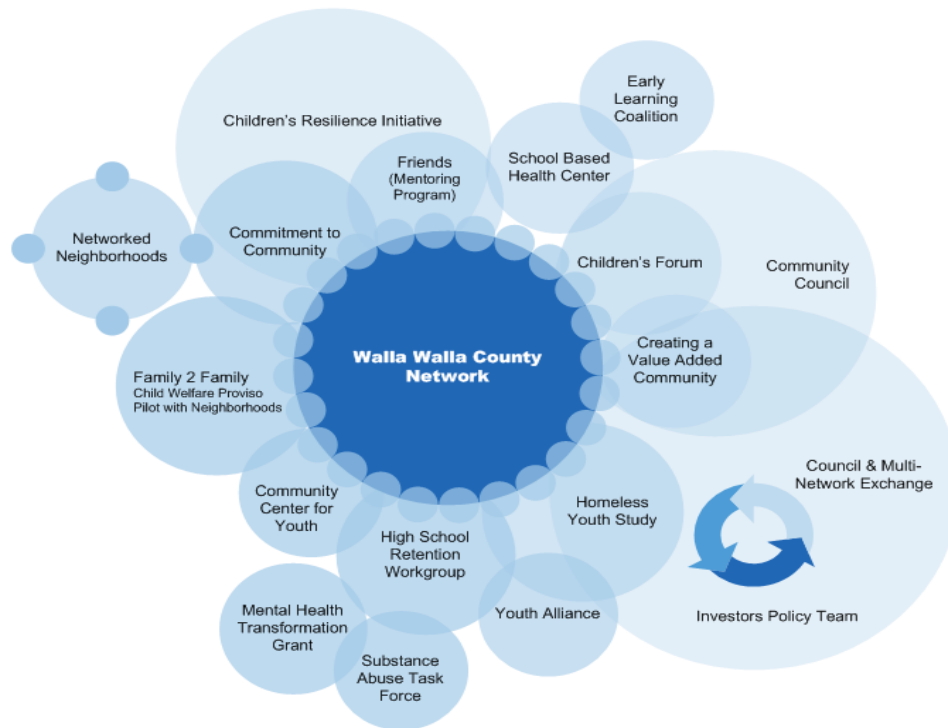# Trauma Informed Practices
Implemented by Eleven Local Organizations,
Members of the Children's Resilience Initiative, in Walla Walla, Washington State

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Abstract

This study examines the degree of commonality or difference in the set of trauma informed practices implemented by eleven different organizations in Walla Walla, Washington -- including schools, health providers, non-profits, public agencies, and neighborhood organizations. The people involved were social and health professionals, and also volunteers, parents, neighbors, and youth helping each other.

Our analysis of seven focus groups found an unusually common set of trauma informed practices organized around three objectives:

1. To create conditions aimed at overcoming ACE barriers and increasing resilience - safety, calmness, respect - that enable developing trusting relationships and mutual supports.
2. To build personal skills – knowledge of ACEs and resilience, socio-emotional regulation, problem solving and self-sufficiency, hope and positive self-image/future and accountability.
3. To develop caregiver skills – self-awareness, ease in shifting mental models, self-care, reflecting (in learning type organizations), partnering and collaborating (with other organizations).

These findings may provide other communities with insights not only on **what** trauma informed practices to implement but also on **how** to implement them. Walla Walla has done this by developing a 'scaffolded' strategy of prevention activities building higher community capacity over the past 18 years.

Our hope is that these findings will help other communities trying to increase resilience and reduce ACEs.

