



Edwin Lee
Mayor

SAN FRANCISCO MENTAL HEALTH BOARD

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Adopted Minutes

Mental Health Board Meeting
Wednesday, [January 21, 2015](#)
City Hall, 2nd Floor, Room 278
One Carlton B. Goodlett Place
San Francisco, CA
6:30 – 8:30 PM

BOARD MEMBERS PRESENT: David Elliott Lewis, PhD, Co-Chair; Wendy James, Vice Chair; Kara Chien, JD; Ulash Thakore-Dunlap, MFT; Deborah Hardy; Terence Patterson, EdD, ABPP; Harriette Stevens, EdD; Vanae Tran, MS.; Adrian Williams; and Njon Weinroth.

BOARD MEMBERS ON LEAVE: [Ellis Joseph](#), MBA, Co-Chair; and [Terry Bohrer](#), RN, MSW, CLNC.

BOARD MEMBERS ABSENT: Virginia S. Lewis, MA, LCSW, Co-Secretary; Andre Moore; Idell Wilson; and Errol Wishom, Co-Secretary

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Loy M. Proffitt (Administrative Manager); and Gene Porfido, Tom Waddell; Michael Morrissey, Spirit House Pro; Jacqueline Jansen, Marin Founders.org; Cheri Renee Watkins; ([seven](#)) members of the public

CALL TO ORDER

Dr. David Elliott Lewis called the meeting of the Mental Health Board to order at 6:35 PM.

ROLL CALL

Ms. Brooke called the roll.

AGENDA CHANGES

Dr. Lewis stated that due to time constraints the agenda order would be changed. Item 4.0 will follow Item 2.0, and then the agenda will resume with 3.0.

ITEM 1.0 REPORT FROM COMMUNITY BEHAVIORAL HEALTH SERVICES DIRECTOR

Dr. David Elliott Lewis introduced Dr. Ken Epstein, Director of the Department of Children, Youth and Families (DCYF) for Community Behavioral Health Services, who gave the director's report on

behalf of CBHS Director Jo Robinson. After completing the report, he followed with Item 4.0 with his presentation on Trauma Informed Care.

1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

Dr. Epstein highlighted the CBHS director's report. The hiring of new peers to assist with enrollment has broadened participation in services. A wellness and recovery coordinator was recently hired and one of the priorities will be to look at wellness and recovery throughout a person's lifespan.

In the late spring of 2014, San Francisco received a crisis-triage grant to support three programs in the Children's System of Care.

The Mental Health Association (MHA-SF) is almost complete in implementing a 24-hour warm line. The line will be staffed by peers who will talk with and support people experiencing an acute crisis.

The non-profit organization Edgewood in the Sunset received funds to strengthen its diversion unit for children and youth. Within 24 hours of entering the diversion unit, Edgewood can provide assessment, stabilization & treatment, if warranted.

Mobile Crisis can deploy crisis response teams (CRT) to engage intensively with families to provide both adults and children who are affected by trauma with treatment. Institute de la Rasa will serve undocumented youth. Services will also be available at 1099 Sunnydale in Visitacion Valley.

At the February 2015 board meeting, Jo Robinson will talk more about the annual External Quality Review Organization (EQRO), which will visit CBHS February 4th. The report is coming in the spring of 2015. The California EQRO is charged with the responsibility of evaluating the quality of specialty mental health services provided to beneficiaries enrolled in the Medi-Cal managed health care program and of conducting a site visit to San Francisco County to review the quality of the overall service delivery system. In addition to reviewing reports, they interview staff and clients.

Dr. Patterson asked how the new Mobile Crisis is different from the current Mobile Crisis and Child Crisis.

Dr. Epstein said the crisis triage grant provides financial support to three mobile crisis teams for the City and County of San Francisco. Mobile crisis teams are located at 1099 Sunnydale, and Edgewood's crisis stabilization unit. The CRT (Crisis Response Team) responds to shootings with violence prevention experts.

Dr. Epstein replied that crisis response teams of the new Mobile Crisis have a protocol, if necessary, to directly and immediately place children in Edgewood for stabilization. CRT is violence prevention staff who respond to shootings rather than providing long-term care.

Ms. Williams said there was a recent shooting in Western Addition where four youth were murdered. She commented about the lack of crisis response for the children who were exposed to the multiple homicides.

The parents had called authorities and had asked for grief counselors for the children, but no grief counselors responded to their numerous requests. Also, as of last night, January 20th, 2015, the children are still affected by the homicides and still have not seen any follow-up grief response from the authorities.

Dr. Epstein stated that resources are dispatched out depending on which responders are available.

Dr. David Elliott Lewis asked how the City is handling the sudden surge of 350 unaccompanied kids, who were a fraction of the children crossing the border illegally into Texas and Arizona, from Central America and who were relocated to San Francisco in the last few months. Since their perilous journey of coming to the US was fraught with exploitations, many of the unaccompanied minors were most likely traumatized by the experience.

Dr. Epstein said over 350 unaccompanied minors from Central and South America entered the San Francisco system. Many CBHS staff and clinicians are already trauma informed and aware of the “humanitarian crisis”. They are doing their best to coordinate services with other agencies.

1.2 Public Comment

No public comments.

