attendance was disappointing at several events that organizers were confident would meet community need. Is the problem not with the content, but with the way we offer information? Are people fatigued by conversations about COVID and its mental health impact? Rather than inviting people to "attend" scheduled events, even virtually, is it more effective to provide information in venues in which people naturally congregate? Have we done a good-enough job of distinguishing between universally relevant messages about mental health, the impact of challenging situations, and likelihood of resilience, and individual experiences that are best served by more "clinical" interventions? Utilizing a prevention model that matches interventions to universal, selective and indicated levels of need is a useful paradigm. Universal

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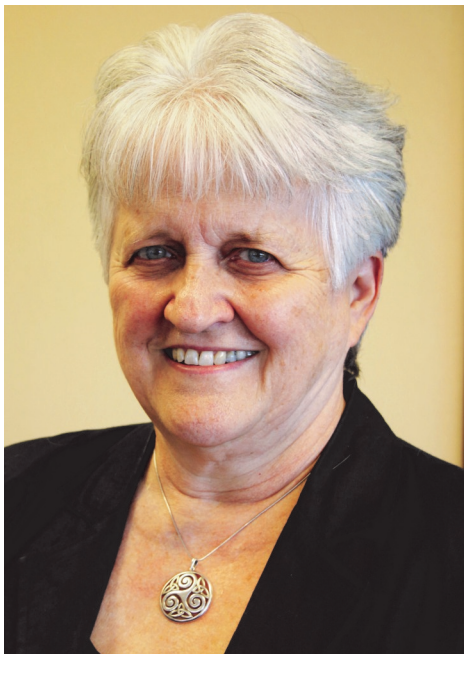
NYS OMH Awards $30 Million for Support Teams to Assist Long-Term Homeless People and Individuals Transitioning from Inpatient Care

By James Plastiras
Director of Public Information
NYS Office of Mental Health

The New York State Office of Mental Health (OMH) today announced an award of $30 million over five years to Coordinated Behavioral Care (CBC) to operate eight treatment teams that work with vulnerable New Yorkers living with mental illness. The teams focus on people transitioning back to the community from psychiatric inpatient care and on long-term homeless people living on the streets and in the subway system.

OMH Commissioner Dr. Ann Sullivan said, "The transition back to the community from inpatient care can be very difficult for many individuals. Coordinated Behavioral Care's Pathway Home program model has an established record of delivering essential behavioral health services to New York City's most vulnerable as they transition back to community settings. This award will expand the program and help reach other vulnerable populations, including long-term homeless people with mental illness. Partnering with the CBC will allow us to help more people, reduce psychiatric hospital readmissions and emergency room visits, and improve health outcomes for more New Yorkers."



Dr. Ann Sullivan

Donna Colonna

CBC Board President and Services for The UnderServed Chief Executive Officer Donna Colonna said, "Pathway Home has been a collaborative endeavor that has positively affected the lives of individuals we support. We are grateful for the team effort and look forward to the continued partnership between community-based providers, government and hospitals through the Care Transition and Support Teams program."

OMH will provide $30 million over five years to operate eight teams utilizing an approach known as Critical Time Intervention. Six of the teams will work with individuals who are transitioning to the community after receiving inpatient care at a psychiatric facility. These Care Transition and Support Teams, made up of behavioral health professionals and peers, will promote continuity of care and ensure individuals remain connected to services. Two other teams will engage people with mental illness living on the street and in the subway system.

Funding for the CTST teams is supported in part by state reinvestment funding made available through the reduction of vacant inpatient psychiatric beds. Since 2014, more than $100 million has been reinvested into community-based mental healthcare across New York State, allowing OMH to provide services to nearly 125,000 new individuals, bringing the total to over 800,000 people served in the public mental health system.

CBC will employ its signature care transition model, Pathway Home™, to operate and manage the CTSTs teams. That model is adapted from critical time intervention (CTI), an evidence-based practice used to provide a broad range of time-limited services designed to ensure continuity of care, avoid preventable poor outcomes among at-risk populations and promote the safe and timely transfer of individuals from one level of care to

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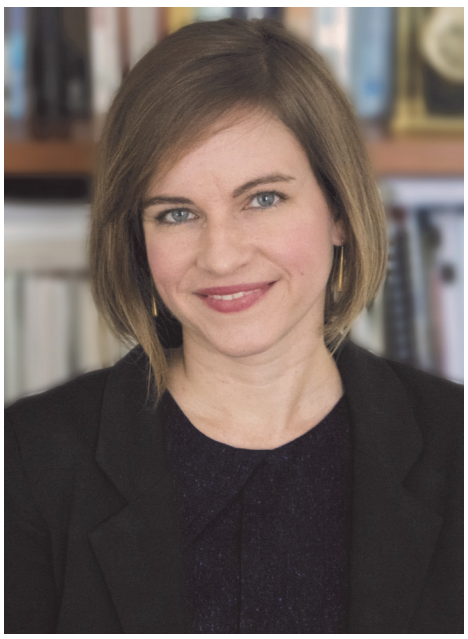
988 Suicide Lifeline Expected in July 2022 Thanks to SAMHSA Grant

By SAMHSA
US Department of HHS

The Substance Abuse and Mental Health Services Administration (SAMHSA) today announced Vibrant Emotional Health (Vibrant) will be the administrators of the new 988 dialing code for the National Suicide Prevention Lifeline (Lifeline). A pair of the agency's grants, totaling $48 million and including $32 million in Coronavirus Response and Relief Supplemental Appropriations Act, 2021 funding, will fund the effort to better harness technology to help Americans in mental health crisis and save more lives. Vibrant, in partnership with SAMHSA, has administered the Lifeline since its creation in 2005. This funding also supports the national Disaster Distress Helpline, a subnetwork of the Lifeline.

"The need for quick, easy and reliable access to emotional support and crisis counselling has never been greater. The COVID-19 pandemic laid bare the stressors faced by Americans; too often, such stressors result in suicidal and mental health crises," said Tom Coderre, Acting Assistant Secretary for Mental Health and Substance Use and the interim head of SAMHSA. "These grants will work to expand the nation's call centers' capacity and



Kimberly Williams

technological readiness as the Lifeline's shift to 988 becomes operational next summer. Until that launch, we ask anyone who needs help or who has a loved one at risk of suicide to call or chat with Lifeline operators at 1-800-273-8255."

"This national three-digit phone number, 988, will be a step towards a more equitable and accessible mental health safety net in this country," said Kimberly Williams, President and CEO of Vibrant Emotional Health. "We look forward to continuing our partnership with SAMHSA to bring life-saving mental and emotional health support to all Americans."

The Federal Communications Commission (FCC) designated 988 as the new three-digit number for the National Suicide Prevention Lifeline on July 16, 2020. The U.S. Senate passed the National Suicide Hotline Designation Act (S. 2661), establishing 988, in May 2020, and the U.S. House of Representatives passed the legislation in September 2020. The National Suicide Hotline Designation Act of 2020 was signed into law on October 17, 2020. The requirement for phone service providers to transition to 988 as the National Suicide Prevention Lifeline will take effect on July 16, 2022.

Until the formal launch of 988, anyone in mental health crisis or emotional distress should continue to call the National Suicide Prevention Lifeline at 1-800-275-TALK (8255). Vibrant is working with the Lifeline network of over 180 crisis centers and other stakeholders to prepare for the nationwide launch next summer. Some carriers have been able to activate 988 before July 2022. Those interested in learning more about early activation should contact the individual carriers for additional information.

Vibrant Emotional Health is a nonprofit organization that helps individuals and families achieve emotional wellbeing. For over 50 years, our groundbreaking solutions have delivered high-quality services and support, when, where and how people need it. We offer confidential emotional support through our state-of-the-art contact center and crisis hotline services that use leading edge telephone, text and web-based technologies and include the National Suicide Prevention Lifeline, NFL Life Line and NYC Well. Through our community wellness programs individuals and families obtain supports and skills they need to thrive. Our advocacy and education initiatives promote mental wellbeing as a social responsibility. Each year we help more than 2.5 million people live healthier and more vibrant lives. We're advancing access, dignity and respect for all and revolutionizing the system for good. Visit www.vibrant.org. And follow Vibrant on Twitter, Facebook and Instagram.

The National Suicide Prevention Lifeline provides free and confidential emotional support and crisis counseling to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week, across the United States. Callers who follow the "press 1" prompt are connected to the Veterans Crisis Line. A Spanish Language line is available at 1-888-628-9454,

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seen before. It was not a pleasant situation. I was thrown out, on the streets at 15, sleeping on subways. Surviving as well as I was able. I got into drugs and got caught up in crime to survive. That led to prison. After I had been out of prison a few years, my daughter died, which devastated me. That sent me into a negative spiral again," Eugene said. "And then years later, my sister died, and I lost it again. My sister was my heart. I ended up back using drugs--that was my pain medication. I ended up losing my job and violated parole. My final time in prison, I realized that so many problems were because of the drugs. I made a promise to myself to never use them again."

