The Integration of Trauma-Informed Care in the Family Partner Program

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Issues Brief

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Introduction: Background and Purpose

> *"Family partners are the most helpful part of the system because they don't judge you."*
> *Family member*

The Commonwealth of Massachusetts, like many states, has made family involvement a key priority in strengthening children, youth and family services.[i] One effective strategy for increasing family voice is employing family members who use their "lived experience" with the service system to support and assist other families. Family members who fulfill these roles are often called "family partners," "family peer supporters," or "family support specialists." Massachusetts has been a leader in implementing the family partner approach.[ii]

The Commonwealth is also playing a leadership role in the adoption of "trauma-informed" approaches to education, healthcare and human services.[iii] Research over the past decade has demonstrated convincingly that a significant proportion of the general population has experienced some form of severe trauma in their lives. Many of the children and families receiving services from the health and human services in Massachusetts - and many of the staff who deliver services - have experienced trauma. Because trauma is so common, family partners are often in the position of responding to its consequences in themselves and others. Addressing this issue could have a profound and positive impact on the effectiveness of family partners, the ability of families to support their children, and child outcomes.

The family partners program and trauma-informed approaches have much in common. Both maximize voice and choice, place a high value on empowerment and personal experience, and create new partnerships in service delivery. And both seem poised for further growth. A recent report from the *Children, Youth, and Families (CYF) Advisory Committee* of the *Executive Office of Health and Human Services (EOHHS) r*ecommends expanding "peer specialists, family partners, and cultural/linguistic brokers" and improving workforce capacity by ensuring that "policies and protocols emphasize trauma-informed care."[iv]

This issue brief is designed to stimulate discussion concerning the integration of trauma-informed care in the family partner program and to consider what the family partner program might look like in the future. Research findings about the impact of trauma on families, youth and children will be reviewed, policy implications for the family partner program will be discussed, and issues for further debate will be identified. One fundamental premise of this issue brief is that families have the right to be informed about everything that impacts on their family's health and well-being, including trauma. A second premise is that researchers, policymakers, practitioners, family members and youth all have significant contributions to make to the dialogue.

Connecting Research, Policy and Practice

This issue brief is a project of the Massachusetts Department of Mental Health's Children's Behavioral Health Research and Training Center. In keeping with the mission of the Center, this document brings research and knowledge building efforts to the center of policy and practice conversations, and was developed using multiple types and sources of evidence. Focus groups were held with family partners, family members and youth to ground the discussion in lived experience; interviews and a site visit were conducted to learn from programs and practitioners across the country; and the best available evidence from the research literature was reviewed.

Throughout this brief, research evidence and policy issues are illustrated with examples and quotes from family members, youth, and providers. This document is intended to begin an ongoing conversation about a timely and important topic, to help inform policymakers, and ultimately to improve services.

Trauma-Informed Care: The National Context

> *"*I didn't realize how much trauma had affected me. Once I did, I wanted to learn everything I could because it helps me as well as the families I support.*"*
>
> *Family Partner*

Across the country, people are recognizing the profound impact of trauma on individuals, families and society. Interest in the impact of trauma and violence on behavioral health has been steadily increasing since the 1970's. While much of the early work was done through the *Substance Abuse and Mental Health Services Administration* (SAMHSA), other federal agencies have also begun to integrate trauma principles into their operations. An intergovernmental initiative focusing on the impact of trauma across a wide variety of settings has stated that trauma has "a huge impact on the health, economy, and even security of our nation." [v] This federal working group, which has met monthly for almost three years, currently involves over three dozen federal agencies and sub-agency divisions and departments.

As people and organizations begin to consider how systems and practices need to change to reflect this new understanding, some questions have arisen over concepts and terminology. How do we distinguish between an event that is traumatizing and one that is challenging but not ultimately damaging? Should trauma-informed approaches be limited to people with diagnosable conditions such as Post Traumatic Stress Disorder (PTSD)? Can approaches based on an understanding about the impact of trauma be used effectively in settings such as schools, courts, social services and health clinics? Research and practical experience provide some answers, although our knowledge base will continue to be refined as the field develops further.

In an effort to clarify terminology and to stimulate a national discussion on this topic, SAMHSA convened a national experts meeting to develop definitions, principles and guidelines applicable across a variety of settings.[vi] The group included representatives from five national trauma centers and from programs serving both adults and children and families. It also included people who experienced trauma as children, adults and family members. The group developed definitions for key terms (see sidebar); principles for trauma-informed approaches (see below); and a matrix to help guide implementation. The working document will be distributed for public comment in September 2012.

Key Principles of a Trauma Informed Approach

The distinction between trauma-informed care and trauma-specific services was first articulated by Maxine Harris and Roger Fallot.[vii] A program, agency or system that is trauma- informed is aware of the widespread impact of trauma and understands potential paths for healing. They recognize the signs of trauma in clients, staff, and others touched by the system, and have responded by integrating knowledge about trauma into policies, procedures, and practices. A trauma-informed approach reflects a culture change, reflected in the shift from asking "What happened to you?" rather than "What's wrong with you?" In contrast, a trauma-specific service has a more focused primary task – to directly address trauma and its impact and to facilitate trauma healing.