Monthly Director’s Report

January 2015

1. Enrollment into Expansion Medi-Cal of Clients of CBHS

Via a state Medi-Cal Outreach & Enrollment grant (AB 82) received by San Francisco county to enroll vulnerable individuals into health coverage, CBHS, in collaboration with San Francisco Human Services Agency (HSA) and Richmond Area Multi-Services (RAMS), embarked on a two-year project (2014 to 2016) to conduct outreach, education and enrollment assistance to uninsured clients at high-volume CBHS civil-service operated and contracted, substance abuse and mental health treatment programs.

RAMS is contracted to hire four Peer Navigators trained by HSA to assist eligible uninsured CBHS clients enroll into Medi-Cal health coverage at CBHS service delivery sites. These peer navigators are equipped with laptops with internet access and portable scanners, and granted certified access into HSA’s *mybenefitscalwin* internet site, to enroll CBHS clients into Medi-Cal. The peer navigators will also help clients retain their Medi-Cal coverage during annual renewals.

CBHS oversees a large county behavioral health system-of-care composed largely of CBO partners, along with civil-service-operated mental health outpatient clinics, providing mental health and substance abuse outpatient, intensive outpatient, day treatment, residential treatment and other services. RAMS is a CBHS contractor that will assist CBHS in meeting its system-wide goal of assisting all clients to obtain health insurance, by rotating office hours through selected CBHS programs with high volume of uninsured clients. RAMS provides the following direct assistance below to the CBHS programs’ clients:

- Sit with clients to do online Medi-Cal application;
- Follow-up with clients in gathering any needed documentation, and in completing the application for those who need more than one session;
- Follow-up with clients to ensure annual renewal of Medi-Cal coverage.

RAMS Peer Navigators will also be deployed daily, Monday to Friday, at CBHS’s Central Access office at 1380 Howard St., San Francisco, CA.

For the two-year period of the project, the goal of the RAMS peer navigators is to achieve the following objectives:

1. Make 500 contacts with individuals in the target population through outreach activities and events.
2. Submit 212 Medi-Cal applications
3. Retain 70% of individuals in these target populations after one year.[\[SP1\]](#)

All CBHS programs (civil service and contractor) are required to achieve a program performance objective to successfully assist a minimum number of their uninsured clients to obtain health coverage. 50% of clients, who appeared on 7/1/2014 as uninsured in a CBHS program's Uninsured Clients Report, will appear as insured in the program's Uninsured Clients Report on 6/30/2015. CBHS programs are required to do the following:

- know the health coverage status of all of their clients by entering into the primary care homes of their clients into the Avatar electronic health record;
- provide basic information about health coverage to uninsured clients;
- assist uninsured clients in obtaining health coverage by providing basic information and referral, and by enlisting the help of the RAMS Peer Navigators."

2. *SFHN Behavioral Health Services Internship Website*

I am pleased to announce that the SFHN Behavioral Health Services Internship website is live; this is a resource for practicum students and University staff to learn about the internship opportunities within our system. The website provides information about training placements, the application process, our Multicultural stipend program and other information needed by students as they investigate potential training sites for their practicums. Please visit the site at <https://www.sfdph.org/dph/comupg/aboutdph/jobs/internships.asp> and disseminate this resource to anyone seeking information about the BHS internship program.

3. *Wellness and Recovery Coordinator*

Please join me in welcoming Gloria Frederico, MFT into the position of Wellness and Recovery Coordinator. Gloria has worked at O.M.I. Family Center for 21 years and most recently has been working as the Acting Clinic Director. She was the Team Leader for "Team O.M.I." in the statewide learning collaborative "Advancing Recovery Practices" which was sponsored by California Institute of Mental Health. At the conclusion of the learning collaborative, Gloria was instrumental in working with clinic leadership and clinic staff in the development of the *O.M.I. Family Center Wellness and Recovery Three Phase Treatment Model* that is being tested and refined using the P.D.S.A. (Plan-Do-Study-Act) model for improvement. Gloria has served on the faculty for the most recent statewide learning collaborative "Advancing Recovery Practices" where she is sharing her expertise in the implementation of wellness and recovery practices; collaborative leadership; and clinic transformation.

4. *CalMHSA Collaboration*

The Gay-Straight Alliance Network and CalMHSA collaborated with the Reach Out Here campaign (www.reachouthere.org) to develop mental health resources (e.g. fact sheets and documenting real stories) geared specifically for LGBTQ youth. For full details visit <http://www.reachouthere.org> or contact Meredith Sire at meredithsires@inspire.org.

5. *Reminder*

We are excited to share with you

What's New?

The 7th Annual Together Against Stigma International Conference

Empowering Community Mental Health through Research, Practice, Policy, and Research

February 18-20, 2015 in San Francisco, CA, USA

Watch the legacy of this international conference continue highlighting prominent champions addressing stigma

[Click here to watch the video!](#) (On the homepage of the website)

Help Individuals with Low or No Income! Donate to our Scholarship Fund

Want to help individuals who have low to no income? We are currently accepting donations to help support these individuals including family members and students who want the opportunity to attend the Together Against Stigma International Conference. [Click here to donate now](#)

Apply for a Scholarship

Apply for a discounted conference registration and/or travel reimbursement. This is a competitive process only for individuals in need of monetary support that requires a completed application by January 12, 2015. [Click here to apply for a scholarship](#)

6. New Spanish Language Parity Resource Available

Disability Rights California's new Mental Health Stigma & Discrimination Reduction Project publication, "The California Mental Health Parity Act Toolkit: A Guide to Appealing Health Plan Mental Health Care Denials" is now available in Spanish. You can find this translation and its English version at the Mental Health Parity page. Contact: Margaret Jakobson-Johnson at Margaret.Jakobson@disabilityrightsca.org or (916) 504-5937.