What Helps Us Recover from Trauma

Trauma-Informed Care is a treatment framework which requires a sensitivity to an individual's past experiences and how they may impact current choices and behaviors. A trauma-informed environment emphasizes client centered services, reduces barriers to treatment, and promotes engagement in quality of life care. S:US has been recognized for successfully integrating trauma-informed practices.

We have all recognized different things that helped us through our challenges, but we all are thankful for and have been helped by housing, mental health services, and community connection.

"I didn't have any housing coming out of incarceration. After 20-some years, you lose a lot of family members, you're on your own. S:US gave me a shot and helped me find housing. They set up a support network that guided me through every nook and cranny, the ins and outs of applying for this and that--they knew every aspect of it. I'm here now because S:US is outstanding," Larry explained.

Elfreda is a member of the Brooklyn Clubhouse, which is a program that supports people living with mental illness, offers TASC (Test Assessing Secondary Completion, which replaced the GED) and basic computer training, as well as skills development in food service, facilities management, computer applications, and office work. The Clubhouse also provides valuable social and vocational opportunities, support from peer advocates, and assistance in developing critical life coping skills and employment readiness.

"I have someone I can vent to. And my medications help a lot. My program director calls me every week. I still have my bi-monthly conversation with my therapist and my monthly conversation with my psychiatrist. Every three months, the nurse calls. Being able to talk to Clubhouse members online helps a lot. At any given day, there's five to 11 people on Zoom for our wellness segment and we compare notes and take suggestions," Elfreda said.

"After I got out of prison for the last time, I contacted my friend and asked for help. He got me into a program with a mental health component. For the first time, I had a therapist and a psychiatrist and was diagnosed as bipolar. Medication, meditation, and therapy: I have stayed on this program and it has saved my life," said Eugene.

see Key on page 30

Responding to the COVID Pandemic and Racial Injustice

By Liane Nelson, PhD
Director, Trager Lemp Center
WJCS

One of the truths that have been exposed by the COVID-19 pandemic is that while the trauma and grief of COVID-19 and the accumulated racial injustices have been widespread, the impact has been felt more strongly in some communities. COVID-19 has been much more harmful to Black and Brown communities due to a broad lack of access to quality health care, quality housing, remote work, access to quality child care, internet accessibility, access to food, and the trauma of discrimination itself.

But COVID is only part of the struggles endured by Black and Brown communities. When the world saw the murder of Mr. George Floyd filmed on a smart phone for 9 minutes and 29 seconds, many recognized it as a time for a long overdue discussion about systemic racism. Many of our Black and Brown brothers and sisters, however, also experienced it as racial trauma. This trauma, coupled with the other challenges posed by the pandemic, leads to an understandable sense of vigilance that makes navigating one's way in the world challenging.

At the WJCS Trager Lemp Center for Treating Trauma and Promoting Resilience, we're very cognizant that the experience of trauma often leads individuals to blame themselves for what they experienced. It is important to provide a clear understanding of where the blame should be laid. This self-examination is difficult to do alone and best looked at as part of a community. Community has the benefit of being a major protective factor and can lead to resilience.

Liane Nelson, PhD

The COVID-19 pandemic accentuated the need for a broad, systemic examination of institutions and agencies, and their ability to support clients and staff. Using the lens of WJCS' antiracist and trauma-informed traditions, this article examines what we, at WJCS, accomplished as an agency, and where we have yet to go. We have been working for several years on becoming a trauma-informed agency. To be trauma informed and racially equitable is aspirational. Any belief that we have arrived at our destination means that we have stopped educating ourselves. We must always strive to be better.

Both the COVID-19 virus and race-based police brutality shared the hallmarks of trauma: danger, unpredictability, and a lack of control. The framework described below allows for recognition of what trauma survivors need to heal: the restoration of safety, celebration of victories, and frequent communication to provide control and predictability.

Safety and Celebration

The first priority for any organization, particularly during stressful times, is to maintain a safe environment for its employees. This was a particular challenge for the Community Programs division of WJCS which operates 13 community-based group homes for individuals with intellectual and developmental disabilities, including former residents of Willowbrook. The needs of the residents are extensive and, even absent the pandemic, their care is complicated and challenging. The staff of the group homes consist largely of Black and Brown Direct Support Professionals who were strongly affected by the traumas of COVID and racial injustice. The clients they care for in the residences were also particularly vulnerable. These dedicated workers needed a high level of safety and protection, as they cared for residents with COVID to protect themselves, their families, and their communities. In the early days of the pandemic, when PPE was difficult to obtain, great effort was made by every level of the organization to obtain the necessary supplies. It was expensive but essential. We also recognized the sacrifice of these workers agencywide. Board members purchased lunches and dinners. Pizzas were delivered regularly. We orchestrated a "virtual" cheering session for staff working in the community residences by having hundreds of employees, board members, and volunteers on Zoom. It was a virtual noisy and emotional cheering session celebrating the courage of our healthcare heroes.

For our clinical clients, safety precautions prohibited us from delivering critical mental health services face-to-face. Telehealth instantly developed as the primary way of working with our clients. We were fortunate that pre-pandemic, our IT department had done crucial work in creating technology systems and investing in laptops and phone systems so that our clinicians could shift to working exclusively from home.

It was also important to help our clinical staff handle their own trauma as well as the secondary trauma they were experiencing in working with Westchester residents who were suffering due to the pandemic. WJCS Chief Clinic Officer Pat Lemp, our Psychology Intern on our trauma team, Dr. Jenna Hennessy, and I created and presented a webinar for staff about working at WJCS during the pandemic. Although first designed for clinicians doing clinical work, it was later modified for non-clinical staff as well. We talked about trauma, resilience, grief, navigating anxiety, not ranking our suffering, accepting our vulnerability and that we are all fundamentally doing our best, and were sure to focus on creating a dialogue. During a crisis, people want to be heard and feel connected. Facilitating conversations about how people were doing, how they were coping, and what they needed was the most valuable part of the webinars. Trauma and grief often lead to a sense of isolation. Fostering community conversations was a powerful antidote. It helped create a sense of emotional safety.

Communication to Provide Control and Stability

The importance of regular and honest communication between executive leadership and staff cannot be overemphasized. As soon as the pandemic began, our CEO, Seth Diamond, began sending emails each Friday, addressing our shared experience and expressing pride about staff activities and accomplishments, such as mobilizing food deliveries across Westchester County (made possible by a partnership between the Children, Youth and Families and Clinic divisions of WJCS), outreach to clients and community members, and the development of a Digital Equity program that provided students in Yonkers with laptops and internet access, which later expanded to adults in need across Westchester. Our CEO also shared updates about the changes in pandemic-related requirements and expectations about plans for clinics reopening. These updates were essential in promoting a sense of predictability and control for the staff. Seth included inspirational music videos or other reflective literature with each email. Always embedded in these messages was a message of support and admiration for the essential work being done by our staff.

When Mr. George Floyd was murdered, company communications focused on acknowledging our collective grief and trauma. WJCS' Undoing Racism committee, which has held regular Lunch and Learn educational staff workshops about racism since 2003, organized Zoom sessions for open forum discussions between WJCS employees and board members about the impact of COVID and structural inequality on Black and Brown communities. These conversations were raw and sometimes painful, as colleagues addressed the racial trauma and grief that they experienced but also focused on resilience and action steps.

WJCS also entered into a partnership with Westchester YMCA's Center for Racial Equity. A consultant specializing in diversity and racial equity held a series of focus groups over the course of two months with our staff and WJCS' Board, to allow for a full accounting of where we are, and where we have yet to go.

The Reverend Daphne Swinton, MPA, MCH-LP, a trauma clinician, and I led a webinar for the Westchester County Trauma Committee in November 2020, as

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24 Organizations Team Up in Westchester's First Trauma-Informed Systems Change Collaborative

By Marie Roth, MA, RDN, NBC-HWC, ACTRP, Director of Curriculum, Program Coordinator for the Eat Well, Be Well Community Wellness Program Blythedale Children's Hospital

Exposure to traumatic stress is increasingly understood as a common denominator among children, youth, and adults across service systems. Experiences surrounding Adverse Childhood Experiences (ACEs) and trauma impact individuals everywhere. The pandemic and other recent events, nationally and locally, have only amplified some of the structural and systemic problems surrounding trauma, making it all the more important and urgent to address trauma at not just an individual level, but also at the organizational and systemic levels.

In Westchester County, the Coordinated Children's Service Initiative (CCSI) Trauma Subcommittee is comprised of stakeholders from various public sectors with a vested interest in creating a more trauma-informed system of care. In 2020, this committee administered a survey to 84 agency leaders of settings ranging from mental health, child welfare, and education, to peer advocacy, law enforcement and others to assess needs and readiness for trauma-informed systems change.