March 2016

Introduction

The research on trauma informed practices (TIPs) is part of a larger set of studies focusing on the key roles of community capacity and resilience and the extent to which they moderate/buffer the negative impacts of adverse childhood experiences (ACEs) on a number of outcomes: education, physical and mental health, employment/wages and fewer ACEs in the next generation (see the factors in the right-hand column of boxes in the model below). Summary findings are available in the Casey Family Foundation webinar (June 30, 2015). Prior research studies have shown the links between:
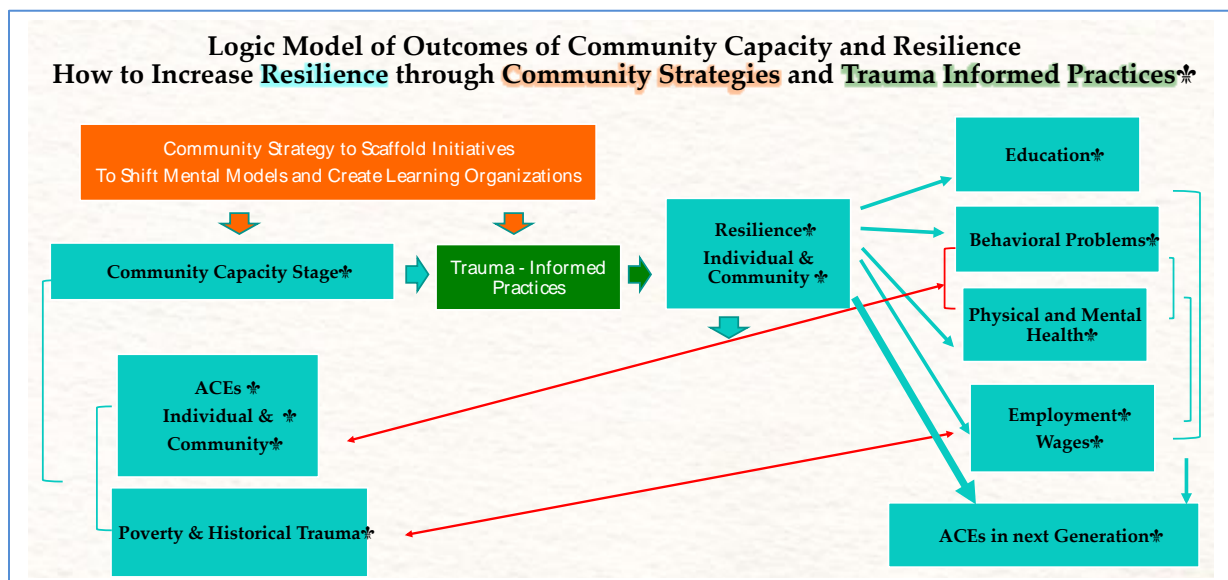
- Community capacity levels and resilience levels (Flaspohler *et al.* 2012)
- Community capacity and employment (Longhi 2012 FPC report)
- Community capacity 'bending the curve' of increasing ACEs for younger adults (Hall, *et al.* 2012)
- Individual resilience and educational attainment (forthcoming)
- Individual resilience moderating the impact of ACEs on mental and physical health (Logan Green *et al.* 2014) and on chronic illnesses (Nurius *et al.* forthcoming 2016)
- Increases in individual resilience and school performance at Lincoln High School (Longhi Barila 2015)
- Contextual resilience and education and health levels across communities (forthcoming)

What the above studies do not show is **how** community capacity levels and resilience can be increased in communities so that these desirable outcomes can be attained (in education, health, jobs, fewer ACEs). Investigating the **how** involves qualitative studies on ways to increase the capacity of communities to implement trauma informed practices (see orange and green boxes below) which increase resilience.

Focusing on Walla Walla, a community at a 'thriving' stage of capacity, two recent reports show:

1. The strategy of scaffolding initiatives to improve community capacity (Barila *et al.* 2015)
2. The use of innovative TIPs in schools to increase resilience and learning (Longhi & Barila 2015)

What is still unknown is if common TIPs can be implemented across various local organizations in order to increase and reinforce resilience, across different community domains -- peer, family school and neighborhoods -- reaching a large proportion (30%-50%) of the population most affected by ACEs.

Logic Model of Outcomes of Community Capacity and Resilience
How to Increase Resilience through Community Strategies and Trauma Informed Practices

This study asks the following question (a 'practice to research' developmental evaluation one):

Are there common TIPs among eleven local organizations operating in Walla Walla? If so, then it may be that these TIPs are the ones that are commonly effective in increasing resilience for both youth and adults across different community domains.

Methods

The organizations: Seven focus groups were conducted over a four-day period, with different local community organizations serving different populations.

