About this Document

Section One. This section is an overview that introduces the idea of Trauma-Responsive Systems, provides an Historical Overview that creates a frame of reference for the ideas, and gives a brief synopsis of how EPower & Associates relates to this frame.

Section Two. Because the majority of organizations that access this material are mental health or social services agencies, this section addresses Trauma-Informed Care, a specific application for Trauma-Responsive Systems. Presented as statements (without a great deal of emotion, and judgments suspended), the content in Section 1 reflects the fact that there are issues of power and control at play in many situations.

As a subset of Trauma Responsive Systems, the content in this section can be generalized to organizations beyond those serving persons with mental health or different disability issues. Everyone is affected somehow to some extent by one or more traumatic events. Our wounds and our healing play out in all our relationships. At work, in social situations, faith communities, recreation, learning and other environments, there is a filter in every situation: trauma and its impact.

Section Three. TReSIA, the heart of this process, begins with an organizational assessment that asks you to rate behavior in your organization relative to practices that reflect Trauma Informed Care and Trauma Responsive processes. Because the organization is the creator of the culture, this assessment looks at macro-to mid-level behavior. There are 50 statements, 10 each for five organizational attributes. Once the items are rated, you'll plot them, review the recommendations for that item, and use the information as you develop your transformation management plan in Section Four.

Different organizations will use TReSIA differently. Some will have only one person in leadership complete TReSIA while others may have teams complete and compile a team version. Others will ask service recipients and others to add their feedback, especially those who with different perspectives.

Section Four. Extending the results of the assessment, this section provides a template for designing your Transformation to a Trauma-Responsive System, and it uses the application of Trauma Informed Care as an example. It reflects general client (consumer, or service recipient), clinical and organizational requirements.

About this Document, continued

It incorporates thinking generated as a result of Sections One and Two, and the recommendations from your review of TReSIA scores in Section Three along with questions for use in creating a narrative. It's realistic to think that some questions will require more thought than others, and begin wherever your organization is in the process. Save a copy to your computer to use as your master.

Section Five: LEAP, the Life Enhancing Action Plan, is an individual tool for planning, implementing and assessing individual change.

Section Six: Resources. This final section contains a set of links and resources that may be useful to you as you explore, transform, and continue changing.

Introduction

TReSIA, the Trauma-Responsive Systems Implementation Advisor, represents an integration of the most current understandings of the prevalence of overwhelming events and of the impact of those events across a person's lifespan into systems of many types.

People are the core of any organization. Without them, nothing happens. No policies, processes, methods, systems, inputs, outputs or work product. No influence. You can't even design an electronically based process without… people.

We are all impacted by the experiences we have from conception on. Before birth, the chemicals transmitted to us through our mother's blood supply surely influence brain development and neurology. After birth, there are so many inputs:

- the nature and type of connection to our early caregivers
- the physical, mental, emotional and spiritual safety of our environment
- access to food, water and shelter
- access to and quality of educational opportunities
- our caregivers' access to meaningful employment
- social and cultural expectations of "people like us"
- local, national, and international environments and events
- the burden of our individual and collective histories.

Introduction, continued

Systems—from families to civilizations—are made up of people. The interplay of what we have learned from these many inputs, of how we are formed, impacts what we think, feel and do in every situation for ourselves and with others. What happens to us at each moment impacts us from that moment on.

If we are overwhelmed by an event of any sort, rendered unable to take it in or make sense of it, we are changed. It doesn't matter what the source of the event is. Whatever meaning we make we carry with us into every organization and every system of which we are a part. This includes the meaning we struggle with and the meaning that is easy to derive.

We propose that it is time to consider this fact openly. We propose that the impact of those overwhelming events—traumatic experiences—shows up in many ways. How can it not? And since it does, we need to consider how to incorporate what we know about the impact of traumatic experiences on every element of systems and organizations to make them more effective.

Historical Overview

Any conversation about traumatic events must include some overview of contemporary response to them. This takes us to the field of mental health, to the ADA, the Decade of the Brain, the talking and learning therapies such as CBT, and the parallel fields of Organization Development, Organizational Change Management, Systems Thinking and Human Resources Development.

The controversial Hungarian psychiatrist, Thomas Szasz, M.D., began to argue strenuously in the early 1960s—prior to the Community Mental Health Act—against the medical community's use of medical imagery and language to describe misbehavior, and its reliance on involuntary mental hospitalization to protect society. Szasz addresses issues of language; the offensive, disturbing, shocking, or other problematic types of behavior that causes people to be labeled mentally ill; and the labeling systems that confuse these patterns of behavior with physiological diseases. His early assertions focused on the fact that by calling certain people "diseased", the field of mental health attempts to deny them self-responsibility as moral agents, in order to better control them. It's fascinating reading.