A trauma-informed approach reflects the adoption of underlying principles rather than a specific set of procedures. These principles are the same across all settings, although language and application may vary widely. The principles identified by the SAMHSA working group reflect earlier work by many of the workgroup members, particularly Rene Andersen, Maria Rodman, Sandra Bloom, Robyn Boustead, Norma Finklestein, Julian Ford, Maxine Harris, Roger Fallot, and Arabella Perez.[viii]

Key Principles of a Trauma-Informed Approach

1. **Safety**. Staff and the people they service feel physically and psychologically safe.
2. **Trustworthiness and Transparency**. All organizational operations and decisions are conducted with full transparency and the goal of building and maintaining trust.
3. **Collaboration and Mutuality**. There is true partnering and leveling of power differences between staff and people served and among organizational staff, recognition that healing happens in relationships and in sharing power and decision-making.
4. **Empowerment**. Individuals' strengths are recognized and validated, the development of new skills is supported, and people who receive services are involved in agency operations.
5. **Voice and Choice**. People served have meaningful choices and a right to decide what language will be used with reference to them and their experiences. It is recognized that each person's experience is unique.
6. **Peer Support and Mutual Self-help.** These modalities are integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety, and promoting self-healing.
7. **Resilience and Strengths-Based**. People believe in the ability of individuals and communities to heal and recover from trauma. Services build on what staff, people who receive services, and communities have to offer rather than responding to perceived deficits.
8. **Inclusiveness and Shared Purpose**. The organization recognizes that everyone has a role to play in a trauma informed approach; one doesn't have to be a therapist to be therapeutic.
9. **Cultural, Historical and Gender issues**. These issues are addressed in a comprehensive manner. The organization actively moves past cultural stereotypes and biases, offers gender responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.
10. **Change Process**. Implementation of trauma informed principles is conscious, intentional and ongoing. The organization actively promotes non-violence and strives to become a learning community, constantly responding to new knowledge and developments.

SAMHSA Working Definitions

***Individual trauma** results from an event, series of events, or set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual well-being.*

*A program, organization or system that is **trauma-informed** realizes the widespread impact of trauma and understands potential paths for healing; recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings.*

*In contrast, a **trauma-specific service** has a more focused primary task – to directly address trauma and its impact and to facilitate trauma healing.*

National Trends in Trauma-Informed Approaches for Children and Families

"A trauma-sensitive lens can be an equalizer. Trauma comes in so many different forms - none of us are outsiders when it comes to trauma."

Family Partner

Trauma-informed approaches are taking hold in health and human service systems across the country, and services for children and families are no exception. Individual child- and family-serving agencies are finding that addressing trauma helps them to deliver more effective services, and systems of care are recognizing that trauma-informed approaches can improve service coordination and help strengthen families.

The system of care model is an organizational philosophy and framework that involves collaboration among agencies, families, and youth. Over the past 20 years, system of care has emerged as one of the most effective service philosophies for serving children and families. Systems of care engage families and youth in partnership with public and private organizations to design services and supports that are effective, build on the strengths of individuals, and address each person's cultural and linguistic needs. A system of care helps children, youth, and families function better at home, in school, in the community, and throughout life. In the past few years, national attention has focused on the importance of using trauma informed approaches in systems of care. Federally funded system of care expansion planning grants call for the incorporation of trauma-related activities, including trauma screening, trauma treatment, and a trauma- informed approach to care. In response, the *National TA Partnership*, a joint effort of the *National Federation of Families for Children's Mental Health* and the *American Institutes for Research*, has offered a series of webinars on trauma-informed approaches. [ix]

The Thrive Initiative in Maine is an example of the positive impact of introducing trauma-informed principles to a system of care. Initially funded in 2005, *Thrive* was the first trauma-informed system of care in the country. Many *Thrive* youth reported experiences that resulted in trauma. In contrast with those reporting no trauma history, youth who had experienced either acute or prolonged trauma displayed significantly more symptoms of depression, anxiety, anger and post-traumatic stress at the beginning of services. After six months of treatment, symptoms of anger, depression and anxiety were reduced. Over 40 percent of caregivers also reported that they had experienced some form of trauma as a child, including sexual abuse, emotional abuse and being separated from their own families. In contrast with those with no trauma histories, almost twice as many caregivers with numerous trauma experiences as children also had chronic physical health problems.[x] *Thrive* sought to create a system of care where values, language, policies and services are trauma-informed. The goal at *Thrive* is for everyone to recognize the signs of trauma in staff as well as in the children and families they serve, and to know how to respond effectively. As a result of this work, all behavioral health agencies that contract with the state of Maine are now required to be trauma-informed. Today *Thrive* is a non-profit entity expanding its legacy to other child-serving systems. In 2011, *Thrive* received a federal expansion grant to adapt its trauma-informed assessment tool for juvenile justice and to engage with military families in awareness-raising.

One of the primary resources for learning about trauma-informed approaches for children and families is the *National Child Traumatic Stress Network* (NCTSN).[xi] Established by Congress in 2000, NCTSN is a collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. The Network is funded by the *Center for Mental Health Services, Substance Abuse and Mental*

Trauma Informed Approaches in Child- and Family-Serving Agencies

In Walla Walla, Washington, a public high school has revamped its disciplinary procedures to reflect an understanding of trauma, resulting in an 85% reduction in suspensions in the first year.