Marie Roth, MA, RDN

Results indicated a strong desire across sectors to become more trauma informed, and a relatively high degree of awareness, knowledge and skills toward achieving these goals. The greatest challenges reported by survey participants were 1) reinforcement and support for these practices were not abundant enough to fully realize systems change; and 2) the need for a comprehensive, evidence-based approach for methodically achieving and maintaining environments of trauma informed care. In response, Blythedale Children's Hospital and Kohl's Eat Well, Be Well Community Wellness Program is sponsoring the first county-wide, trauma-informed systems change Learning Collaborative, which kicked off (virtually) on April 12.

The high number of applications received across the board from Westchester agencies speaks to the collective readiness and current sense of urgency to engage in this process.

"At a time when our community is experiencing such massive collective trauma, it is more important than ever to ensure that our community agencies are equipped to recognize and respond effectively to the signs of trauma in both the individuals we work with and in our staff members. This Learning Collaborative provides an opportunity to capitalize on the great work that has already been done in Westchester and go deeper in our efforts to become increasingly more trauma-informed and trauma-responsive," said Jenna Velez, LCSW, Vice President of External Affairs at The Mental Health Association of Westchester and Co-Chair of Westchester County Trauma Subcommittee.

Trauma-Informed Care (TIC) is an approach that shifts thinking from "what's wrong with you?" to "what has happened to you?" with an understanding of the pervasive nature of trauma. Organizations and communities can become more trauma-informed by making specific service and administrative-level modifications in order to be responsive to both the needs and strengths of those with a trauma history (Harris & Fallot, 2009). Five guiding principles serve as the backbone to these administrative and service modifications:

• Safety: Ensure physical and emotional safety for clients and staff.

• Trustworthiness: Maximize trust, ensure clear expectations and consistent boundaries.

• Choice: Strengthen staff and client experiences of choice and control.

• Collaboration: Engage in partnership and power-sharing between staff and clients, as well as among organizational staff.

• Empowerment: Prioritize validating and building on individual strengths and skills.

Blythedale Children's Hospital, acting as the clinical leader in the initiative, had earmarked grant monies and began planning the training prior to the pandemic. When Blythedale set out to promote and support a shared approach that influences innovation and improvement in both organizational processes and individual care practices to achieve better experiences and outcomes for staff, patients, students

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vendor, TenEleven, BAC designed and created an electronic trauma-informed care module known as the Treatment Wizard, which uses a decision tree structure to determine the workflow based on individual scores from the screening and assessment tools.

Simultaneously, we conducted an organizational assessment for trauma readiness and offered all providers and managers training and re-training in trauma-informed care, screening and assessment tools, workflow, and documentation. BAC also ran a pilot test with the harm reduction program to examine the validity of delivering trauma-informed care using MBC. The work done in the pilot was worthy of semi-finalist status in Healthcare Informatics' 2017 Innovator Awards Program.

Creating a trauma-informed culture is a journey involving continual training, re-evaluation, and modification of current practices. In 2018, BAC joined the National Council for Behavioral Health (NATCON) learning community, which focused on resilience-orientated trauma-informed approaches to client services. Subsequently, BAC developed a Steering Committee and various subcommittees using NATCON's Wellness-Oriented Trauma-Informed Care instrument as a guide.

The positive outcomes of the pilot demonstrated that routinizing trauma-informed care and using a standardized trauma-informed approach has positive effects on clients' overall wellness. In our experience, the value of MBC is improved wellness = reduced cost + decreased symptoms. The plan was to use the pilot test results to inform the rollout of TIC in the rest of the BAC programs. To measure wellness outcomes over time, a client would need to be accessing services for at least three months to allow BAC to capture baseline and follow-up data. Because BAC is a complex organization offering multiple services, workflows could vary by programs and program departments. Looking back, these variations in workflows have posed a significant challenge for TIC implementation, and BAC is currently addressing the areas identified for improvement.

Re-evaluating Implementation and Capitalize on Lessons Learned

In the fall of 2020, BAC had the opportunity to begin working with Cicatelli Associates, Inc. (CAI) Trauma-Informed Care (TIC) Initiative funded by the New York State AIDS Institute and Amida Care through our membership with the EngageWell IPA. Participation in the CAI TIC Project has allowed BAC to complete a second cultural assessment (including environmental), re-train staff, and re-evaluate our current practices. It has also deepened our understanding that transforming organizational culture to one of TIC is a continual process, not a one-time project. While our experience in implementing TIC has been rewarding – opportunities to explore new ideas, learn new skills, create new partnerships, and improve our infrastructure, it has also presented challenges we did not fully anticipate.

BAC has learned that regular communications, check-ins, and re-engagements are quintessential to a successful organizational culture transformation. To ensure members of our teams understand the implementation of TIC as an agency priority, BAC leaders provide updates on this subject in all-staff and monthly management team meetings. In addition, BAC has incorporated a TIC introduction as part of the onboarding process and modified all job descriptions to include staff responsibilities to be knowledgeable about the TIC approach and principles.

BAC is investing much time in providing skill-building training to improve staff delivery of trauma-informed care. However, one of the missing links is direct observation of the team and incorporating TIC principles in staff supervision. Our work with CAI has allowed us to build capacity in this area. It has also allowed us to learn new tools, including providing brief psychoeducation to clients, a component that was missing from our original implementation plan.

Although technology advancements augment the workflow, data integrity plays a crucial role in producing valuable information to demonstrate client progress. Incomplete data collection and inconsistent documentation, lack of buy-in, and staff turnover have affected the number of clients screened and assessed and caused failures in translating trauma objectives into the care plan. BAC has begun re-engaging and re-training existing staff on screening and assessment tools, strength -based language, and the Treatment Wizard in our EHR to address these issues.

A cultural change requires buy-in from the top down, including the Board of directors. TIC has not only changed our relationships with our clients but also our relationships with our staff. Notably, the TIC approach fosters a community of leaders who lead by example. To be successful, BAC leaders need to model the behaviors we want to see in all relationships—managers, staff, and partners. Using wellness as an example, a shared goal of TIC and MBC, promoting wellness among our teams is as important as promoting wellness among our clients, and we must do both.

Looking Forward

The COVID-19 pandemic has left an indelible mark on behavioral health services. During the last year, trauma has been exacerbated, especially in our client population, with marked increases in substance use and mental health issues, making TIC an even more critical need than before.

We are very grateful for the generous support from the New York State AIDS Institute and New York Community Trust for helping us build on our successes, strengthening our infrastructure, and improving our TIC model of care. BAC envisions becoming a national thought leader in trauma-informed care by helping organizations transition to a TIC agency through sharing our experience with them, actively cultivates partnerships, and seeking funding to replicate our TIC approach.

BAC recently convened a strategic planning retreat where our Board of Directors approved the provision of trauma-informed comprehensive care as the agency's strategic direction. As we begin a new fiscal year in July, we are excited about supporting our Board's commitment

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traumatic stress reactions such as secondary traumatic stress (STS) and compassion fatigue (CF). VT, STS and CF represent reactions to work-related secondary trauma exposure that can lead to emotional, cognitive and physiological responses impacting quality of life and job performance (Zerach, 2013).

More recently, literature investigating work-related primary and secondary trauma exposure has extended to different professions within behavioral health, mental health and child welfare, covering a continuum of services. These studies repeatedly indicate behavioral health staff are at an increased risk for the development of trauma reactions and reveal significant prevalence rates of VT, STS and CF in the behavioral health/mental health workforce (Ivicic & Motta, 2017; Kerig, 2019; Zerach, 2013; Salloum et al., 2019).

Traumatic reactions contribute to turnover: One study examining the relationship between VT and staff turnover included nearly 1,200 child welfare workers across five organizations in four states. Results found approximately 33 percent of participants experienced varying degrees of VT; these numbers are congruent with the majority of studies examining VT in therapists. In addition, nearly 10 percent of participants endorsed "to some extent" that their personal trauma is an issue in the workplace (Middleton & Porter, 2015). Results also indicated that 50 percent of participants "often thought about leaving their organization," and results of a structural equation model found a significant relationship between VT and intent to leave, revealing that staff with higher levels of VT were more likely to hold intensions of leaving.

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Trauma-informed Care (TIC) Guidelines also indicated that retention in behavioral healthcare is significantly influenced by an organization's lack of attention to the realities of STS; failing to normalize trauma reactions in staff and, instead, treating them as staff failures; and not supporting staff's utilization of personal therapy (SAMHSA 13-4801, 2014).

These findings reveal a need for more attention and interventions to address the impact of primary and secondary trauma on turnover.

TIC guidelines and training: A core principle of TIC is safety, which includes the physical and psychological safety of individuals receiving services, as well as staff at all levels within an organization.

TIC guidelines for creating a trauma-informed organization highlight the importance of not only attending to the trauma experienced by individuals in care, but also requires that organizations develop procedures for supporting staff with personal trauma histories and those experiencing aspects of STS or VT resulting from their work (SAMHSA 14-4884, 2014). "An organizational environment of care for the health, well-being, and safety of, as well as respect for, its staff will enhance the ability of counselors to provide the best possible trauma-informed behavioral health services to clients" (SAMHSA 13-4801, p.173, 2014).