1. Focus Group 1: Lincoln (Alternative) High School (LHS)
2. Focus Group 2: Jubilee Leadership Academy, a private boarding school for boys
3. Focus Group 3: The Health Center, providing physical and mental health services to several schools
4. Focus Group 4: Valley Residential Services, a non-profit organization providing residential services mainly to adults, including parents, veterans and people with developmental disabilities
5. Focus Group 5: three non-profit organizations focused primarily on youth: Catholic Charities, Friends of Children providing mentoring to students, and Children's Home Society
6. Focus Group 6: organizations providing court-related services: the local Children's Administration office, Juvenile Justice for Walla Walla County, and CASA (Court Appointed Special Advocates)
7. Focus Group 7: Commitment to Community (C2C) -- a community organization that has worked for many years in the low income, high poverty, high diversity neighborhoods.

The organizations, all partners in the Walla Walla Children's Resilience Initiative (CRI), had received training on ACEs, brain development effects, and resilience strategies, but not on specific practices that each agency could utilize to help increase resilience within their agency's culture and environment. Figuring out how to implement practices was an ongoing learning process by all CRI partners, facilitated at monthly team meetings. What was known in 2009, when CRI started, was that:

- Cumulative traumas (ACEs) had neuro-biological effects on brain development with concomitant physical health consequences and;
- Resilience, not well defined or measured yet, had the promise of moderating the impact of ACEs.

The participants: Focus group members were recruited as **<u>representative</u>** samples, 4-5 per organization, who were:

1. Implementing trauma informed practices (TIPs), making changes to do so, training others, or:
2. Considering doing so, wanting to learn more.

Input from individual participants was anonymous. See Appendix for the invitation to participate.

Focus group purpose: to learn about successes and challenges in implementing trauma informed practices over the course of CRI's development (2009 to the current study):

1. **Changes in practices**: In your organization/agency what <u>kinds of practices have</u> been implemented to increase resilience? <u>How</u> have they been implemented? <u>By whom</u>?
2. **Challenges:** What <u>kinds of changes</u> (if any) were required to start and/ or continue implementing such practices? What <u>obstacles or barriers</u> did you originally, or still encounter?

The focus group facilitator collected input from each individual participant (who wrote each practice(s) on a piece of paper) and then asked the group to organize all the inputs (the separate pieces of paper) into patterns. The focus group had to come to consensus on the grouping of practices and what to call them – i.e. what the practices on each piece of paper had in common (see photo below). Focus group recorders documented the patterns achieved and took notes on the group discussion and conclusions.
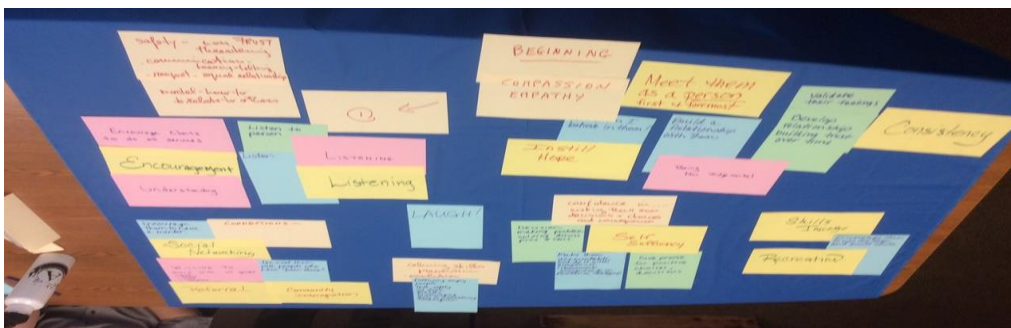
Results

1. Results of the qualitative analyses led to a summary for each focus group in a common format. The pattern of practices identified by each focus group was written up in the sequence that the focus group had devised, with labels that the group had decided on. Specific behaviors were listed under each label. This process produced seven summary results, one for each focus group, in the language of each organization (see Appendix 2). The eleven organizations are listed in Table 1.

2. Common practices were identified across focus groups and organizations.

Based on focus group discussions and majority conclusions, practices were organized into three groups:

- those that <u>create conditions</u> to overcome trauma and to start the development of resilience;
- those that <u>develop personal skills</u> to increase resilience;
- those that <u>develop caregiver skills</u> to implement the above trauma informed practices (TIPs).