In Wisconsin, trauma informed approaches are being used to reduce the use of seclusion and restraint with children with disabilities in schools, residential treatment facilities, psychiatric hospitals, day treatment centers and other programs.

In Kansas City, Missouri, and Philadelphia, Pennsylvania, principles of trauma-informed care have been successfully introduced into preschool and daycare settings.

In Washington State, the introduction of information about trauma into the Nurse-Family Partnership program –already considered to be one of the most effective programs in the country for preventing adverse outcomes - significantly improved outcomes for both mothers and children.

In Connecticut and Florida, juvenile justice programs are implementing systematic screening for traumatic stress and are using the TARGET trauma model to teach self-regulation skills.

The Administration for Children and Families of the US Department of Health and Human Services is organizing many of its activities around the promotion of meaningful changes in the social and emotional well-being for children who have experienced maltreatment, trauma or violence.

Health Services Administration, US Department of Health and Human Services through a congressional initiative. NCTSN includes a *National Center* that oversees resource development and dissemination and coordinates national education and training efforts; *Treatment and Services Adaptation Centers* that provide support for the specialized adaptation of effective treatment and service approaches; and *Community Treatment and Services Centers* that implement and evaluate services in community settings. NCTSN also supports the development of trauma-informed systems through strategic partnerships with national organizations representing services and systems important to children and families.

Individual child- and family-serving agencies and programs across the country are introducing trauma-informed approaches. Many are seeing an increase in effectiveness (see sidebar). [xii] [xiii] [xiv] [xv] [xvi] Federal agencies are also adopting policies to encourage the application of trauma-informed approaches. [xvii]

Trauma-Informed Care in the Commonwealth

Trauma informed care and trauma specific services have also received considerable attention in Massachusetts. In 2011, the Department of Children and Families (DCF) was awarded a 5-year cooperative agreement to improve services to children and youth with complex trauma entitled "Integrating Trauma-Informed and Trauma-Focused Practice in Child Protective Services Delivery." The *National Child Traumatic Stress Network* has a number of members/projects in Massachusetts including (among others): the *Trauma Center at Justice Resource Center* which has collaborated to develop the *New England Trauma Services Network*; the *Latino Child Trauma Stress Initiative*; *Project BRIGHT*, a collaboration between the *Institute for Health and Recovery* and several other agencies to address trauma in children 0-5 and their parents in recovery from substance abuse; and the *Massachusetts Child Trauma Project.* This project includes training on evidence-based trauma treatments and implementation of "breakthrough collaboratives" in all area offices to coach local teams in trauma-informed practice.

Several initiatives are pioneering trauma-informed approaches in the educational system. *Massachusetts Advocates for Children,* in collaboration with *Harvard Law School*, formed the nationally recognized *Trauma and Learning Policy Initiative* to ensure that children impacted by family violence and other adverse childhood experiences succeed in school. Their activities include legislative and administrative advocacy, coalition building, outreach and education, research and report writing, and

individual case representation for children affected by family violence or other traumatic experiences who are not getting the special education services they need. The *Trauma and Learning Policy Initiative* also published the groundbreaking report, *Helping Traumatized Children to Learn*, and led advocacy efforts to pass legislation establishing a grant program to create trauma sensitive schools.

The *Child Behavioral Health Initiative* (CBHI) is an interagency initiative of the Commonwealth's *Executive Office of Health and Human Services*. The mission of CBHI is to strengthen, expand and integrate Massachusetts state services into a comprehensive, community-based system of care and to ensure that families and their children with significant behavioral, emotional and mental health needs obtain the services necessary for success in home, school and community. It was created to implement the remedy in Rosie D v Patrick, a class action law suit filed on behalf of MassHealth-enrolled children under age of 21 with serious emotional disturbances. CBHI includes family support and training, intensive care coordination and in-home services as well as other therapeutic services and supports. The 2012 report from the Advisory Committee to the EOHHS's children's behavioral health initiative states that "Many of the children involved with our agencies have experienced trauma; agencies cannot effectively serve children if that trauma is not addressed and considered as part of any core planning."[xviii]

In another effort directly relevant to family partners, The *Center for the Study of Social Policy*, the *Massachusetts Department of Early Education and Care (*CEEC), the *United Way of Central Massachusetts*, and the *Children's Trust Fund* have partnered to implement a research-based, cost-effective strategy for increasing family stability, enhancing child development and reducing child abuse and neglect. Building on the research on resilience (see next section), this project seeks to strengthen five protective factors: parental resilience, social connections, knowledge of parenting and child development, concrete supports in time of need, and social and emotional competence in children. The protective factors framework is consistent with a trauma informed approach. For example, teaching families about the impact of trauma would strengthen the protective factor reflecting knowledge of parenting and child development. Ensuring safety is a fundamental part of providing concrete support in times of need. Understanding the isolating effect of trauma is essential to strengthening social connections. And building resilience for families and children is a key element in both conceptual frameworks.

While this list is illustrative not exhaustive, it is clear that there is a strong movement towards adopting trauma-informed programs and approaches in the Commonwealth. The presence of others in the state who are working to understand and apply this approach will contribute to the discussion about developing trauma-informed family partner programs.