Specific suggestions for TIC training, to help employees address trauma reactions, include helping team members identify signs of STS and VT within themselves, and developing skills to implement self-care strategies shown to prevent and manage traumatic stress reactions (SAMHSA 13-4801, 2014). While these guidelines are helpful, and a necessary starting point to guide organizations in the development of TIC, there is limited research regarding specific interventions for training staff in the recognition and management of trauma reactions and outcomes related to job retention and job satisfaction.

Measuring compassion fatigue/satisfaction: Much of the current research regarding interventions utilized by TIC organizations to address staff trauma have included examining changes in compassion satisfaction and compassion fatigue following completion of trauma training and trainings focused on helping staff develop trauma-informed self-care practices (TISC).

A city-wide study, conducted in Baltimore between 2015 and 2016, evaluated changes in organizational and provider specific factors following the completion of a nine-month training focusing on the six core principles of TIC, outlined by SAMHSA (Damian et al., 2017). The sample of participants included 88 staff from a number of organizations (social services, health, education and law-enforcement) serving traumatized youth, including community and residential programs.

Pre-and post-surveys measured a number of factors, including:

• *Compassion fatigue (CF)* includes aspects of burnout, such as feeling hopeless and ineffective with job tasks, as well as STS, which encompasses problematic reactions to others' traumas (Damian et al., 2017).

• *Compassion satisfaction (CS)* is defined as "the pleasure derived from being able to do one's work well" (Damian et al., p. 2, 2017).

Results indicated that employees reported higher levels of CS following the training, which contributed to greater empathy and camaraderie among colleagues. In addition, results revealed higher levels of CF, highlighting an increased awareness and ability to identify burnout and STS following the training. Staff also reported a greater awareness of the need to enact better work boundaries and greater self-care (Damian et al, 2017).

TISC training also has proven useful for lessening the impact of STS in staff. A study, conducted with 177 child welfare workers (primarily case managers), examined the mediating effects of TISC utilization on the relationships between burnout and STS with mental health functioning, focusing on three areas:

• utilization of resources/supports for TIC training (e.g., stress management, trauma in individuals, helping professionals and secondary trauma).

• organizational supervision and support practices (peer support and supervision/consultation); and

• personal self-care (stress-management skills, work-life balance) (Salloum et al., 2019).

Results indicated that the use of self-care strategies mediated the association between burnout, STS and mental health functioning. Also, the use of organizational resources/supports mediated the effects of STS and mental health functioning, while organizational supervision and support practices did not. When STS rates were higher, there was a significant negative effect on mental health functioning, but mental health functioning was not as significantly impacted when staff utilized organizational resources (e.g., TIC training) and self-care practices.

Creating safe and healthy organizations: Literature and empirical studies reveal the high prevalence of VT, STS and CF among social service and behavioral health employees, highlighting the emphasis on TIC and the need for organizations to: 1) educate their employees about trauma and 2) attend to trauma histories and trauma reactions in staff and individuals receiving services.

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Even if we do stop to acknowledge these risks, we may be slow to take the extra steps to create the changes needed, whether because it demands even more of our time and energy or because we lack a roadmap to guide our changes (Figley, 2002).

While STS affects the individual, it can also have a systemic effect. Ironically, an organization marked by secondary trauma may struggle to deliver quality trauma-informed care. I have observed that teams whose staff are experiencing significant secondary traumatic stress seem prone to groupthink, lapses in judgment, boundary-blurring, overextension, detachment, team conflict, and high staff turnover.

Though the mental health field is not the only field at risk of its workforce developing secondary trauma, it is well-equipped to lead the way on how to respond to STS and be a model for other industries in this area.

The mental health field can start by making discussions of STS a commonplace practice. These discussions benefit not only individual staff, but also foster a trauma-informed and supportive team culture, increase retention of mental health staff in the field, and also ensure that staff are able to provide high quality of care to patients.

Leaders who have a strong understanding of the impact of secondary trauma can incorporate this understanding into their management approach in order to foster resilience amongst individual providers, as well as within their organizational culture. In turn, they will be better equipped to serve their clients, staff, and carry out their organizational mission.

Secondary trauma stress is nearly unavoidable in settings where staff are exposed to extremely heavy work on a daily basis. It is a systemic risk within the field and can stymie organizations' ability to carry out their mission. Thus, recognizing the strategic importance of tackling STS at an organizational level is crucial to the field of mental health.

Organizational leaders can take steps to encourage self-care practices that have been shown to mitigate the impact of secondary trauma. Physical activity stands out as being particularly helpful in combating these impacts. Mindfulness practices, healthy nutrition, and good sleep hygiene are key elements of good self-care (Figley, 1995). Mental health organizations may find creative ways to incentivize these practices or create space for them in the work week, for instance by reimbursing gym memberships, setting up friendly workplace competitions, or designating a regular physical activity or self-care hour during the week.

Leaders can also take a number of steps to foster increased awareness of secondary traumatic stress. First by developing organizational fluency and regular discussion around STS through staff training, developing shared concepts and terms, and building awareness of telltale signs of secondary trauma.

Managers can also play a significant role by having regular discussions with their staff about STS and help them to identify when they may be impacted. Managers who openly have these discussions and share about their own experiences with STS normalize stress reactions and reduce feelings of isolation and helplessness.

Lastly, leaders can encourage social connection through the creation of buddy systems (Peterson, 2018). Staff can be paired with a peer with whom they have regular conversations about self-care and the impact their work has on them. They can hold each other accountable in recognizing signs of STS and take steps to address each others needs.

Today, leaders in the mental health field are looking to strengthen their organizations through trauma-informed approaches. This should include an awareness of STS and how to mitigate it. As the field incorporates intentional practices to counter STS, mental health staff will feel more supported, be more self-aware of their own reactions, and be better equipped to stay in the field longer while providing high quality care.

Amy Petersen, LCSW, is Program Director of Children and Family Treatment and Support Services at Vibrant Emotional Health. She also has a private practice where she works with children and adults across NYC. She can be reached at apetersen@vibrant.org.

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Strategies from page 1

We are in a pivotal moment in building an equitable behavioral health system that can effectively address trauma (Grape et al., 2014). We know the needs, and now the resources are available. In addition to the American Rescue Act, New York State is preparing for its long-anticipated waiver renewal.

We have a long way to go, but this is the time to start implementing the approaches we already know work for those who need care the most. Providers and community based organizations must play an active role in establishing what outcomes have value, with an active focus on systemic change. Targeted outreach, community engagement, and services that align with the principles of trauma-informed care and are coordinated within integrated networks offer a blueprint. For example:

The Emma L Bowen Community Service Center (BowenCSC) aka Upper Manhattan Mental Health Center, a behavioral health provider in West Harlem, has developed a network of community-based and faith-based organizations to promote trauma and mental health awareness, offer community-based support, identify those in need of formal intervention, and create new access points for treatment in its Certified Community Behavioral Health Clinic (CCBHC) program. By leveraging the entities already reaching those who remain outside of the BH system and need a pathway "in", BowenCSC has established a community-wide trauma response for outreach, screening, and engagement of Black and Latinx children, youth, and their families in the Upper Manhattan and South Bronx communities. With support from Adelphi University, they are addressing the community's double jeopardy of pre-pandemic vulnerabilities and pandemic-exaggerated disparities by supporting partners to expand screening using the UCLA Brief COVID-19 Screen for Child/Adolescent PTSD and engaging a Certified Recovery Peer Advocate (CRPA) to offer the Attachment, Regulation, and Competency (ARC) and Trauma -Adapted Family Connections (TA-FC) approaches. While fortifying its existing network, BowenCSC is also further expanding the organizations able to screen and referral community members to behavioral health treatment, as well as establishing virtual telehealth sites to improve access. Recognizing the heightened value of early intervention, BowenCSC has also modified its scope of practice to enable treatment of co-occurring disorders beginning at age 12, and is participating in the Mayor's initiative to expand the membership and rehabilitative reach of the Clubhouse model to promote sustainable supports in the community.

Heidi Arthur, LMSW

Catherine Guerrero, MPA

Lawrence Fowler

Mark Sasvary, PhD, LCSW

Another highlight: Coordinated Behavioral Health Services (CBHS), an integrated network of behavioral health and community-based providers in the Hudson Valley, has initiated a process to develop trauma-informed standards of care, informed by the values of social justice and anti-racism. This initiative is being led by representatives from CBHS' two dozen member agencies, including Pat Lemp, Chief Clinical Officer of Westchester Jewish Community Services and Susan Miller, Vice President, Hudson Valley Services, of Rehabilitation Support Services, Inc. They co-chair a CBHS Trauma Informed Care (TIC) committee that includes diverse membership from the CBHS

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complicated, but should be done thoughtfully and with clear intention, emphasizing the principle of transparency. This can be done in a team or in smaller peer groups, based on the size and structure of the organization. Emphasizing the importance of safety and choice, participation in the narrative process should not be required. However, there are benefits to simply observing and hearing that have the potential to be transformative, so passive participation could be recommended as an alternative. Another principle of trauma-informed care inherent in this method is empowerment, as individuals identify how to move forward with purpose and intention. Partnering and engaging in this process with peers also emphasizes the importance of mutual self-help.