7. Mission A.C.T. and Wellness and Recovery

The Mission A.C.T. (MACT) team just completed a 14 months of restructuring services to incorporate wellness and recovery approaches to helping its member's lead better more productive lives. They participated in a series of teleconferences and trainings with California Institute of Behavioral Health's Advanced Recovery Collaborative. The collaborative seeks to build hope and belief in recovery by consumers as well as staff.

Mission A.C.T. developed the following charter: "We aim to cultivate independence and improve the quality of life of MACT members. We will do so by utilizing a recovery-oriented approach in which members will define their own recovery. We will implement a strengths based approach where members design treatment goals that are meaningful to them. Overall, the goals are to move members towards independence, create and maintain stable community connections, and decrease dependence on crisis services."

The goals this team worked on operationalized the aim in concrete terms:

1. To increase member involvement in vocational rehabilitation.
2. To increase member involvement in meaningful community activities.
3. To decrease the rates of post-disenrollment hospitalizations.

The objectives the team designed involved measurable outcomes that required the entire team to collect data over a period of twelve months:

1. 60% of members will be participating in a vocational rehabilitation activity.
2. 50% of members will be involved in meaningful community activities.
3. 75% of members will not be hospitalized for mental health concerns within 90 days of graduation.

To meet these goals and objectives, MACT utilized the Plan Do Study Act (PDSA) model of change to incorporate a recovery model into the daily operations. Numerous PDSA's were tried utilizing the tools

provided by the Collaborative. In working with their consumers, they tested the Strengths Assessment (SA) to help members develop treatment plan goals meaningful to them. The SA is used to help consumers identify and utilize strengths, natural supports, self-help, peer support, and community resources. This then drives a personal recovery plan designed by the consumer.

The SA was well received by consumers and clinicians. It is a clinical tool designed to move away from pathology and into a recovery track. The team learned new things about their members (work histories, family relationships, aspirations, etc.). Following the adoption of the SA, MACT began to incorporate the Strength Based Group Supervision during their staff meetings. The clinician presents the consumers SA during the Strength Based Group Supervision. The session is moderated by a clinician who follows a specific agenda guiding the session. Once the team has reviewed the consumer's SA questions are asked to clarify items on the SA. Lastly Staff will provide a given number of suggestions that may be appropriate for the consumer. The presenter will take note of all suggestions and then will pick several that may be appropriate for the consumer. To build hope and belief in recovery, MACT tested a number of approaches and implemented those that they felt would have the greatest impact in changing the program's culture:

- Adopted a Living Recovery wall where members write goals and aspirations, share recovery moments, and placed inspirational art throughout the building.
- Consumers and staff share recovery moments during community and staff meetings.
- Present recovery videos during the community meetings.
- Began to use recovery oriented language during staff meetings, and began to design a new program brochure to reflect this approach.
- Incorporated a Graduation Ceremony for those consumers going to lower levels of care. Invited graduates to come back to share their progress with the community.

Now that the collaborative is over, MACT is working on solidifying changes and sharing the information when other programs and clinicians show an interest in learning about wellness and recovery.

Tell us your clinic story and we will add it to the upcoming Director's Reports

Past issues of the CBHS Monthly Director's Report are available at:

<http://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/CBHSdirRpts.asp>

To receive this Monthly Report via e-mail, please e-mail vita.ogans@sfdph.org

ITEM 2.0 MENTAL HEALTH SERVICE ACT UPDATES AND PUBLIC HEARINGS

2.1 Mental Health Services Act Annual Update: Public Hearing

No additional items were reported.

2.2 Public comment

No public comments.

ITEM 3.0 ACTION ITEMS

3.1 Public comment

No public comments.

3.2 Proposed Resolution: Be it resolved that the minutes for the Mental Health Board meeting of November 19, 2014 be approved as submitted.

Unanimously approved

3.3 Proposed Resolution: Be it resolved that the notes from the December 6, 2014 Mental Health Board Retreat be approved as submitted.

Unanimously approved

3.4 Proposed Resolution: Be it resolved that the following Mental Health Board Goals and Priorities for 2015 be approved as submitted.

Board members will take the lead for each priority area and develop agendas that will inform the board about the issues. Kara Chien will lead Incarcerated Mentally Ill, Vanae Tran will lead Information Services, and Adrian Williams and Terence Patterson will co-lead Chronic Trauma.