Implications of Trauma Research for Children and Families

> "If you were trauma-free before getting involved in the system, it won't last for long. As parents we are traumatized by the system. Leaving your child at the psychiatric hospital, walking away as the door locks, or seeing your child in handcuffs, there is nothing in the world more traumatizing than these experiences."
>
> *Family Partner*

Children and families face trauma in many ways and from many sources. Trauma is so prevalent in our society that for all practical purposes it can be considered a near-universal experience. Trauma-informed approaches often recommend the use of "universal precautions"– i.e., assuming that everyone who walks in the door has experienced some form of trauma, whether or not they discuss it.

The *National Child Trauma Stress Network* reports the following as the most common traumas experienced by families, in decreasing order of frequency: loss, domestic violence, emotional abuse, neglect, physical abuse, sexual abuse, community violence, sexual assault/rape, serious injury/accident, illness/medical trauma, natural disaster, and kidnapping.[xix] Types and sources of trauma may also vary according to the specific circumstances of the family. Focus groups conducted with family members in Baltimore reported domestic and community violence as the two most frequent sources of trauma, along with child abuse, crimes (including homicide), and life threatening illnesses. Much of the violence experienced by families in Baltimore City was related to drug use and distribution.[xx]

Children and families may be affected by *acute trauma*, a single traumatic event that is limited in time, or *chronic trauma,* the experience of multiple traumatic events. Trauma may also result from the withholding of material or nonmaterial resources essential to healthy development or well-being; persistent small psychological or physiological injuries that accumulate over time; events that occur before or during birth; or historical events and circumstances that affect the primary group with whom the individual identifies (e.g., genocide, extreme violence against a racial or ethnic group.) *Complex trauma* results from multiple traumatic events, particularly those that begin at a very young age, or from trauma caused by adults who should have been caring for and protecting the child.[xxi] Caregivers who can fall into this category might include teachers, coaches, babysitters, clergy, scout leaders, and professional caregivers in addition to family members. Children and families may also experience *system induced trauma*, such as admission to a detention or residential facility or multiple placements within a short time.

Both children and family members may also be unintentionally *re-traumatized* by things that happen to them in their lives – in school, in helping systems, with their peers, or at home. Re-traumatization occurs when any situation, interaction, or environmental factor replicates events or dynamics of prior traumas and evokes feelings and reactions associated with those original traumas. Because trauma often occurs in relationships and in a specific environmental context, a wide variety of factors can elicit a re-traumatization response. Sounds, smells, lighting, a particular behavior or emotion or sequence of events - virtually any environmental or social variable - can be re-traumatizing.

Finally, family members and staff may experience *secondary traumatic stress*, the emotional duress that results when an individual hears about the firsthand trauma experiences of another. Individuals affected by secondary stress may find themselves re-experiencing personal trauma or notice an increase in arousal and avoidance reactions related to the indirect trauma exposure.[xxii] Family partners are particularly vulnerable to secondary traumatic stress because their jobs entail the intentional use of

their personal experience to relate to the families they support, who may be going through challenges very similar to their own.

Epidemiological Research

According to a survey conducted by the Office of Juvenile Justice and Delinquency Prevention and the Centers for Disease control, children and youth under 18 years old in our society are exposed to a surprisingly high level of interpersonal violence (see sidebar.)[xxiii] Children and families are also directly affected by high levels of other forms of social violence – including disasters, terrorism, war trauma, domestic violence, and crime.[xxiv]

The largest and most widely recognized epidemiological study on the prevalence of childhood trauma and its impacts on health and well-being over the lifespan is the Adverse Childhood Experiences (ACE) study conducted jointly by the Centers for Disease Control and Kaiser Permanente.[xxv] Over 17,000 Kaiser HMO members completed a confidential survey, reporting surprising high levels of adverse childhood experiences: Physical abuse (28%); sexual abuse (22%); emotional abuse (11%); living with a person who is depressed, suicidal, or diagnosed with a mental illness (17%); having a drug addicted or alcoholic family member (27%); witnessing domestic violence against the mother (13%); loss of a parent to death or abandonment, including divorce (23%); incarceration of a family member (6%); and physical (19%) and emotional (15%) neglect. Their "ACE scores" were then correlated with a wide range of physical health, behavioral health, and social conditions.

There were two major findings of the ACE study. First, ACEs are very common – 70% of subjects had one or more ACE, 25% had two or more, and one in six had four or more. Second, the impact of ACEs is cumulative – there is a significant positive relationship between adverse childhood experiences and a very wide range of adverse outcomes, including depression, hallucinations, panic and anxiety, flashbacks and dissociation, multiple somatic problems, sleep problems, impaired memory, smoking, obesity, suicide, self-injury, alcoholism and drug use, eating disorders, heart disease, autoimmune disease, lung cancer, chronic obstructive pulmonary disease, asthma, liver disease, skeletal fractures, sexually transmitted diseases, HIV/AIDs, and early death. The correlations between ACE scores and health and social problems in adulthood are very strong (see sidebar.) Adverse childhood experiences affect adult health and well-being

Children's Exposure to Violence

In the 12 months prior to the survey:

More than 60% of children 17 and younger were directly or indirectly exposed to violence

Nearly 50% were assaulted at least once; more than 10% were injured in an assault

25% were victims of robbery, vandalism, or threats

Nearly one in four witnessed a violent act; nearly one in ten saw one family member assault another

10% suffered from child maltreatment (physical or emotional abuse, neglect, or a family abduction)

One in 16 was victimized sexually

Multiple victimizations were common: More than a third experienced two or more direct victimizations

Lifetime exposure rates were generally one-third to one-half higher than past-year exposure

in two ways – they have a direct impact on the neurological development of the child, and they pre-dispose the individual to the use of coping strategies or behavioral adaptations that can cause physical and emotional problems.