Individual practices identified by each focus group were listed as part of the three groupings.

3. Common practices implemented across organizations are displayed in Table 2.
   - Check marks indicate what practices were implemented by each organization in Table 3;
   - Profiles of practices implemented by each organization, in their own language, are in Table 4.

We found that all eleven organizations have been implementing remarkably similar trauma informed practices. However, some types of practices are more common, some less:

- Most common are the set of practices creating conditions to overcome trauma and increase resilience:
  - Practices creating safe, non-judgmental social environments and calm state of minds;
  - Practices that are respectful, understanding and warm;
  - Practices that enable the development of trusting relationships, and mutual supports.
- Second most common are the set of practices that build personal skills:
  - Practices that increase knowledge of ACEs and resilience, helping develop socio-emotional regulation skills that enable increased self-awareness;
  - Implementing mastery skills involving problem solving and self-sufficiency, that are aided by:
  - Practices that encourage hope, positive self-image and future;
  - While fostering learning accountability skills.
- Less commonly implemented across all organizations are the practices that develop caregiver skills:
  These are skills that develop more:
  - Self-awareness;
  - Ease in shifting mental models;
  - Self-care;
  - Reflecting in a learning organization;
  - Partnering and collaborating with other organizations.

  These 'caregiver' practices, which may require organizational changes, occur more commonly in six of the eleven organizations, ones that are smaller, non-hierarchical, voluntary organizations, often non-profit, health, social and education organizations. These practices may be harder to implement in more hierarchical organizations managed by regulations, policies and procedures. This category of practices has been the priority for CRI in the past year, including the development of six modules addressing caregiver skills and an understanding and awareness of self-regulation. Seven of the 11 agencies in the Focus Groups had participated in this training.

Table 1
Organizations Participating in Focus Groups

Types of Organizations	Eleven Specific Organizations
Schools	Lincoln (Alternative) High School (LHS) Jubilee Leadership Academy (known as Jubilee)
Non-Profits Serving Individuals: Youths, Parents	The Health Center (THC) Valley Residential Services (VRS) Friends of Children (F), Catholic Charities (CC) Children's Home Society (CHS)
Court-related Organizations	Children's Administration (CA, formerly DCFS) Court Appointed Special Advocates (CASA) Juvenile Justice (JJ)
Community/Neighborhood Organizations	Commitment to Community (C2C)

Table 2
Common Trauma Informed Practices Across Eleven Organizations

Common Trauma Informed Practices to Create Specific Conditions and Develop Specific Skills

Practices that help create conditions for resilience among persons with ACEs	Specific Social Conditions – Mindfulness, Relationships/Connections
	• Safe, non-judgmental social environments • Calm psychological/ emotional 'green zones' • Respectful, understanding • Warm personal attention • Trusting relationships • Mutual supports
Practices that develop personal skills to increase resilience across social contexts	**Specific Personal Skills – Mastery, Hope** • Knowledge of ACEs and Resilience • Socio-emotional regulation • Planning, problem-solving, self-sufficiency • Hope, positive self-image and future • Becoming accountable
Practices that develop caregiver skills to increase resilience	**Specific Caregiver Skills--Mindfulness, Values** • Becoming more self-aware by increasing understanding of brain architecture due to ACEs; and Resilience • Shifting mental models, values and automatic reactions • Developing self-care by sharing challenges and barriers • Reflecting in a learning organizations • Partnering and collaborating with others

Table 3 Common Practices
as reflected in the Focus Groups
(NA-not ascertained, blank-not implemented)

	Schools		Non-profits Serving Individuals			Court Orgs.	Comm Org.
	LHS	Jubilee	THC	Valley	F CC CHS	DCFS CASA JJ	C2C

Practices that help create conditions for resilience among persons with ACEs

- Safe, non-judgmental social environments
- Calm psych - emotional 'green zones'
- Respectful, understanding
- Warm personal attention
- Trusting relationships
- Mutual supports

LHS	Jubilee	THC	Valley	F CC CHS	DCFS CASA JJ	C2C
✓	✓	✓	✓	✓	✓	✓
✓	✓	✓	✓	✓	✓	NA
✓	✓	✓	✓	✓	✓	✓
✓	✓	✓	✓	✓	✓	✓
✓	✓	✓	✓	✓	✓	✓
✓	✓	✓	✓	✓		✓