Historical Overview , continued

A little later in the 1960s, the Community Mental Health Act from the Kennedy era began the process of "deinstitutionalization" as well as the process of increased access to mental health care. Perhaps the social understanding of mental health issues was too yet undeveloped, and inadequate resources were committed to the process. It has not gone well for deinstitutionalization. Increased access to mental health care was helpful, yet tending to the needs of people whose thoughts, feelings and behavior was troubling to them or to others still focused on coercion and "power over."

In the **workplace**, the stigma of seeking help was profound. In the 1960s, there could be no recognition of personal histories in the workplace: the definition of professionalism excluded it. There were still very strict social rules about the relationships of superiors and subordinates, men's and women's roles, cultural differences about who had power and who didn't. After all, women had only gained the national right to vote in 1920. The Civil Rights of 1964 outlawed discrimination against people based on race, religion, gender or ethnicity. Transforming society to accomplish the full inclusion and recognition of all people's moral agency is still ongoing.

Organizations such as ours began to talk about the relationship of traumatic experiences to organizational process with the return of Vietnam veterans to the workplace, the impact of crime on women who were assaulted, or who were victims of domestic violence who were in the workplace. We were concerned about the relationship of these to work such as then-President Jimmy Carter's report and legislation related to Mental Health Systems. That was in the late 1970s. The changes and results were short-lived.

In those days, some states even had Offices of Prevention in their mental health functions (which are coming back into vogue!). Preventing mental illness and promoting mental health were beginning to be important. Recognizing how these two functioned hand-in-hand in large systems was an important beginning. So was the subtle and unspoken need to preserve historically entrenched cultural beliefs about people labeled mentally ill. It allowed all of us to avoid facing the reality of the impact of "bad things that happen" and let us continue focusing on "brain-based disease" or "faulty brains" as cause.

With the implementation of the Americans with Disabilities Act (ADA) in 1990, workplaces began to struggle with how to openly include individuals with disabilities

Historical Overview , continued

in the workplace. The ADA brought what most people considered traumatic experiences to the forefront. Then, as now, concerns about disabilities (almost always physical) in the workplace were relegated to the world of Human Resources (HR).

People's reaction to their disability, or to issues in their personal lives, was relegated to Employee Assistance Programs, HR, and something to be taken outside the workplace to the privacy of the clinician's office. "Accommodations" were related to making room for a person with a disability to function in the workplace, and most often, expensive consultants were called in, even though the majority of the accommodations cost under $500. It was something we could see, do, and address at the physical level.

1990 was also the inaugural year of President George W. Bush's "Decade of the Brain," a joint project of the Library of Congress, the National Institutes of Health, and the National Institute of Mental Health. This increased focus on and exposure to what was then cutting edge brain research. This corresponded with the exponential increase the development of psychotropic medications, and the patterns of increase in prescriptions, polypharmacy, and off-label uses soared in the latter half of the "Decade of the Brain." They continue to soar.

Countering the overemphasis on medication as the primary tool for managing people's thoughts, feelings, and behaviors, different schools of thought began to focus on developing and researching tools such as cognitive behavioral therapies, skill development, and helping people learn different ways of thinking, feeling, and acting.

The different psychologies began to look at outcomes based on interventions. This too continues, and the efforts to balance what we continue to learn about the brain and how its incredibly complex systems work, the difference and complementary relationships of changing brain chemistry through drugs and changing brain function through learning and doing is becoming clearer. This dance will go on, and that is a good thing.

Meanwhile, organizational development (OD), organizational change management (OCM), and the disciplines of industrial and organizational psychology, adult learning, and social psychology were also making gains in understanding systems and their interrelationships, and in looking at the organizational functioning.

Historical Overview , continued

Work on group dynamics and action research from the 1950s and 1960s are the foundation of OD, and the history of OD is best explored though the lens of Kurt Lewin's work, the National Training Laboratory, the UK organization the Tavistock Institute of Human Relations and now the Journal of Applied Behavioral Science.

Systems thinking, leadership studies, and other multi-disciplinary fields contribute greatly towards understanding the relationships between change agents and sponsoring organizations. All of these function outside of the model of labeling individuals as mentally ill or mentally healthy, instead looking at how functional specific dynamics among multiple parties may or may not be in the service of accomplishing a goal.