1. Issues Concerning Incarcerated Mentally Ill
 - Indigent people and Issues
 - Family member visiting
 - Jail psychiatric housing and facility for men similar to that for women
 - Re-entry housing and programs
 - Senior issues
2. Information And Access To Behavioral Health Services
 - Evaluate Network of Care – information referral services
 - How new consumers get access to care
 - How new consumers find a peer support provider
 - Barriers to accessing services
 - How integration of mental health and substance abuse is working
 - Special needs and special populations
 - Impact of mental health parity legislation
3. Chronic Trauma As Related To Violence And Youth And Family Issues
 - Southeast Trauma Report: follow up, execution and expansion.
 - Grief counseling for youth and family members
 - What are the successful programs?
 - Explore trauma citywide
 - Trauma informed care related to children's mental health
 - Police and provider collaboration regarding trauma
 - Mental health first aid.

Unanimously approved

ITEM 4.0 PRESENTATION ON TRAUMA INFORMED SYSTEM OF CARE, KEN EPSTEIN, PH D., DIRECTOR OF CHILDREN, YOUTH AND FAMILIES, COMMUNITY BEHAVIORAL HEALTH SERVICES.

Dr. Epstein presentation is at the end of the minutes

4.1 Presentation: Trauma Informed System of Care, Ken Epstein, Ph D., Director of Children, Youth and Families, Community Behavioral Health Services.

Dr. Epstein introduced Kaytie Speziale as his co-presenter. He shared that he has over 25 years of experience working with children and youth. He said that the Department of Public Health (DPH) Director, Barbara Garcia, mandated that the entire workforce become a trauma informed system. Dr. Epstein is directing that process. The training includes receptionists, maintenance workers to clinicians. Over 400 people collaborated in developing the principles of Trauma Informed Care. We have recognized that there are ways to help people get better when traumatized. when a staff is interacting with a traumatized client, the response from the staff should not be “what is wrong with them” but, rather, “what has happened to them.

The first mandate is to train 9,000 public health personnel in the workforce. Over 1,400 people were trained so far. The bi-monthly training can accommodate 80 participants at a time. It is expected to take two years to train the entire health department. During training sessions, participants are encouraged to think about resiliency and perseverance as innate assets. Resilience is asking what is right with a person and building on that. At each training the trainers ask for a commitment to change from the participants. Dr. Epstein’s team will follow up with the commitment with the expectation that 75% will remember having made the commitment and 50% will follow through.

Through the trainers’ training initiative, the second goal is recruiting more trainers within the department to “mass” populate the training to the entire health department. The health system already has built-in groups of champions who have offered to be trainers. The champions are in Transitional Age Youth, Adolescent Health Working Group (AHWG), with Dr. Aragon, and Health Service Agency (HSA). This initiative can embed champions in every city department to be trauma-informed-care trainers.

Effective leadership is the third component. Mayor Ed Lee wants trauma-informed-care training to be a long-term commitment. He would like to see on-going evaluations to ensure long-term sustainability.

In the alignment phase, he will be looking at how others fit into the trauma informed care initiative. For example, staff experiences and client experiences can be aligned with trauma informed care. Other agencies from the HSA, Probation, the First 5 Commission, to the San Francisco Police Department have expressed interest in having a citywide alignment to include their departments in the training.

The entire city of Philadelphia and the state of Maine are trauma informed systems of care, however, San Francisco is the only system that is training itself rather than flying in consultants.

Mr. Weinroth asked about the statistics of 16.5% evaluators saying the trauma training is “too basic”.

Dr. Epstein said there is an on-going tweaking of the training to keep the sessions interactively engaging and comprehensive. Some attendees are already very informed about the impact of trauma..

Ms. Speziale said training sessions are designed to build a common vernacular and to empower city employees to participate in the trauma informed system of care.

Dr. Patterson commented on two trauma assumptions: that trauma is pervasive in the workforce and that trauma is systemic with clients.

Dr. Epstein said trauma is a public health crisis! He cited the Adverse Childhood Experience (ACE) study which showed negative impacts on health and longevity resulting from trauma. Historical trauma from centuries of enslavement and discrimination and community violence impact health outcomes.

Hiring of public employees needs to reflect community diversity. So many employees may have faced trauma, and the work force has to be better prepared to deliver services.

Ms. Chien shared last Sunday's New York Times had an article discussing trauma. She asked what qualifications are required to be a trauma trainer.

Dr. Epstein said the department is looking at developing a team approach where co-trainers train together as a team. For example, a team trainer composition would include pairing a social worker with a person who has lived experience.

Ms. Chien asked who is helping trainers with lived experience being traumatized during trainings.

Ms. Speziale: said there is a pilot program for peer support.

Ms. Stevens asked what other evidence is being collected for data analysis.

Dr. Epstein said the commitment to trauma training is still a work in process which, ideally, includes a baseline before a training with check points throughout the process. Staff are collecting qualitative data and talking to universities regarding evaluation on sick days, grievances, moral and hope and trust and changed outcomes in the community. There isn't a model for this type of evaluation.

Ms. James inquired about the training format.

Ms. Speziale said that training is experiential and informal. The first 45 minutes is teaching the basic information about trauma, then there are breakout groups to discuss principles and to share experiences.

Ms. Hardy asked for types of data being considered for evaluation.

Ms. Speziale said they are collecting industrial data and staff surveys.

4.2 Public Comment

Ms. Watkins made a couple of comments. She wondered if trauma training would include public school teachers. She followed up on Ms. Williams earlier comment and wondered why a quick response regarding grief counseling has not been available to Western Addition children.