Practices that develop personal skills to increase resilience across social contexts

- Knowledge of ACEs and Resilience
- Socio-emotional regulation
- Planning, problem-solving, self-sufficiency
- Hope, positive self-image and future
- Becoming accountable

LHS	Jubilee	THC	Valley	F CC CHS	DCFS CASA JJ	C2C
✓	✓	✓	✓	✓	✓	✓
✓	✓	✓	✓	✓	✓	NA
✓	✓	✓	✓	✓	✓	✓
✓	✓	✓	✓	✓	✓	✓
✓	✓	✓	✓		✓	

Practices that develop caregiver skills to increase resilience

- Becoming more self-aware by increasing understanding of ACEs and Resilience
- Shifting mental models, values and automatic reactions
- Developing self-care by sharing challenges and barriers
- Reflecting in a learning organizations
- Partnering and collaborating with others

LHS	Jubilee	THC	Valley	F CC CHS	DCFS CASA JJ	C2C
✓	✓	✓	✓		✓	
✓	✓	✓	✓		✓	
✓	✓	✓	✓	NA	NA	NA
✓	✓	✓	✓	NA	NA	✓
✓	✓	✓	✓	✓	✓	✓

Table 4
Descriptions of Common Practices in the Language of Each Organization

Common Practices	Schools Public/Private	Health Non-profit	Other Non-profits	Court Related	Community/ Neighborhoods
Safe/no-judgment calmness	safe – 'green zone' calm down	safe place for <u>all</u> stop and breathe	believe in them calming, breathe	focus on child safety teach yoga	Safe space to gather
Respectful, understanding	respect for all always having time	open door, first name warm handoffs	meet them as a person first	be friendly, smile build rapport	door to door introduce each other
Trusting relationships	trust and love compassion	inclusive, trust with adult	build trusting relationship	instill trust, build common ground	trust, form relationships
Mutual supports	student norms shared justice	peer support groups	connect with people who have been there		bring together, potential leaders
Socio-emotional regulation skills	self-awareness train. learning supports	include students in their care	sharing dreams, grief counseling	look for, identify resilience factors	ask neighbors. respond to ideas
Planning, problem-solving skills	notice progress tracking learning	Solution focused – not problem focused	decision-making, self-sufficiency	Get at core issues	shift 'glue' to community leaders
Hope, positive self-image/future skills	praise, encouragement	focus on strengths and the positive	positive outlook, resilience seeds hope	Recognize, validate strengths, hope	change image of community, hope
Becoming accountable skills	change in suspension restorative justice	regulation skills		Understand ACEs before accountability	
Self-aware skills Mental model skills	respond to 'red zone' mind-set change	don't want to go back to old ways	write down own values, own ACEs	Need time, energy, 100% head space	
Self-care skills	self-care weekends,	share challenges	laugh, appreciation		
Learning org. skills	group discussions consult/refer THC,	philosophy/culture counselors/doctors/	freedom to learn willing to work with	Use ACE language of belonging	schools, THC, fire, Salvation Army
Partnering skills	active CRI member	teachers, Blue Ridge	all groups		

Discussion of Findings

Implications for Walla Walla: Study findings suggest that Walla Walla is implementing trauma-informed practices in different domains that will likely increase resilience among higher ACE, poorer sectors. Quantitative studies across Washington State communities have shown that higher resilience has moderated the impact of ACEs and poverty on education, mental/physical health and employment levels.

Implications for other communities: These findings may provide other communities with insights on **what** trauma informed practices to implement. However, one should be wary about simply conducting training courses for professionals and volunteers across all types of organizations and all different community sectors. The success of specific practices may be highly contingent on unique community conditions and specific cultural contexts and populations.

Findings regarding less common practices, those involving caregivers' mental models (self-awareness, reflection, self-care and collaborative leadership in 'learning' organizations), suggest that challenges remain, particularly in more hierarchical organizations with more regulations. The study found, however, that even within these organizations, some people have made remarkable progress in developing a common language regarding what is 'trauma-informed.' Focus group discussions revealed that a common trauma-informed language can transform even traditional organizations.