The belief that post-traumatic growth is possible is essential to the process, and highlighting examples of growth is one way of demonstrating this potential. In fact, this was the impetus for the launching of MHA's podcast, Surfacing: The Meaning in the Story. The podcast highlights the stories of individuals who have faced trauma or adversity and how the process of making meaning from those experiences led to the person's growth. It is a way for us to use storytelling to reach people on a more global scale, spreading the hopeful message that growth is available to us all.

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behavioral health spending in the U.S.

Beyond service need, there is also a need to mitigate the social and economic conditions that contribute to the development of emotional distress and mental and substance use disorders. Some of these—such as increased economic hardship and social isolation—are consequences of the pandemic and the public health measures taken to contain it. Some, such as economic and health disparities, unsafe living conditions, racism, and community violence—are longstanding faults in the American society. They will be impossible to rectify in time to help today's young people make the transition from adolescence to adulthood. Hopefully, the next generation will benefit.

But before bemoaning the psychological fate of young people in America, we should think about Justine and those like her, who are making lives for themselves despite the pandemic and even if they are emotionally distressed. They are, to quote the novelist Jay Neugeboren, "honing their character against the edge that life has given them."

Human life is not easy. Some would say that it is inherently tragic. We human beings are emotionally vulnerable. But we are also resilient. Which will dominate the post-pandemic period is not yet known; but there is, in my opinion, as much reason for hope as for despair.

Michael B. Friedman is a retired social worker and mental health advocate. His writings are collected at www.michaelbfriedman.com.

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Crisis Respite

The S:US Crisis Respite Center has provided critical support for a few of us. The Center is a unique alternative to a hospital emergency room or inpatient care as it is a gentle means of reintegrating back into the community after intensive psychiatric care. S:US' respite provides a safe, secure, and supported home-like environment for people experiencing an emotional crisis. The Center offers psycho-educational, peer support, and social and recreational groups.

"The best thing for me is to have a place to go and get serenity. I'm not good in a chaotic environment. Stress is one of my triggers. If you have a room, you can get away from that atmosphere and deal with yourself. Here I have my own room. It's hard to focus on your stuff when you have to deal with someone else's," said Timothy. "I'm on medication for depression and anxiety, which I take regularly and that helps. I have people to talk to when I'm going through something."

"S:US reached out, heard my cry, and took me to the place that was best for me at that time. When I was at the respite center, I had time to think. I never experienced what can take place in a setting like that. It can be hectic in a shared apartment. I had my daughter too--she also intervened and spoke up on my behalf to show support. I got through it and I was relocated. I'm in scattered-site supported housing right now. It's pretty decent," Raymond said.

Making Progress

We are all thankful for the support and services S:US provides to us and how that makes it possible for us to make progress in other areas of our lives. It's amazing what's possible when our basic needs of food, housing, mental health support, and connection with family and community are met.

"My transition wasn't that easy. I had ups and downs and S:US staff worked some miracles to get me through it. I'm still out here facing my mental illness and S:US is there. I gotta commend S:US, my family, and the community. Everybody plays a part. The community really accepted me as a whole in their way of life," Larry said.

"I focus on maintaining my healthy habits every day. That's the only thing I can do. There's no miracle potion. I just have to learn coping skills. I'm stressed out but am overcoming that. I'm getting ready to move into supported housing so that will be better," Timothy shared.

"Because of S:US, I'm where I'm at today. I can't yet say that I can live on my own, I have my up days and down days. I have more up days now than when I first came home from prison. We all have our ups and downs," Raymond said. "I got my driving permit. I'm going to do a driving class next so I can get my license. Then I can save my money, get a car, and do food delivery. I can get an apartment and get my son and we can live together. I can be more of a father and provide for him better than I am right now."

"I have a son and a daughter now. I have five grandsons. I have three nephews. Before I sink again into the pit of drugs, I have my medication, mindfulness, and therapy. I'm better off for my family by being who I am today. At 70-years-old, I don't have all I want, but I have what I need. I have learned from my mistakes and the things I've read and been able to grow from. I'm thankful for a roof over my head and a home. This is all possible through S:US," Eugene said.

Advice for Others

We have more to share about our stories and advice to give for others who may be in similar situations.

We know that we have to do the work--no one else can do it for us. When you look closely, the injustices facing our society are really a universe of highly individual obstacles. We appreciate that S:US doesn't prescribe paths that define us; they establish a relationship with each of us, offer solutions for our individual situations, and give us the tools to empower ourselves. Realizing that it's rare that just one thing keeps a person from leading a healthy, productive life of purpose, S:US' services are designed to serve the whole person and are tailored to each person's unique needs. The results are that we're no longer limited by our obstacles but propelled by opportunities for a richer experience with the world. This ripple effect extends from each of us out into our communities.

"S:US helps me as much as I help myself. If you want to do better, they'll help you do better. They'll show you the water, but won't force you to drink it," said Raymond. "The program is not just about mental health or re-entry, it's also about getting back to being a law-abiding citizen, a person who is looked at as a regular person. Not just someone who was incarcerated."

Eugene shared, "Whenever there's been an issue, S:US has fixed it. They have been a lifesaver for me. I recognize how fortunate I have been in life. S:US has been an integral part. I cannot say enough about the impact they've had. In society, you're looked down upon as an ex-felon. With S:US, I'm looked at as a human being, not an ex-felon or an addict, and I'm treated as such."

"Mental health affects the old as much as it affects the young. Parents should really recognize mental health. My parents didn't -- they just thought I was a bad child. I had to go on my own to get help. I was in my 40's before I got the help I needed. Early recognition and diagnosis are key," said Elfreda.

"Whatever you're going through, just continue to hold your head up and move on. It's soon gonna pass. We all go through things in life. Learn to make better decisions and choices in your life. Be around positive people," said Timothy.

Together with S:US and our community, we are overcoming trauma. We know we can beat back stigma, build communities, and lead a life of purpose and dignity.

Read MHNE Founder's Inspiring Story:
"From the Depths of Despair to a Mission of Advocacy"

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a kickoff to a new series of Trauma-Informed Supervision work groups. The presentation included a discussion about trauma, vicarious trauma, racial trauma, and self-care. A particular focus on Trauma-Informed Supervision was especially well-received. SAMHSA Trauma-Informed Supervision guidelines include: safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment and choice, and cultural, historical, and gender issues. The challenges of incorporating these concepts, during a pandemic, with the financial pressures facing not-for-profit organizations, engendered a very thoughtful conversation. We are continually learning, and we still have work to do.

The COVID-19 pandemic has provided an unanticipated opportunity and necessity to further our understanding of trauma and resilience. Our commitment to the values of trauma-informed care and the foundational work our agency has done on undoing racism provided the guiding principles for this challenging work. WJCS worked hard to provide safety, predictability, and control for its staff and our community. These are all works in progress, and, like trauma survivors, we discovered strength and resilience at our core. We are by no means finished with this work. We will continually reevaluate whether or not we are hitting the mark, and if not, how to correct our course. We are proud of our agency values, and that we have a strong commitment to Trauma-Informed Care. That was our North Star during this pandemic.

Liane Nelson, PhD, is Chief Psychologist and Director of the Doctoral Psychology Internship Program at WJCS (Westchester Jewish Community Services). She is also Director of the Trager Lemp Center for Treating Trauma and Promoting Resilience. Contact her at lnelson@wjcs.com and by phone at (914) 949-7699 x2475

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The Need from page 4

trauma-informed care and are incorporating universal routine screenings for trauma and take notice of clients' past traumatic experiences. They are also taking steps to examine their own treatment strategies, program procedures, and organizational polices, to evaluate whether they could cause distress. Programs are incorporating peer support services, which reinforce the message that a provider–consumer partnership is important. They're shifting their perspective from, "we, the providers, know best" to "together, we can find solutions."

A successful program can help an individual overcome their personal obstacles to developing a strong, healthy relationship with their provider and more fully taking part in their treatment. Incorporating trauma-informed practice can help to improve individual care by more effectively engaging individuals and helping them stay in treatment.

Promoting and Expanding the Use of Trauma Informed Care

According to the CDC, developing a trauma-informed approach "is not accomplished through any single particular technique or checklist. It requires constant attention, caring awareness, sensitivity, and possibly a cultural change at an organizational level. On-going internal organizational assessment and quality improvement, as well as engagement with community stakeholders, will help to imbed this approach which can be augmented with organizational development and practice improvement."

To help expand the use of trauma informed care, the New York State Office of Mental Health, together with Coordinated Care Services, Inc., provides funding for the NYS Trauma Informed Network, a collaboration of individuals, caregivers, professionals, and organizations dedicated to enhancing trauma-responsive practice change throughout the state.

The Network enhances communication and encourages collaboration and sharing of resources among agencies implementing trauma-informed practices. The organization's website allows "… individuals and organizations to connect to one another, share training or event information, and to easily obtain resources to enhance their own work in becoming more trauma-responsive."