Impact of Adverse Childhood Events

Compared to a person with an ACE score of zero, a person with an ACE score of 7 or more is:

30 times more likely to attempt suicide as an adult

51 times more likely to attempt suicide in childhood or adolescence

78% of IV drug use in women is attributable to adverse childhood experiences

55% of women with ACE scores of 7 or more reported becoming pregnant before age 18, compared with 15% of women with an ACE score of zero

Adverse childhood events underlie two-thirds of all alcoholism

Children who experience both neglect and physical or sexual abuse are 26 times more likely to become homeless than those who do not

Higher ACE scores result in significant rises in chronic health conditions and early death

Neuroscience Research

Recent developments in neuroscience shed light on the effect of adversity and chronic stress on the central nervous system and the architecture of the developing brain. When children encounter a perceived threat to their safety, a complex set of chemical and neurological events known collectively as the *stress response* is triggered.[xxvi]

When a child operates in overwhelming states of stress or fear, the areas of their brains controlling the fear response can become overdeveloped. Survival responses that may be fully appropriate in danger-laden situations (e.g., shutting down, constantly surveying the room for danger, expecting to fight or run away at a moment's notice) can become a regular mode of functioning. Even when danger is not present, they may react to the world as if it is a dangerous place.[xxvii] Over time, they become less able to regulate heightened levels of arousal and emotional responses, resulting in social, emotional and cognitive impairments. In order to cope, they may engage in behaviors - like smoking, using drugs, overeating, or engaging in sex - that further contribute to health and social problems.

Stress hormones affect us from the first moment of conception throughout infancy. If parents bear high levels of stress, their children may be at risk for becoming hyper-alert, impulsive, and emotionally reactive. On the other hand, if a child's earliest experiences are soothing, warm, safe and loving, they are more likely to be calm, easy-going, and relationship oriented. Both pathways are adaptive, helping us to survive as a species in different circumstances.

Early childhood, middle childhood, and the years just before puberty are all times when brain development is particularly sensitive to experience. These are also key times for intervention. It is important for parents, caregivers, and children themselves to understand that the ways in which a child is responding or behaving is his best way of adapting to the world he has experienced and has incorporated into his biology, and to help him to learn the skills needed to adapt to different environments.

Research on Resilience and Protective Factors

"My experience has made me stronger, an observer of my own life, unwilling to accept the system as it is. These are the things that guide my work as a Family Partner."

Family Partner

The statistics on violence and trauma in our society can seem overwhelming. On the other hand, just observing the obstacles that family members and family partners overcome every day is inspiring, and reminds us that both children and adults can be incredibly strong and resilient. Research on resilience over the past two decades supports the position that resilience is the *normal* process of human development and adaptation, and that it occurs in both favorable and unfavorable environments. [xxviii] According to one researcher, "What began as a quest to understand the extraordinary has revealed the power of the ordinary. Resilience does not come from rare and special qualities, but from the everyday magic of ordinary, normative human resources in the minds, brains and bodies of children, in their families and relationships, and in their communities."[xxix] Although resilience is normative, there are many things that can be done to support it.

Research on resilience has important implications for family partners and family services. It reminds us that the impacts of trauma on the developing brain, while critically important to understand, are not necessarily indelible. We are just beginning to explore the plasticity of the human brain, but the research clearly indicates that appropriate, targeted services and supports can help overcome or ameliorate the impact of even severe trauma. [xxx] Early intervention can help to promote and strengthen resilience by affecting the neurological system positively,[xxxi] by helping the child to develop cognitive and emotional skills, or by strengthening resilience factors in the child's environment, especially within the family.

Research also reminds us that resilience is not a quality that some people possess and others do not. Every child and every family, regardless of challenges, has the innate capacity to heal and grow. Maintaining a strengths-based approach – identifying and building on the unique gifts of every child, every family, and every community – lies at the heart of a trauma-informed approach. Using the language of strengths helps practitioners, families and family partners to find positive qualities in young people, in families and in themselves. And it allows them to name and reflect back the strengths they have witnessed – which is a source of both healing and positive role modeling. Children develop new abilities at each age and stage of life. For example, at age two children develop the ability to speak for themselves, to say "no," "mine," and "me do it." By age ten, children become industrious, learning how to focus their attention for longer periods of time and they begin to master skills that require practice. Each developmental stage provides a new arena within which to find and focus on strengths and capacities.

Resilience also rests as much in the environment as it does in the individual. Certain characteristics of families, schools and communities are associated with healthy development and successful learning. Changing the life trajectories of children and youth from risk to resilience starts with supporting and strengthening the families and the environments they live in. Caring relationships, high expectations, and opportunities for participation and contribution have been consistently identified as "environmental protective factors." [xxxii] Family partners can play a significant role in helping to develop and support these environmental protective factors.