Ms. Speziale said two trainers are founders of the HEARTS program at the University of San Francisco (UCSF). The San Francisco curriculum was developed from HEARTS training. The school district decided to just train counselors but not teachers.

She also said there is a contact number for children and youth and family members to find healing from trauma.

Mr. Porfido stated that he is a consumer in the system and has been on various community advisory boards. He has seen traumatized people coming into Tom Waddell clinic. He wondered if there will be opportunities for peers to help with trainings.

Ms. Speziale said people with lived will be involved in trauma trainings. She believed there is a big difference in expertise from work/academic-subject experience versus lived experience. The department wanted to protect people with lived trauma experience from further exposure and exploitation. She wants to be sure there is an infrastructure in place to help people with the next step, but ultimately there will be subject matter experts and people with lived experience as trainers. There will also be spots in the Champions program to bring back information to the programs.

Ms. Park commented that workforce retention is important when the city invests so much manpower and monetary resources in training the workforce on trauma informed care. She applauded the City leaders for being so forward thinking.

ITEM 5.0 REPORTS

5.1 Report from the Executive Director of the Mental Health Board.

Ms. Brooke commended the board for the successful December 2014 retreat and reported the following:

1. The MHB should be back in its office by February 9, 2015
2. The Program Review Committee meets the 2nd Tuesday of the month at 1 PM and 1380 Howard Street, 2nd Floor.

5.2 Report of the Co-Chairs of the Board and the Executive Committee.

Dr. David Elliott Lewis shared that serving on the board as a consumer has been a healing experience for him. He thanked the board for selecting him as the board's co-chair. He cited that at the 2015 State of the Union, President Obama mentioned mental health care in his speech to Americans and the world.

David shared that he is encouraging Supervisors Mar, Wiener and Farrell to apply for the open seat for a member of the Board of Supervisors.

5.3 Report from the Nominating Committee. The Nominating Committee will propose the slate of officers to be voted on at the February 2015 Board Meeting. Additional nominations can be taken from the floor in February.

Dr. David Elliott Lewis reported that the Nominating Committee consisted of him as Chair, and Kara Chien and Harriette Stevens. The Committee nominated Kara Chien for Chair, Ulash Thakore-Dunlap for Vice Chair and he, himself, for Secretary. He announced that elections will be held at the February 2015 board meeting and additional nominations, including self-nomination, can be taken from the floor at tonight's meeting as well as in February.

Dr. Patterson nominated Ms. Wendy James for chair.

5.4 People or Issues Highlighted by MHB: Suggestions of people and/or programs that the board believes should be acknowledged or highlighted by the Mental Health Board.

None were suggested for honorary.

5.5 Report by members of the Board on their activities on behalf of the Board.

Ms. Hardy informed the board that NAMI-SF has been planning to move its meeting time to another day that won't conflict with the Mental Health Board meeting.

5.6 New business - Suggestions for future agenda items to be referred to the Executive Committee.

Dr. Patterson suggested chronic trauma related to youth and family issues and would like the board to revisit the District 10 report that was completed by former board member Ms. Lena Miller.

5.7 Public comment.

No public comments.

6.0 Public Comment

No public comments.

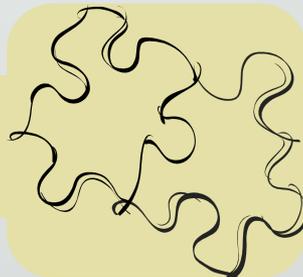
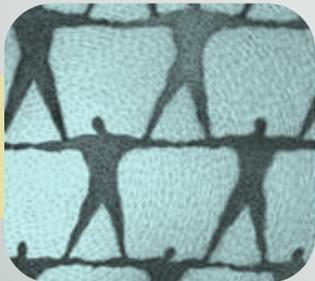
ADJOURNMENT

Meeting adjourned at 8:16 PM.

Trauma Informed Systems Initiative

SFDPH

A Model For Promoting Change in Public Systems Service Delivery



The Path to Change



Relational Leadership

“I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.”

Maya Angelou

Reflection

“When people move beyond their windows of tolerance, they lose the capacity to think rationally...Conscious awareness allows for self-reflection, which can enable the mobilization of strategic thoughts and behaviors and can therefore enhance the flexible achievement of goals.”