For more information visit: https://www.traumainformedny.org.

As we recover from the COVID-19 pandemic, the importance of, and need for, trauma informed care, has never been clearer. Fortunately, more and more healthcare providers are integrating knowledge about trauma into their treatment practice, policies, and procedures. This helps individuals who have experienced trauma to be validated, supported and empowered ultimately providing better health outcomes.

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membership, which includes both clinical and non-clinical treatment and recovery support providers. The TIC committee has embedded the principles of TIC in the development of the standards of care and an attestation process to reinforce the commitment to TIC throughout the network. The TIC subcommittee recognizes that providers are at different places in the development of trauma-informed cultures and that TIC is not an endpoint but an ongoing process of growth and learning. The TIC committee is laying the foundation to provide the support and resources needed by the complex and vulnerable populations CBHS seeks to better serve by ensuring that TIC, with an intentional focus on racial justice, is woven into the delivery of all essential services and that robust community partnerships facilitate access to care.

These examples demonstrate how addressing trauma and racial disparities at the community level provides the opportunity to advance healing for individuals while also building the community infrastructure needed to support resilience and change the trajectory of social relationships and connections (Pinderhughes et al., 2015). When planning includes the application of a trauma lens, there is the potential for long term impact. For these new models to work, government and payors must advance alternate payment models that centralize health equity and continue to allow providers the regulatory flexibility that innovation demands (Klinenberg, 2018). This is time for power sharing and collaboration in the interest of optimal outcomes. By mobilizing community assets to promote access and realize the cost saving economies of effective care, we can achieve the behavioral health system we have needed all along.

Bowen Center Tobacco Cessation Group

About the Authors: Heidi Arthur, LMSW, Principal, Health Management Associates. Catherine Guerrero, MPA, Principal, Health Management Associates. Lawrence Fowler, Deputy Executive Director, The Emma L. Bowen Community Service Center. And Mark Sasvary, PhD, LCSW, Chief Clinical Officer, Coordinated Behavioral Health Services.

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and more than 150 languages are supported through a Tele-Interpreters service. The Lifeline comprises a national network of more than 180 local crisis centers, uniting local resources with national best practices. Since its inception in 2005, the Lifeline has engaged in innovative public messaging, development of best practices in mental health, creative partnerships, and more to improve crisis services and advance suicide prevention for all.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. To that end, it funds billions of dollars in grants that enable states, territories and tribes to address behavioral health needs at the community level. SAMHSA also operates public-facing treatment locators and helplines to help connect Americans to needed services and support. People searching for treatment for mental or substance use disorders can find it by visiting https://findtreatment.samhsa.gov or by calling SAMHSA's National Helpline, 1-800-662-HELP (4357).

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another, or from one type of setting to another.

The mobile multidisciplinary teams engage individuals prior to hospital discharge (or while still homeless) and promote community integration by offering comprehensive support for emotional, physical and social needs during the critical time period following inpatient discharge or once an enrollee is no longer living on the streets or in the subway system.

Early engagement allows for increased participation and rapport-building, as the team identifies, mitigates and resolves barriers that to successful reintegration. The intervention continues into the community and facilitates integration and continuity of care by ensuring support systems are in place and enduring ties to the community are established.

CBC's engagement approaches are extraordinarily highly effective: 91 percent of individuals receiving intake interviews enrolled in Pathway Home™. Graduates of the programs had significantly fewer psychiatric inpatient days per month during and after enrollment, relative to their pre-enrollment standards, and engage with outpatient behavioral health services with greater regularity during enrollment and sustain this adherence to care on follow-up.

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prevention addresses an entire population, all of whose members are likely at the same general risk of the outcome to be prevented or mitigated. Universal prevention programs are generally delivered to large groups without assessment of individual needs. Selective prevention strategies are directed toward sub-groups of the population that share some characteristic – e.g., demographic, socioeconomic, historical factors; again without assessment of individual needs. In contrast, indicated prevention strategies are directed toward individuals who show emerging signs of the undesired outcome. Specialized programs are employed toward that end. For our purposes, universal education is appropriate for our communities as a whole – e.g., Public Service announcements, community education events etc. Selective prevention strategies can be directed to the group of Frontline Workers - even though this is a highly diverse group with respect to service sector, geography, socioeconomic, race, ethnicity and multiple other factors. Selective prevention strategies which are most specific should be available to individuals who experience challenges related to COVID and its related disruptions. This paradigm is useful to satisfy our workgroup charge to identify evidence-based resources for FLW workers. I expect we will discover that there are many practices based on proven principles of trauma informed care and promoting resilience but that few non-"clinical" supports and resources have been evaluated for effectiveness. With respect to promoting resilience, I hope that you will also read the article about priming for post-pandemic growth submitted by Jenna Velez, Mental Health Association of Westchester VP of External Affairs also in this edition of *Behavioral Health News*.

Another complex challenge, I believe, is how to promote interest and acceptance of conversations about the impact of trauma in organizational and community settings in which currently this is not culturally syntonic? This is a big topic, beyond the scope of this article.

The challenges and tasks I've identified are indeed substantive. I believe that the work starts with a group of committed "champions". Fortunately, NYS has them in this group's leadership and members and among our state legislators.

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health professionals and legal professionals. We strongly believe that this partnership was a key to the training's success, and that continued partnerships across interdisciplinary providers on trainings is essential to better serve clients as well as to providing educational learning that is impactful and meets the goals of TIC.

This outreach beyond the usual silo of psychiatry is even more pressing during the COVID-19 pandemic. Together with the increased psychological stress experienced by all during this crisis, as well as disruptions to accessing institutions of service and health care, there is an urgent need for society and systems of care to provide trauma-responsive care to everyone. Psychiatry has the opportunity, knowledge, and skill to help shape this conversation. "There is no health without mental health."

Elizabeth M. Fitelson, MD, is Associate Professor of Psychiatry at CUIMC, and Director of The Women's Program at Columbia University Department of Psychiatry. Obianuju O. Berry, MD, MPH, is Medical Director at NYC Health and Hospitals Gender-Based and Domestic Violence Mental Health Collaboration, and is Clinical Assistant Professor, Department of Child and Adolescent Psychiatry, at NYU.

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and communities-- Covid-19 and the global trauma tsunami it has triggered were unimaginable. Now, it is clear the destructive waves of this trauma tsunami may likely be hitting us for a long time to come-- making the incorporation of universal precautions fundamental to Trauma -Informed Care all the more crucial across all public service sectors.

There is strong belief that the guidance and support of this collaborative workgroup will be impactful and have strong reverberations. When organizations across multiple communities and sectors move in the same direction, a deep ripple effect that results in better experiences and outcomes for staff, patients, students and communities can be expected.

"Many of us in Westchester have increasingly come to realize the pivotal role of trauma in social determinants of health, racism, physical health and emotional wellness. This awareness brings a renewed sense of urgency to take real and meaningful action that fundamentally changes how our systems operate," said Andrew Bell, Ph.D., a Program Director at Westchester County's Department of Community Mental Health and Co-Chair of the Trauma Subcommittee. "This Learning Collaborative has come just in time to help us tackle this daunting task together. Blythedale's leadership and vision will allow us to create a comprehensive blueprint that will serve us for years to come."

This six-month learning collaborative, which consists of 37 Champions from 24 organizations across various disciplines and service settings, is being facilitated by The Institute on Trauma and Trauma Informed Care (ITTIC). ITTIC is a University at Buffalo School of Social Work-based research center with nine years of experience in providing training, consultation, coaching, and evaluation for organizations and service delivery systems on trauma and Trauma-Informed Care. The Institute is dedicated to providing the public with knowledge about trauma, adversity and its impact, and promoting the implementation of Trauma-Informed Care. Recognizing the centrality of trauma is the key to accomplishing ITTIC's overall mission of establishing a multidisciplinary trauma-informed system of care, thus ensuring that service systems are not re-traumatizing the individuals within them. As part of New York State's University System, ITTIC remains eager to bring their services and expertise to other NY-based entities and communities.

"We are struck by the collective influence and diversity of experience represented among this learning collaborative's Champion cohort," said Whitney L. Marris, LMSW, Project Manager at The Institute on Trauma and Trauma-Informed Care, Buffalo Center for Social Research, University at Buffalo School of Social Work. "The last 14 months have been emotional, stressful, and potentially traumatic. These Champions come from cornerstone community spaces where they witness the indelible—and, indeed, often inequitable impacts that navigating this era continues to have on individuals, families, the workforce, the community, and service systems across Westchester County every day. Coming together to enliven a trauma-informed approach through participation in this Learning Collaborative will provide a framework for folks to honor these experiences in ways that are more helpful than harmful, while equipping Champions with the requisite strategy and intention to set the stage for healing, resilience, and growth in Westchester County moving forward."