Trauma-Informed Family Partners

> "When I began with Family Partners, I thought I would be sharing information about my experiences with my child. I didn't realize I would be sharing my own trauma experiences."
>
> *Family Partner*

Because trauma is a near-universal experience, everyone benefits from a trauma informed approach. Learning about trauma creates a sense of common experience and it provides a new way of looking at problems. For family partners, it provides specific tools to help in their work. Trauma-informed family partners are able to provide information to families about trauma and its impact. They understand and model compassionate self-observation, and they use what they know about trauma to help create relationships based on equality and mutuality. They help families apply protective factors, build resiliency, and navigate service systems effectively. They also help families to know when, how, where, and with whom to intervene for the best outcomes following traumatic incidents or events.

Family partners are in a unique position to support other families on their journeys because they have first-hand knowledge about the family experience and because they operate from a philosophy of mutuality. Family support does not focus on diagnosis or deficit but on building relationships where people can share their strengths and support each other's healing. Family support is not about "helping" in a hierarchical way but about learning from each other, building connections, and taking collaborative action.

Being a family partner can be challenging. Family partners provide individual support, facilitate groups, and assist families in school meetings, juvenile court, hospital meetings, and with other community providers. They visit families at home, provide access to educational materials and resources, help families build natural supports and negotiate relationships with other service providers, and coach them in the skills they need to advocate for their family's needs. Family partners must have the ability to balance their own needs with the needs of the families they support, and to share their own stories and experiences in a way that is empowering both for themselves and others. All of these tasks require family partners to create an empathic bond, to stay focused on the family's strengths even during crises, and to use their own experience without being overly drawn back into it.

Family partners are already dealing with trauma – their own and others – on a daily basis. Information about trauma, a language to talk about it, and skills related to trauma support and recovery can be powerful tools for family partners to use in their work.

Recognizing and Responding to Trauma

The first step in responding effectively to trauma is to recognize it. Sometimes people aren't even aware that the challenges they face are related to trauma. For family members, understanding how trauma has affected them may help them to stop blaming themselves, to begin recognizing that they are doing the best they can in the circumstances.

Often when a person is experiencing violence – especially as a child – they have no way of knowing that it isn't normal. An abused or neglected child may grow up believing that the world is a hurtful place,

that they are unworthy and deserve whatever they get. Even adults can have a hard time recognizing abuse and trauma. They might blame themselves for what happened, or see certain types of violence as an unavoidable part of life in their family or neighborhood, something to be endured and not discussed. Even when they recognize that the violence they experienced was wrong and was not their fault, they may find it very hard to talk about – especially if they were silenced, blamed or shamed in the past for speaking out.

Trauma-informed family partners understand that defining one's own experience in one's own terms is essential to healing. They know that words do matter, and words that describe our identity matter a great deal. How family members choose to talk about what has happened in their lives – or if they choose to talk at all – is a very personal matter. Family partners play an important role in ensuring that people can choose the words they want to use and helping other people in the system respect those choices. They can also play an important role by ensuring that family members have an opportunity to look at what has happened in their lives and think about how those events might have impacted them.

Trauma-informed family partners can also help family members recognize the ways in which their children are affected by trauma. People often respond to children on the basis of their behavior or symptoms without understanding what lies underneath. Children responding to unrecognized trauma may be labeled as a "disciplinary problem" by the school or a "delinquent" by the juvenile justice system. They may be given a psychiatric diagnosis that misses the role of trauma altogether. According to the National Child Traumatic Stress Network, the most common diagnoses for abused children are, in order: Separation anxiety disorder, Oppositional defiant disorder, Phobic disorders, PTSD, and ADHD.[xxxiii] When family members understand what trauma is and how it affects children, it becomes easier for them to communicate with children who have experienced trauma, to help the child cope more effectively, and to get needed help. Some children – and adults – don't openly display signs of emotional distress, but keep to themselves, focus intently on school or work, use substances or take risks. But there are many signals that may indicate possible trauma (see sidebar).

What to Look for: Common Signs of Trauma in Children and Youth

Nightmares or sleeping problems

Being very sensitive to noise or to being touched

Always expecting something bad to happen; fear of being separated from the family

Difficulty trusting others

Confusion about what is safe and what is dangerous

Feeling very sad, angry, afraid or anxious or having emotional swings

Losing focus or concentration; difficulty imagining the future

Attention seeking

Unexplained physical or medical problems

Reversion to younger behaviors

Blowing up when being corrected or given instruction by an authority figure

Fighting when criticized or teased

Resisting transitions or change

Thinking one's personal space is being violated – e.g., "What are you looking at?"

Reckless or self-destruction behavior

Self Reflection and Mutually Supportive Relationships[xxxiv]

> "If I'm not well, how can I take care of my kids?"
>
> *Family member*

There are several reasons why compassionate self reflection is of critical importance for family partners. Their work is demanding and they need to be at their best to do their jobs well. They need to provide a good role model for the families they support. And they need to be aware of their own histories in order to avoid the possibility of unintentionally causing a trauma response in a family member – or in themselves.