Daniel Siegel

Impact of Trauma

Health Outcomes

Stress

Trauma

Historical Trauma

Microaggressions

Traumatic Life
Events

Physical & Sexual

Coping

Cultural Buffers

Identity Attitudes
Enculturation
Spiritual Coping
Resilience
Attachment

Traditional Health Practices

Health

Greater Risk &
Morbidity

AOD Use

Abuse & Dependence

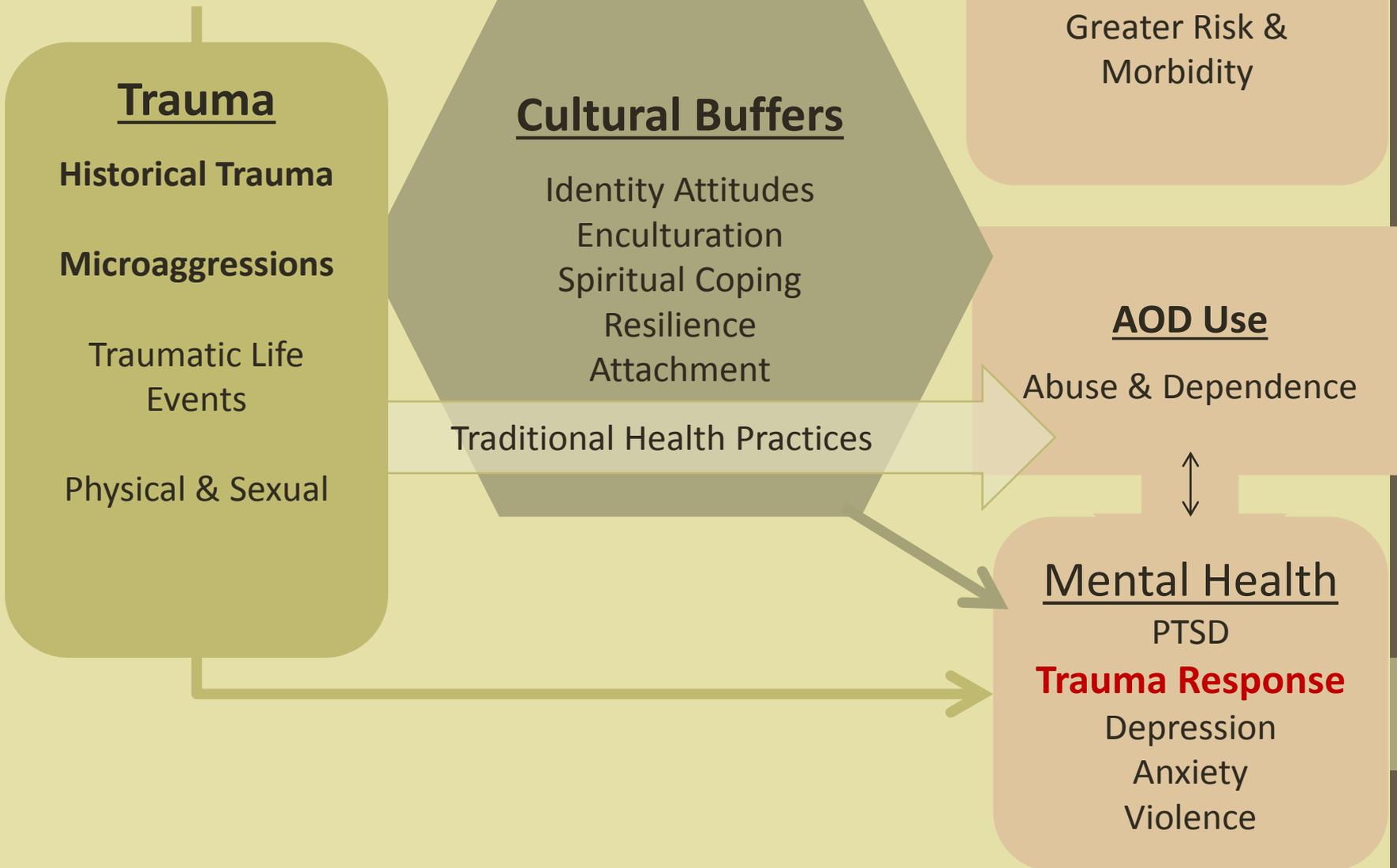


Mental Health

PTSD

Trauma Response

Depression
Anxiety
Violence



Historical Trauma

“A society that cannot remember its past and honor it is in peril of losing its spirit.”

Vine Deloria Jr.

Community Impact of Racism

Historical
Unresolved Grief

Disenfranchised
Grief

Internalized Oppression

A Traumatized System

Reliving/Retelling

Increased Arousal/Reactivity

Avoiding

Multiple Lens,
Multiple Initiatives

The African American
community in particular
and other communities of
color are underserved are
poorly served

Why Workforce Development?

Multiple databases,
multiple measurements,
multiple entry points,
limit the capacity to utilize
data to foster change

The workforce is not fully
prepared and supported
to meet the complex
needs of the children,
youth, families and adults

Change

“People don’t resist change.
They resist *being* changed.”

(Senge, 1990)

Implementation

The example of Staff Infection:

- 2 million people acquire Staph Infections
- 90,000 deaths
- Hand-washing is 33-50%
- After an intensive effort it went up to 70% which is still not good enough to stem the infections.



Why is it so hard to implement new practices ?

Change Management

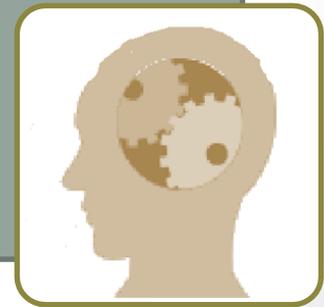
In 1996, John Kotter published *Leading Change*. His research revealed that only 30 percent of change programs succeed.

In 2008, a McKinsey survey of 3,199 executives around the world found, as Kotter did, that only one transformation in three succeeds.

