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Trauma-Informed Care or Trauma-Informed Services?

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Over the past 20 years, there has been growing interest in and study of the impact of trauma on the functioning of individuals. This research has created an awareness of the need for change in many organizations that provide a multitude of services to children, youths, adults, and families (DeCandia & Guarino, 2015). Many agencies identify themselves as *trauma informed* or as practicing trauma-informed care (TIC). These terms are often used interchangeably, but there is a significant difference between an organization that practices TIC and an agency that provides trauma-informed services or interventions.

Trauma-informed services or interventions are targeted to help clients. These are generally evidence-based or research-based interventions that an agency can employ to help its clients deal with the trauma they have experienced. Examples of interventions used with individual clients may include eye movement desensitization and reprocessing or trauma-focused cognitive behavioral therapy; with families they may include child-parent psychotherapy and functional family therapy; and with groups they may include seeking safety or trauma recovery and empowerment model or systems training for emotional predictability and problem solving. These interventions support clients and their families develop coping strategies and process their traumas. The staff who implement these interventions must be trained to use them, and to implement them effectively the staff must understand trauma theory and neuroscience. These and other effective treatment strategies help clients; however, by themselves they do not constitute practicing TIC. Many agencies that train their clinical staff in evidence-based, trauma-informed interventions may say they are a trauma-informed agency, but these trauma-informed services do not require the agency to change its structure agency-wide, assess itself, or examine how trauma may be affecting the providers of these interventions.

TIC, in contrast, is not just a mental health intervention that clinicians provide to clients; it is a much larger agency-wide commitment to change the culture within an organization. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) defines TIC as an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. TIC emphasizes physical, psychological, and emotional safety *for both consumers and providers*, and helps survivors rebuild a sense of control and empowerment.

This means TIC is not simply an evidence-based, trauma-informed intervention clinician use in their therapy or treatment of clients. Rather, it is twofold, affecting and empowering both the consumers (e.g., clients, students, patients) and the providers (e.g., employees, organizations, systems) who are responding to all types of trauma. When an agency practices TIC, it validates that anyone, including staff and organizations (not just clients) can experience trauma, and trauma can affect people's perception of their relationships, their safety, their sense of control, and their sense of competence.

Hummer, Haynes, and Rickus (2015) identified four essential elements of TIC:

- Connect – Focus on relationships.
- Protect – promote safety and trustworthiness.
- Respect – engage in choice and collaboration.
- Redirect – teach and reinforce, encouraging skill-building and competence.

These four elements are applied to both consumers and providers. For providers, they require the agency to be open to a paradigm shift in its organizational structure, including hiring practices, policies and procedures, training and education for all staff, universal trauma screenings and interventions, and administration commitment to change (DeCandia & Guarino, 2015; Fallot & Harris, 2009).

Fallot and Bebout (2013) suggested we ask these five client-based questions:

- Safety – Do we promote clients' physical and emotional safety?
- Trustworthiness – Do we maximize and build clients' trust, make tasks clear, and enforce appropriate boundaries?
- Choice – Do we enhance clients' consumer choice and control?
- Collaboration – Do we maximize opportunities to collaborate with clients and share power in decision making?
- Empowerment – Do we prioritize clients' skill-building at every opportunity?

Fallot and Bebout (2013) further asserted we ask the same five staff-based questions:

- Safety – Do we ensure staff's physical, emotional, psychological, and moral safety?
- Trustworthiness – Do we (as administrators and supervisors) maximize and build staff's trust, make tasks and procedures clear, and promote consistency?
- Choice – Do we enhance staff's choice and control in their day-to-day work?
- Collaboration – Do we maximize opportunities to collaborate and share power with staff members?
- Empowerment – Do we prioritize staff skill building and provide the resources necessary for them to perform their job assignments?

According to Fallot and Bebout (2013), the basic lesson is the following: "Staff members—all staff members—can only create a setting of, and offer relationships characterized by, safety, trustworthiness, choice, collaboration, and empowerment only when they experience these same factors in the program as a whole. It is unrealistic to expect it to be otherwise." This parallel process forms the crux of an agency that practices TIC. Bloom and Farragher (2013) identified this parallel process in their Sanctuary Model.

When an organization commits to practicing TIC, it is committing to a journey that will require organizational assessments that involve all staff, review of agency policies and practices, and establishment and empowerment of a trauma workgroup. This changes the question for clients from "What is wrong with you?" to "What happened to you?" (DeCandia & Guarino, 2015).

An organization that practices TIC must be aware of secondary traumatic stress or vicarious trauma for its employees. Secondary traumatic stress can occur when individuals have chronic exposure to traumatic materials. Educating and promoting self-care is an essential component in mitigating the impact of secondary traumatic stress. Employees have a responsibility for their own self-care within the workplace through managing their time, pacing their workload, taking short breaks, and using supervision and consultation to debrief. Employees' responsibility for their own self-care also extends outside the workplace through seeking help with personal trauma history and regularly participating in relaxation activities or meditation. Organizations that practice TIC also have a responsibility to provide self-care for their employees by providing regular supervision, training, mental health benefits, variety in job duties, and a nontoxic workplace (Fallot & Bebout, 2013). This constitutes a joint effort to balance the parallel process in a positive direction.

The Adverse Childhood Experiences (ACEs) study showed that the adversities and toxic stress people experience in childhood have a significant impact on them as adults in their physical health, emotional health, mental health, relational health, and work performance. The study also showed that trauma and adversities are common in the general population; two-thirds of those surveyed had one or more ACEs. Given this information, agencies must recognize their employees have trauma histories that may impact their performance at work with colleagues and their ability to provide quality services to clients. Providing trauma-informed services is a good option in helping clients understand the impact of trauma; however, it is not the same as practicing TIC. The journey of an agency practicing

TIC is not a "one and done" training on evidence-based interventions. The journey is ongoing and has a larger systemic impact that requires a change in the organization's structure to benefit both the consumer and the practitioner (DeCandia & Guarino, 2015). Understanding this concept is essential to understanding that providing trauma-informed services is different from practicing TIC.

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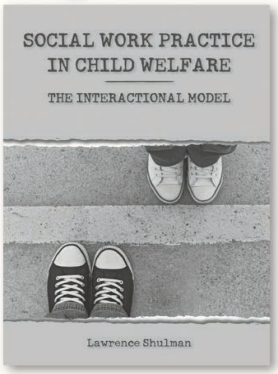

SOCIAL WORK PRACTICE IN CHILD WELFARE

THE INTERACTIONAL MODEL

Lawrence Shulman

Social Work Practice in Child Welfare: The Interactional Model integrates and illustrates practice theory and practice skills. It demonstrates how evidence-based practices can be integrated into a practice framework, consistent with a social worker's professional role, while avoiding overly prescriptive practices. The general practice model is presented, illustrated, and then applied to the different areas of social work in child welfare, including protection, family support, foster care, adoption, and residential care. Process recording examples drawn from child welfare practice are analyzed and then connected to the practice model. *Social Work Practice in Child Welfare: The Interactional Model* presents a paradigm shift from the current medical model to the emerging interactional model. This book is an excellent resource for those social workers and practitioners who work in the field of child welfare.

NASW PRESS

ISBN: 978-0-87101-495-5. 2015. Item #4955. 208 pages. $42.99

1-800-227-3590 • www.naswpress.org

NASW National Association of Social Workers

CODE:PCWM15