People vary in their level of self-awareness. Some circumstances – including trauma - can interfere with the natural ability to pay attention to one's own needs. It may take time for people to learn to value their inner wisdom. But people **do** know what works for them, and with practice, can identify physical, mental, emotional and spiritual practices that contribute to their well-being. By making self-reflection and self care a priority, and by identifying those things that they already do that are self-healing, family partners demonstrate the importance of self care, taking a strengths-based approach, and building resiliency skills.

Family partners need to be especially attuned to anything that evokes in them a strong emotional reaction – reactions that may have little to do with the situation and a lot to do with their own history. Our nervous system is constantly evaluating risk and safety in the environment. The question: "Am I safe?" is processed by the body, mostly unconsciously, throughout our life. Becoming aware of the things that make us feel unsafe and the ways we unconsciously react to them is an important step in compassionate self-observation that leads to actions to care for oneself. Because trauma occurs in a context, almost any environmental cue can evoke a trauma response – a certain smell, noise, the light at a specific time of day or year, a body posture, a tone of voice, a particular sequence of events. While it may not be possible to completely avoid these cues, just being aware of what is happening can be helpful.

> "We are very tender. It doesn't take much to make us feel guilty. We're told that we were either too strict or not strict enough; no one ever tells us that we are good parents. We blame ourselves already."
>
> *Family member*

Learning about trauma can also help sensitize family partners to the ways in which issues of power and control can affect their work. Trauma often happens in relationships where one person misuses power over another, and trauma survivors are often extremely sensitive to power dynamics. The very fact that family partners hold a formal position in the service system puts them in a position where power issues are likely to arise. For example, there might be a person or person higher up in the organization that makes them feel unsafe. Or, the family members they are supporting may feel unsafe, simply because of the family partner's perceived position of authority. Being aware of the strong grip environmental and personal cues can have on feelings and behavior can help in addressing these issues. Once family partners are adept at identifying and responding effectively to the environmental factors that most affect them, they will be able to help family members do the same thing for themselves and their children.

While the family partners' role may place them in a position of perceived power, their job depends on their ability to develop mutual relationships. In a mutual relationship, the needs of both parties are important. This is different from therapeutic support, where the role of helper and helpee are discrete and remain relatively fixed. A major part of the family partner's job is maintaining mutuality in the

relationship, supporting the family member's decisions and actions. If those decisions or actions feel risky or uncomfortable – which can happen if the situation resonates with a past trauma – the family partner may be drawn into caretaking or rescuing behavior. Understanding trauma can help the family partner to avoid this scenario.

Family partners also have the right to decide how much, to whom, how often, and under what circumstances they feel comfortable talking about their own experiences. Because sharing their personal stories is a key part of their role, family partners may feel like they do not have the right to create boundaries around what they choose to share. If they start to feel uncomfortable, they must be able to acknowledge their discomfort and pull back. In this way they are not only taking care of themselves, but are modeling the importance of trauma informed self care for others.

Supporting Resilience and Building Protective Factors

> "We need to look at the family as a system, how trauma affects everyone, not just the person who was directly affected."
>
> *Family member*

The most important message a family partner can give to a family member is not to give up hope. Taking a strengths-based approach and reframing what might have been seen as problems or weaknesses as adaptations can help a discouraged family to see new possibilities. Family partners can help create safety for families by understanding and coaching them about trauma dynamics. Understanding trauma helps family members understand their own and their children's behavior better.

Family partners can be of great assistance simply by *being there*, by developing and modeling collaboration and partnership. For a family member with a trauma history, this may be an incredibly important step. Trauma is a fundamentally disconnecting experience, and trauma survivors may have difficulty trusting people. The family partner may be the first person outside a very small circle of friends that the family member has let into his or her life, which can open the door to others. A trauma informed family partner will be sensitive to these issues and will communicate to the family member that they know how much courage it takes to open up.

All family partners help the families they support to identify their own resilience, to recognize and build on the coping strategies they already use. Understanding trauma can enhance this function. Armed with knowledge about how trauma is processed by the brain, a trauma informed family partner will know that there are ways to tell a story that are healing, not re-traumatizing.[xxxv] They will make sure the family member is in control of *if, when and how* they reveal their histories, and will encourage them to focus on what they did right rather than on what they did wrong. Family partners can help family members to respond to trauma without letting it overwhelm their identity. That, in turn, gives the family member new tools and approaches to use with their children.

Trauma-informed family partners also understand that when trauma happens to any member of a family, it affects the entire family system. When a child is sexually abused, for example, the siblings and parents are also traumatized. Unfortunately, helping systems often tie services to the person with the identified problem, and needed resources are frequently not available for other affected family members. Family partners can help strengthen family resilience by advocating for access to legal services, counseling and for family members, and other necessary family support.

Family and Youth Advocacy

> "I speak up now because for so long I had no voice."
>
> *Family Partner*

Family partners advocate for the families they support, help make connections to formal service systems and natural supports, and teach self-advocacy skills. They also work in an organizational context that may be still in the process of adapting to the role and function of family partners, and that may not be fully trauma-informed. Family partners who understand trauma will be better able to handle some of the organizational and systemic challenges they encounter in their roles as advocates.