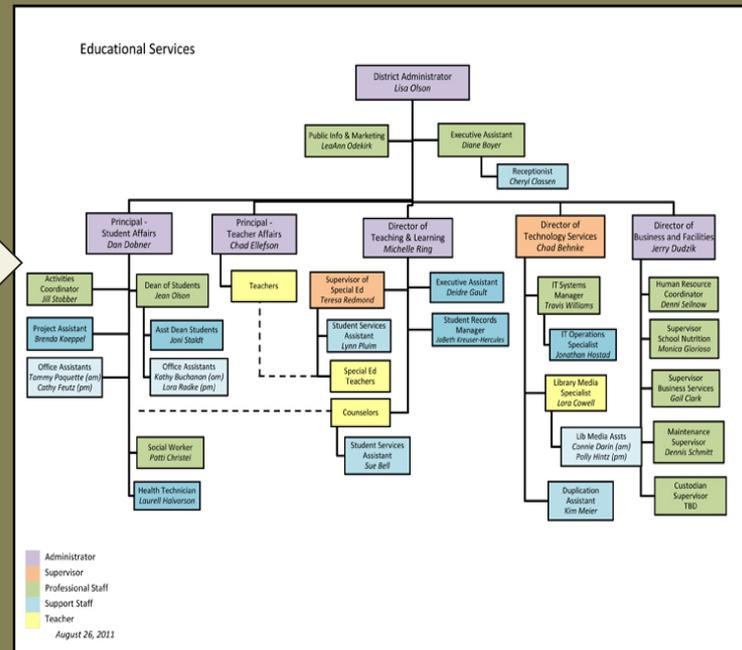
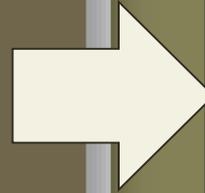
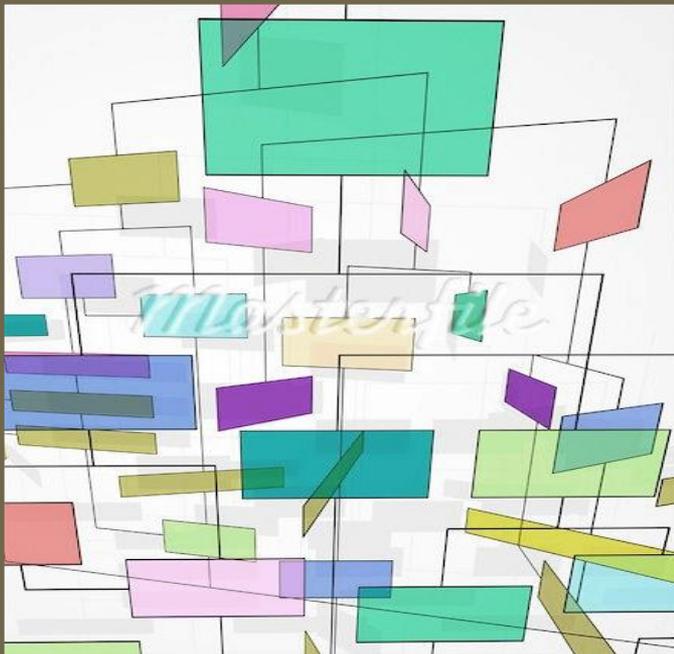
It seems that, despite prolific output, the field of change management hasn't led to more successful change programs.