Blythedale's vision goes beyond endorsing a shared framework and expanding Trauma-Informed Care throughout the county. Other key objectives related to the initiative include building a referral network of trauma-informed agencies, within and across, service sectors to foster a continuum of care that better serves patients, students, Health Home families and communities and encouraging the Champions to join the county's longstanding Trauma Committee to continue the work and foster sustainability after the conclusion of the Learning Collaborative. Ultimately, our goal for this Learning Collaborative is to provoke meaningful change with regard to addressing ACEs and trauma and add significantly to the growing list of advancements in Westchester County. With evidence-based models and best practices available to guide us forward, now seems like a vital time to prioritize a collective movement in the direction of Trauma-Informed Care.

"We are proud to bring together such an important cohort of community leaders to improve not only the provision of care at our individual organizations, but to bring about systemic change within the communities we serve," said Blythedale Children's Hospital President & CEO Larry Levine. "At Blythedale, we are caring for an extremely vulnerable population and the pandemic has only amplified the challenges our families face. It is only logical that we would support such a vital and much-needed initiative."

Continued proof of commitment and momentum in this movement will also need to come from local and state policymakers who could eventually codify ACE, trauma and resiliency science into additional legislation. Two bills passed in late 2019 mark the first time ACE science has been signed into law in New York State. Serving as a fierce advocate for children and families, Blythedale's leadership continues to work tirelessly to influence public policy. Champions of this collaborative along with other local entities are viewed as a coalition that possesses the unique opportunity and responsibility to use their leadership positions to speak out on important causes and issues that give a voice to the voiceless.

To spur change and progress toward becoming a trauma-informed county, we must collaborate and forge our efforts and resources. Like the old adage says --- if you want to go fast, go alone. If you want to go far, go together.

This training is funded by Blythedale Children's Hospital and Kohl's Eat Well, Be Well Community Wellness Program. Through generous grants, the Kohl's Cares program has supported vitally important community programs at Blythedale since 2000, donating nearly $3 million.

For more information about Blythedale Children's Hospital, visit blythedale.org.

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Retention from page 28

Research reveals promising evidence of reduced rates of VC and STS, and increased awareness of personal trauma reactions, when staff receive TISC training, specifically the implementation of personal self-care practices and trauma-informed training that focuses on understanding manifestations of trauma in: 1) those being helped and 2) helping professionals.

Although empirical data exists regarding the negative influence of trauma reactions on staff retention, more studies are required to examine the impact of TISC on employee retention for TIC organizations. This is particularly needed in the current climate since the COVID-19 pandemic, in which we are seeing an exacerbation in behavioral health conditions and lower rates of employee retention.

The traumatic impact of COVID-19 for staff and individuals receiving services has already begun contributing to psychotherapist's rates of VT and will likely continue for some time (Aafjes-van Doorn et al., 2020). Development of strong TIC organizations that focus on TISC practices and trainings have the potential to create safe, healthy and effective work environments where high staff retention and the use of empirically-supported practices fuels the highest standards of care for individuals served, and contributes to healthier and happier communities.

To learn more about Devereux Advanced Behavioral Health, visit https://www.devereux.org/. To contact Crystal Taylor-Dietz, PsyD, email: CTaylo11@deveruex.org.

Devereux Advanced Behavioral Health: Devereux Advanced Behavioral Health is one of the nation's largest nonprofit organizations providing services, insight and leadership in the evolving field of behavioral healthcare. Founded in 1912 by special education pioneer Helena Devereux, the organization operates a comprehensive network of clinical, therapeutic, educational, and employment programs and services that positively impact the lives of tens of thousands of children, adults – and their families – every year. Focused on clinical advances emerging from a new understanding of the brain, its unique approach combines evidence-based interventions with compassionate family engagement.

Devereux is a recognized partner for families, schools and communities, serving many of our country's most vulnerable populations in the areas of autism, intellectual and developmental disabilities, specialty mental health, education and child welfare. For more than a century, Devereux Advanced Behavioral Health has been guided by a simple and enduring mission: To change lives by unlocking and nurturing human potential for people living with emotional, behavioral or cognitive differences. Learn more: www.devereux.org.

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Black/African American and Hispanic/Latinx communities. Culturally competent care plans are therefore critical when serving racial/ethnic minorities, as studies have shown that patients feel higher levels of trust when providers share their racial/ethnic background.

The Importance of Adopting a Trauma-Informed Model at the CEO Table

I have been in the primary care, behavioral health, and human services fields for over 20 years. Over the past two decades, I have witnessed firsthand the undeniable impact that adopting a trauma-informed lens can have on the way providers and practitioners approach their work, and how clients engage in their recovery processes.

In my early career, I was given the opportunity to develop and lead trauma-informed trainings for community outreach workers. Fast forward a few years, and I was running the day-to-day operations of a federally-qualified health center that served women and children, where I was able to put into practice what I had been training community outreach workers to do. Until then, I had considered myself an expert in the whys and how you should adopt a trauma-informed model, but I hadn't had the opportunity to witness the true power of this approach.

Today, I have the honor of serving as the Chief Operating Officer at Acacia Network, one of the largest Latino-led nonprofits in the nation, serving more than 150,000 individuals annually through integrated, trauma-informed services in the areas of health, housing, economic development, social services, and cultural revitalization. Among other resources, we provide comprehensive and culturally responsive behavioral health and addiction services to youth and adults in vulnerable communities such as the South Bronx.

At Acacia, I have challenged our leaders and champions –from the CEO to our frontline staff– to see every aspect of their work through a trauma-informed lens: from the color of our walls and the artwork we display, to the way we interact with our program participants in their own language.

Trauma-informed work requires leading by example and acknowledging our own trauma before addressing the challenges our communities face on a daily basis. Recognizing these challenges requires a cultural competence lens that takes into account our shared history, our struggles, our background, our trauma.

Frontline organizations like Acacia are uniquely positioned to effect lasting change because most of us, from the leaders to the staff, come from the very communities we serve. As practitioners and essential services providers in the trenches, we have a duty to our communities. We have an opportunity.

Let's all rise to this challenge, so we can continue serving our communities with the compassion and care they deserve.

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provider community is what will continue to move the system forward on becoming trauma informed. Internally, the OASAS "Trauma Champions" continue to meet and explore how to further move the system and OASAS forward in becoming more trauma informed. This has been helped by the leadership and support of OASAS Commissioner Arlene González-Sánchez, who knows, "Many people who use substances have experienced trauma and are often more vulnerable to ongoing trauma. This is why, OASAS is committed to our work with the Institute on Trauma and Trauma Informed Care, to assist our provider system in becoming more trauma-informed in order to create opportunities for healing and person-centered care."

Samantha P. Koury, LMSW, is Project Manager/Trainer, and Susan A. Green, LCSW, is Co-Director, at the Institute on Trauma and Trauma-Informed Care. Maria L. Morris-Groves, MSEd, is Director of Adolescent, Women and Family Services at the New York State Office of Addiction Services and Supports.

For more information about ITTIC and OASAS, please visit their websites at: http://socialwork.buffalo.edu/ittic and http://oasas.ny.gov.

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will last for decades. For the children and youth we serve, who had been living in a state of crisis long before COVID-19, the pandemic may have reversed years if not decades of progress for children, youth and families. But our experience with trauma-informed care has been instrumental in our ability to help many youth and families navigate the many traumas – including the pandemic -- that have effected them for much their lives. We are optimistic that the damage of these negative life experiences can be turned around and allow a person – whatever age -- to lead the most fulfilling life possible.

Amy E. Schmelz, MS, NCC, is Clinical and Training Support Specialist and Clinical Partner at ICL.

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to learning more about TIC. We are also committed to providing our clinicians and managers the environment and opportunities to improve their skills. With this in mind, BAC has created a new learning space where our staff meets monthly to share, practice, observe and reflect on applying TIC principles in their work. We are looking forward to learning with them.

Nadine Akinyemi, MHA, is Executive Director (nakinyemi@bac-ny.org), and Esther W. Y. Lok, MEd, MPA, PMP, is Chief of Staff (elok@bac-ny.org) at Bridging Access to Care.

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treat clients with ACEs backgrounds in a framework of "What happened to you?" instead of "What's wrong with you?" Such a lens helps to promote awareness and sensitivity to the lasting effects of traumatic events on the individual (SAMHSA, 2018).

Individuals with disabilities may have traumatic experiences that stem from treatment, as well as events that are independent of the treatment context. Within treatment, there may have been instances of restraint or seclusion that triggered trauma. While clinical guidelines and safeguards exist for the use of such procedures (APBA, 2016), they are relatively recent, they are not universally followed, and they may not prevent trauma for especially vulnerable individuals. Perhaps more importantly, assessment and treatment must be tailored to ensure that trauma has been considered and that appropriate modifications have been embedded into individualized plans (Kolu, 2018;2019). Issues such as a history of food insecurity, sexual abuse, or neglect must be considered as reinforcement, redirection, or monitoring procedures are selected. In many ways, trauma-informed care is an additional lens through which clients are viewed, and thorough which assessment and treatment is planned.