The research reviewed earlier in this paper suggests that many of the people family partners come into contact with – agency staff, teachers, volunteers, emergency personnel – will have trauma histories of their own. Remembering this fact can help family partners to view and respond to their behavior differently. In addition, organizations themselves may be traumatized. Events like layoffs, the death of a co-worker or someone served by the organization, lawsuits, or negative media attention can be intensely traumatic, and can radically change organizational culture. Tragic events sometimes lead organizations to redefine what safety, support and help mean for everyone, and may legitimize controlling practices as a way to deal with distress. Understanding trauma can help family partners to work with difficult internal and external situations. Schools, for example, are often particularly challenging for family partners. Recognizing that rigid adherence to rules may be one way of trying to cope with what feels like an external threat – and that direct confrontation may elicit a fear response – may help the family partner to remain positive and focus on problem-solving. Family partners who understand trauma can also use their knowledge, along with their own stories, to help educate others about trauma.

> "Instead of blaming the child or the school, we try to focus on 'What can we do?'"
>
> *Family Partner*

> "Trauma-informed care is about leveling the playing field. People need to be real about the power they have and about giving it up. It's about finding the places that are hard and naming them."
>
> ***Thrive*** *Youth Advocate*

Family partners may also get involved in helping youth to develop self-advocacy skills or even to form their own organizations. Youth advocacy grows directly out of living the values of a trauma informed approach, and can be a major force for change. Learning to advocate for oneself teaches skills, provides opportunities for self expression and empowerment, and can be healing – especially for someone who has had their personal power taken away.

Trauma-Informed Family Partners: Issues for Discussion

The research reviewed in this brief, along with the testimony of families and family partners, suggests that developing a trauma-informed approach could strengthen the family partner program in significant ways. During the preparation of the brief, many issues arose that require further discussion and deliberation. The issues listed below raise controversial questions, and none have easy answers. Hopefully this brief will stimulate a dialogue on these issues – and others - that involves all key stakeholders: policymakers, providers, community leaders, family partners, family members, and youth.

Policy Issues

1. **Screening for traumatic events and symptoms.** Being sensitive to the widespread incidence of trauma and being able to identify its impact are fundamental components of trauma-informed approaches. However, there is debate about how best to operationalize this capacity. Most agree that a "universal precautions" approach is important, that people should always be given the opportunity to talk about their experiences when and how they choose, and that we need to work to develop trauma-informed referral settings. Some programs use formal screening and assessment processes, and many tools exist. There is significant ongoing discussion about how to do screening and assessment in a trauma-informed manner.
2. **Funding that recognizes the impact of trauma on the whole family.** Policymakers need to explore how best to make funding available to assist whole families impacted by trauma rather than providing services only to individuals identified as primary trauma survivors.
3. **Strengthening of youth advocacy and support groups**. *Thrive*, the trauma-informed system of care in Maine, has developed a youth advocacy movement to parallel the family movement. The youth have become a strong voice for change and for introducing trauma-informed principles of care. While maintaining a balance between youth and family empowerment can be delicate, *Thrive's* experience has been that it is worth the effort.
4. **Increased interagency collaboration.** In order to bring about the kinds of changes described in this issue brief, it is essential to bring all agencies that touch the lives of children and families into the discussion. Whether or not they choose to introduce some version of trauma-informed family partner models, understanding the language and principles of family partners and trauma informed care is key.
5. **Trauma-informed agency assessment**. Once a system has made the commitment to becoming trauma-informed, there needs to be some way of measuring progress. A number of instruments and organizational change processes are available. There is considerable debate about how to select a process and whether or not assessments should be conducted and/or required by the funding and/or regulatory body.

Research Issues

1. **Studying the effectiveness of trauma-informed approaches**. How best to measure the impact of trauma-informed care on the lives of families and children is an open question. Some argue that the approach is fundamentally values-based and shouldn't need to prove its effectiveness. Other feel it is important to begin identifying what aspects of the approach are most helpful, in what circumstances.
2. **Involving family partners, family members, and youth as research collaborators**. One of the principles of a trauma-informed approach is empowerment, and part of empowerment is creating opportunities for people who receive services to play a role in research and training as

well as in agency operations. How best to do this – what roles are most appropriate, what kinds of training and supports are necessary, etc – is the subject of considerable discussion.

3. **Including the ACE study in annual public health surveys**. Many states have added adverse childhood experiences questions to annual public health surveys in order to gather state-specific epidemiological data.

Program and Service Issues

1. **Culture change in agencies**. Agencies often have to make significant changes in their language, vision, and operations to support the family partner program. Introducing a trauma-informed approach can also be a huge shift. There is significant national discussion about how best to support agencies going through these changes.
2. **Trauma learning communities**. Many organizations and systems that have moved in the direction of trauma-informed care have done so with the help of ongoing learning communities. Creating opportunities for family partners, youth, family members, other community partner, and staff to learn together and to share perspectives can be an effective way to demonstrate and develop partnership model. Local learning communities, if they are themselves empowered, can be an effective way to build on cultural and geographic differences.
3. **Public education and social marketing**. There are many possible strategies for reaching broadest possible audience with this message. Some communities have developed resource collections in libraries for children, youth and adults. Others have developed broad social marketing campaigns or worked with the media.

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