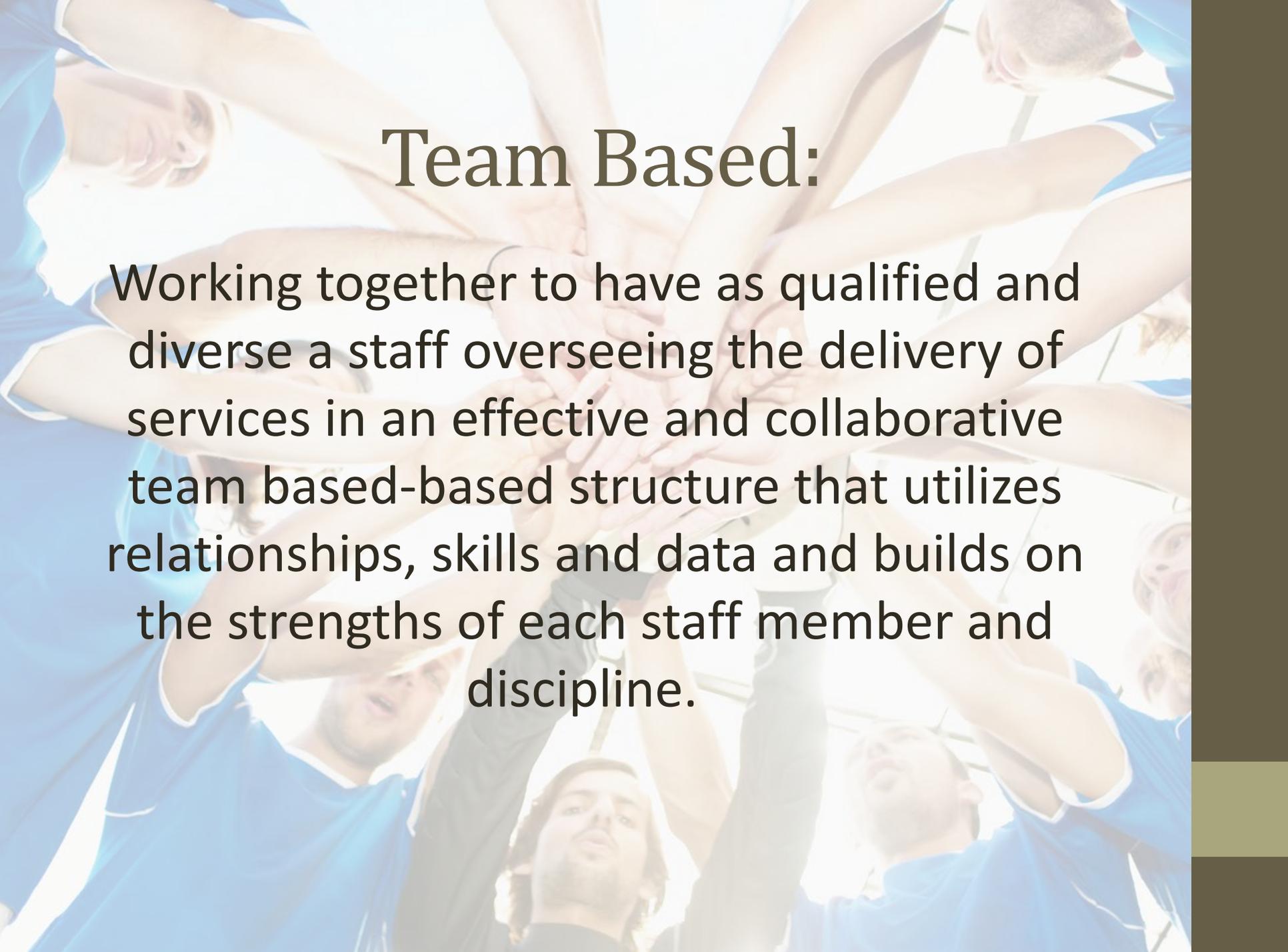
Leadership and Trauma

When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of trauma.



Fragmentation to Cohesiveness: Systemic Trauma



A group of people, likely a sports team, are huddled together in a circle. They are wearing blue athletic shirts. Their hands are raised and stacked in the center, forming a pyramid shape. The background is bright and slightly blurred, suggesting an outdoor setting. The overall mood is one of teamwork and unity.

Team Based:

Working together to have as qualified and diverse a staff overseeing the delivery of services in an effective and collaborative team based-based structure that utilizes relationships, skills and data and builds on the strengths of each staff member and discipline.

Service Excellence

Setting the Stage
Goal: Earning rapport

Gather & Respond to
Data
Goal: Sharing
Perspectives & Expanding
Empathy

Negotiate a Shared Plan

Positive Outcomes



A Five Pronged Approach

Everyone in the system has common knowledge and shared understanding

Regular process and outcome evaluations associating the training initiative with concrete changes in service delivery, service excellence and staff satisfaction

Carefully selected practitioners receive coordinated training, coaching in order to disseminate change

Focus on Equity and Disparity includes fully involving communities, families, youth and consumers in the development and evaluation of the initiative

Leadership support to provide the infrastructure necessary for sustainability including policy development, timely training, skillful supervision and coaching

Principles of a Trauma-Informed System

Trauma Understanding

Without understanding trauma, we are more likely to adopt behaviors and beliefs that are negative and unhealthy. However, when we understand trauma and stress we can act compassionately and take well-informed steps toward wellness.

Safety & Stability

Trauma unpredictably violates our physical, social, and emotional safety resulting in a sense of threat and need to manage risks. Increasing stability in our daily lives and having these core safety needs met can minimize our stress reactions and allow us to focus our resources on wellness.

Cultural Humility & Responsiveness

We come from diverse social and cultural groups that may experience and react to trauma differently. When we are open to understanding these differences and respond to them sensitively we make each other feel understood and wellness is enhanced.

Principles of a Trauma-Informed System

Compassion & Dependability

Trauma is overwhelming and can leave us feeling isolated or betrayed, which may make it difficult to trust others and receive support. However, when we experience compassionate and dependable relationships, we reestablish trusting connections with others that foster mutual wellness.

Collaboration & Empowerment

Trauma involves a loss of power and control that makes us feel helpless. However, when we are prepared for and given real opportunities to make choices for ourselves and our care, we feel empowered and can promote our own wellness.

Resilience & Recovery

Trauma can have a long-lasting and broad impact on our lives that may create a feeling of hopelessness. Yet, when we focus on our strengths and clear steps we can take toward wellness we are more likely to be resilient and recover.

A Pyramid Model for Implementation



Implementation: Trauma 101 Training

622 Participants

10 Trainings

*As of 8/1/14

Evaluation:

Trauma 101 Training

TIS Training Evaluation Data Snapshot* – 3/14-5/14

**averages across first 5 training dates*

Support for Initiative: Participants reported moderately high approval for the initiative (“agree” 4.11 out of 5); however, many participants expressed concern that the initiative would be abandoned or poorly implemented and some felt that DPH is already trauma informed and new efforts are not needed.

Level of Content: 70% of participants felt the content was “just right”, 16.5% felt it was “too basic”, and 1% reported it was “too advanced.”

Overall Course: Participants gave the course a moderately high overall rating (“agree” 4.32 out of 5).