Given the increasing impact of trauma on childhood experiences, many regulators and funders have begun requiring organizations who provide behavioral health services to adapt treatment packages to include TIC (Center for Health Care Strategies, 2017). Integration of TIC requires organizations to evaluate and potentially change current processes both at the organization level and clinical level (Menschner & Maul, 2016). At the organizational level, Menschner and Maul (2016) discuss "key ingredients" for organizations to be successful with the integration of TIC. One key ingredient is the need for senior leaders to be involved throughout the integration process. Unick, Bassuk, Richard and Paquette (2019) suggest organizations start by assessing how trauma affects the organization, including both individuals served and the employees. In addition, an assessment should include to what extent the current mission/vision, policies and procedures support TIC. Understanding these components assists organizations with the development of an infrastructure for guiding and supporting change (Substance Abuse and Mental Health Services Administration, 2014).

A second key ingredient discussed by Menschner and Maul (2016) is the need for training. Substance Abuse and Mental Health Services Administration (2014) suggests training at all levels regardless of prior experience with TIC. Training for administrator and direct care staff should include the effects trauma can have on an individual and how to avoid retraumtization. Training for clinical level staff should include more in-depth training on evidence based practices and interventions for treatment. Throughout the integration process and after, organizations should continue to collect data on the ongoing impact of trauma training efforts. A systematic review conducted by Purtle (2018), found TIC interventions had a more meaningful impact on client outcomes when the training package included components such as the inclusion of competency based tools for assessment of training participants, review of policies to ensure they align with trauma informed practices and ongoing research on interventions, participant and client outcomes.

Menschner and Maul (2016) also discuss the importance of a comprehensive clinical approach to treating trauma. "Upfront and universal" screening procedures are suggested to provide a screening process with less racial/ethnic bias, to better understand the client's trauma history, and to help target treatment interventions (Menschner and Maul, 2016). Bassuk, Richard and Paquette (2019) also found the involvement of the "service user" model to be very beneficial to the success of the organization. When "service users" feel their feedback is being heard, their outcomes are improved (Bassuk Richard, & Paquette, 2019). Meaningful involvement includes contributing to the organization's policies and procedures, and to their own treatment, through methods such as self-assessment.

Furthermore, Substance Abuse and Mental Health Services Administration (2014) suggests a peer support network aids greatly in the treatment of trauma. Peer support provides an abundance of opportunities for personal growth and support through activities such as: crisis management, recovery, advocacy, modeling, and encouraging and facilitating empowerment, collaboration and empathy (Substance Abuse and Mental Health Services Administration, 2014). The key element to this component of intervention is access to empathic support. This can be provided through a group of peers, through a selected peer, or by a trusted staff member.

Earl et al. (2017) propose several strategies specific to the Autism Spectrum Disorder (ASD) population and effective trauma treatment. Since individuals living with ASD may have difficulties with verbal and abstract reasoning, using visual stimuli, providing coping skill training, and helping to identify triggers and/or trauma cues are recommended treatment elements (Earl et al., 2017). Creating a "trauma narrative," which helps with cognitive processing, and then teaching when, where and with whom it is safe to share this narrative, are also important elements of treatment for individuals with ASD. Earl et al. (2017) further encourage the trauma narrative to be created in ways that are appealing and understandable to individuals with ASD, such as using visual aids, structured play scenarios, and/or creating a story. Earl et al. (2017) also stress the use of "in-vivo exposure to trauma reminders" as a viable therapy option. Presenting exposure in a scaffolding approach, creating step-by step plan for exposure, developing contingency plans, and incentivizing exposure practice are suggested in-vivo accommodations for individuals with ASD.

The awareness of trauma and its' impact on individuals has increased tremendously in recent years, and this has recently been extended into care planning for individuals with disabilities. The prevalence of adverse events, and the concomitant trauma, is recognized, and treatment that is tailored to these needs is increasingly common. The tenets of compassionate care can easily be integrated with the principles of trauma-informed care, and TIC provides a natural extension of the humane care provided to individuals with disabilities. Furthermore, the individualization that defines a behavior analytic approach to the care of individuals with disabilities is entirely congruent with the highly individualized assessment and treatment needed to meet the needs of those with traumatic experiences. The evidence-based strategies that have been identified as effective for individuals with autism can be used in the context of TIC, and can ensure that treatment is a delivered in a manner that is comprehensible, supportive, and humane. The integration of TIC presents an opportunity for intervention to be even more specifically individualized, tailored to the unique needs, history, and strengths of each and every individual.

Mary Jane Weiss Ph.D., BCBA-D, LABA, is Senior Director of Research, Jennifer Mucellin, MA, BCBA is Director of Operations Children's RTF, and Jennifer Ruane, MS, BCBA, LPC is Director of Professional Development and Clinical Training at Melmark.

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Lessons from page 17

caseloads, and policies that enable wellbeing (employee assistance programs, adequate paid time off, good health benefits including mental health, etc.). This is equally if not more the case for behavioral health professionals, who are increasingly called upon to provide local support for their peers (while themselves often lacking the same benefit). Too often trauma-informed care training participants share implementation barriers not about their patients or workspaces, but about their management and leadership. Trauma-informed organizations begin with trauma -informed leaders.

3. Many healthcare professionals just learning about trauma-informed care are often not starting from 'zero'. Trauma-informed care is not dissimilar from other approaches to good care that are sometimes already familiar to staff, including person-centered care and culturally-competent care. As trainers of healthcare professionals, we develop trainings on each of these topics and frequently find the discussions touching on similar themes. For example, when taking a patient or person-centered approach to care, healthcare staff consider the whole-person and their unique goals instead of their singular diagnosis or illness. The practitioner's job is not always to 'fix' an identified problem as much as it is to incorporate a person's goals into a broader care plan, facilitate open conversation and create context for safe discussions in present and future episodes of care. If an organization has already worked to incorporate cultural humility, taking an open and curious stance in learning about patients' backgrounds, cultures and values, they have already begun to embrace trauma-informed principles of collaboration and empowerment. Capitalizing on existing efforts around enhancing care can be a significant boon to any new trauma-informed initiative.

4. Leadership take note: it starts with you but lives with your staff. While leadership buy-in and support is essential, the sustainability of trauma-informed care implementation typically resides with staff. Recognizing and including key members of the team in preparation and implementation of trauma-informed care can support the ultimate viability of the work. In the case of screening for adverse childhood experiences and trauma, daily practice of these efforts is often not as simple as it may seem. Staff that play a part in screening- from the front desk team to the clinicians, need to be involved in the roll-out of any new practices to troubleshoot the process and develop a sense of ownership in the work. When planning for a new trauma-informed patient flow, screening process, or treatment space, no one knows better how it will go than the staff involved in the daily practice. If staff feel they were not consulted or considered in a new initiative, especially related to trauma-informed care, they may feel caught off guard, devalued, and generally start off already experiencing a lack of choice contrary to trauma-informed care itself.

5. Trauma-informed care can be practiced just about anywhere (even in small exam rooms or dated clinics). We've assisted in planning and financing beautiful facility renovations for trauma-informed redesign, but completing a recent year-long training series for small practices implementing trauma-informed screening for adverse childhood experiences revealed that trauma-informed care can happen in even some of the tightest corners. Staff in small practices and clinics- those with fewer than about six providers (and sometimes just one)- and agencies practicing in older or cramped spaces- sometimes share that they feel their workspaces make trauma-informed care impossible. Leadership may also feel that without a major overhaul or a new building, it's not worth incorporating trauma-informed care.

It is a fair question: "how could anyone feel safe and empowered in this kind of place?" A tiny clinical room barely big enough for the exam table or an old office in the shadow of a decaying industrial area may seem impossibly unforgiving, but we have witnessed training participants find ways to incorporate trauma -informed principles in their care no matter the space. Sometimes creating safe and welcoming spaces is as simple as replacing a flickering white florescent bulb with a new warm-colored replacement, but most trauma-informed care really occurs in the client and staff interactions. Offering clients some choice about where they sit or even how they position their chair (we've even shared stories of providers offering to sit on the exam table if patients felt more comfortable on their stool!) can be a meaningful gesture towards empowerment. Listening carefully to patients wishes and needs, respecting personal boundaries and asking permission before making physical contact or asking invasive questions can all send important messages that enhance safety, trust, and confidence in the practice of trauma-informed care.

Every agency, organization and clinic is unique in their steps toward navigating the best implementation of trauma-informed care. After training and learning from hundreds of healthcare professionals from mental health, substance use, social service, and primary care systems, it is increasingly clear how valuable trauma-informed care is for both clients and staff. As much as we must focus on reducing unnecessarily healthcare costs and improving key outcomes and metrics, to get there we must begin by focusing on the humanity inherent in the practice of care. Healthcare practitioners bring powerful personal and professional experiences to the table, and with strong leadership support and thoughtful execution of trauma-informed principles, we are seeing a nation of dedicated caregivers ready to rise to the occasion of trauma-informed care.

Yael Lipton, MPH, MCHES, is Curriculum Development Specialist and Trainer, and Andrew Philip, PhD, is Clinical Lead and Senior Director at Primary Care Development Corporation.

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