Findings also provide insights on **how** to implement such trauma informed practices within a systemic strategy of change in individual, organizational and community capacity. Walla Walla has developed a 'scaffolded' strategy of prevention activities building higher community capacity since 1998. They have also created progressive changes in mental models, where close to 40 percent of the population is conversant in ACEs and resilience terminology. People in more neighborhoods and students in more schools are helping each other, becoming mutually supportive.

System change in other communities will hopefully be faster than in Walla Walla, and these communities may benefit from learning about the principles, strategies and phases of community capacity building that have been developed in Walla Walla.

Limitations and Next Steps

This study did not focus on how people in different organizations developed their own trauma informed practices. We do not know the extent to which:
- People learned from similar principles of how the effects of cumulative trauma can be moderated by various dimensions of resilience;
- People learned from experience (trial and error) on what worked best with individuals they worked with;
- People learned from each other in a community of practice, sharing innovations and lessons learned -- although we know that the Children's Resilience Initiative (CRI) was a community of practice that held monthly meetings, trainings, events, focus groups, surveys, and conversations.

Focus group discussions revealed that people had not attended a common 'trauma informed practices' course. We hope that this study could be used to help other people and other organizations in other communities to:
- Learn about innovative practices already adopted in Walla Walla so that they could avoid 're-inventing the wheel';
- Learn about collaborative strategies so that they could increase resilience in their communities.

References

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Appendix
Invitation to Children's Resilience Initiative (CRI) Partners to participate in a Focus Group

Purpose of the Focus Groups

Learn from our successes and challenges, by documenting:

- What *trauma sensitive practices* have been implemented by each CRI partner, with what *increases in resilience,* in different sectors of our community?
- What *challenges* do we face in this work?- sharing similar and unique challenges

So we can:

- *Communicate to others where we are in our journey to build community resilience* and
- *Strategize together our next steps, with possible new funding and/or supportive policy changes*

Introduction

Part of capacity development and learning is taking the time to reflect on our work, to step back and assess our progress and pitfalls, and to re-align, as necessary, our goals and objectives. To this end, we are conducting a series of Focus Group sessions for CRI team partners.

> Dr. Dario Longhi, Participatory Research Consulting, will facilitate the Focus Group sessions, assisted by his partner, Dr. Marsha Brown, and Emily Grossman, Whitman College summer volunteer with CRI.

We want this to be an honest and open evaluation. While we value and appreciate the success stories that motivate us, we also want to learn more about the challenges that impede our progress.

Dates/Times for Focus Group sessions: July 27-July 30, 2015, 9-11am or 1-3pm options.

Special arrangements can be made for those needing an alternative time.
<u>To do:</u> Please contact Teri Barila, 509/301-2488, to schedule the time for your Focus Group.

Number of people to invite to the Focus Group

4-6 from any one CRI partner is optimum, but up to 10 maximum.
If a Focus Group has more than one partner the maximum is still 10 for the Focus Group.

Criteria for selection of people to invite

A **<u>representative</u>** sample of people from your organization/agency who are:

1. Implementing trauma sensitive practices, making changes to do so, training others etc., or
2. Considering doing so, wanting to learn more

Some people in your organization, or working with you, may not be able/want to change or oppose such changes. Please do **<u>not</u>** invite them since they may disrupt the focus group, arguing how these changes may not be necessary – counterproductive -not feasible etc. This resistance is often due to 'mental model' or policy constraints that we can discuss as challenges/barriers in the Focus Group.

What to expect in the Focus Group session:
Discuss, organize into patterns answers to two questions:

1. **Changes in practices**: In your organization/agency what <u>kind of practices</u> have been implemented to increase resilience? <u>How</u> have they been implemented? <u>By whom</u>?
2. **Challenges:** What <u>kind of changes</u> (if any) were required to start implementing such practices… and to continue doing so? What <u>obstacles or barriers</u> did you encounter or remain, for example 'mental model' ones, policy ones, organizational ones… problems working with other partners?

Input from individual participants will be kept anonymous.

Dario will facilitate by collecting input from each individual participant, and then asking the group to organize all the inputs into patterns of new trauma sensitive/resilience building practices and challenges to their implementation. Marsha and Emily will record the discussion and conclusions.