While the concept of "Trauma Informed Care" (TIC) in mental health systems began to be formalized prior to 2005, SAMHSA formed the National Center for Trauma-Informed Care in that year. TIC continues to evolve, with different organizations working to promote slightly different concepts varying based on understandings of power, relationship, and process.

How EPower & Associates Relates to These Ideas

Our CEO's first article in a peer-reviewed publication was in the Journal of Management Science and Policy Analysis. It focused on organizations, disability and shame and the relationships of these to W. Edwards Deming's work in TQM. Written in 1991, it focused on adaptation as a key characteristic for both quality and people with disabilities.

From there, the issue of stigma emerged in our work as an organization, with significant contributions in the Non-Profit Management field, where judging others defective because of differences in origin, character or physiology proves harmful to the organization and to its constituents. This work is based on Erving Goffman's sociological understanding of stigma, and influenced by Hannah Arendt's keen clarity in political psychology.

The nature and challenges of connection was also a critical influence through involvement with the Stone Center for Research on Women, and in particular, Jean Baker-Miller's work on relational psychology. The need to connect in meaningful ways is part of being human and fundamental in meaning making.

How EPower & Associates Relates to These Ideas, continued

Throughout all of these "wanderings," our work in adult learning, team development, policy formation, and organization development/change management in the corporate world continued. Now, we consider such issues as how the mental health of CEOs impacts everyone in the organization and the presence of psychopaths and sociopaths in the boardroom and C suites.

We look at the impact of individual and organizational history on how people learn and perform. Considering ideas such as "managing cognitive load" as well as "managing personal and cultural histories" are now as important in our work as helping skilled helpers learn to respond to the people they serve from the perspective of Trauma-Informed Care.

Paralleling this is our CEO's long-standing history in social change and in working with social issues as early as the 1960s. From providing services in storefront crisis intervention services during the Vietnam era, to working as the Executive Director of the North Carolina Rape Crisis Association working on a federal training grant in rape and sexual assault supervised by Ann Burgess in the 70s, our CEO has an extensive history of addressing issues of trauma.

She has helped replicate multiple evidence-informed and evidence-based programs for the National Child Traumatic Stress Network, and for other organizations serving survivors of traumatic stress. She is currently involved with two federal grants related to Sidran Institute's keystone program, Risking Connection®.

We live in a time when over 75% of the people in many populations have experienced something that overwhelmed them and caused them to fear for their sanity, safety, and bodily integrity. People who come home from combat deployment, who have lived in zones where combat and terrorism are everyday occurrences, who grew up in the presence of violence or abusive behavior are the norm, not the exception. Over 90% of the people receiving mental health care have histories of traumatic events.

You can be sure anyone who has been incarcerated has a history of trauma, if from nothing else, the experience of incarceration. Divorce, domestic violence, emotional, spiritual, sexual and physical abuse are in every community, every social strata, and every demographic. Many people have experienced the horror of natural disaster—Katrina, the earthquake and tsunami in Japan, the tornadoes in Alabama, the flooding along the Mississippi, and the wildfires in the West are but a few examples. All of America witnessed and was fixed on the events of 9/11. We are inundated by traumatic events that begin for some in their earliest years.

How EPower & Associates Relates to These Ideas, continued

All of those of us who work with EPower & Associates, and our CEO, have histories of overwhelming experiences of some sort at different points in life. Those experiences include exposure to violence, relational trauma, the experience of criminal violation, natural disaster, medical and health related trauma, and the trauma of the diagnosis of mental health issues, along with the trauma of recovery.

We can speak firsthand to the impact, and yet we choose to filter our remarks and work through the work of others: we have found well-grounded models that rely on thinking and research that are coherent with an integrated and holistic approach. The difference between our work and the work of other organizations that are perhaps far more well-funded and well-publicized is the open admission of lived experience coupled with the highest levels of organizational experience and functioning.

Section 1: Trauma-Responsive Systems

About Trauma-Responsive Systems

As is implied from the previous materials, **Trauma-Responsive Systems (TReS)** synthesize multiple disciplines across different settings—and from a different frame of reference. In some ways, this represents the greatest challenge to systems change.

Why? While this change, like others, requires a shift in basic attitudes (from which changes in actions follow) the shifts are both inward- and outward-facing in multiple ways. It requires:

- Acknowledging the prevalence of overwhelming experiences in the lives of everyone along the customer-supplier chain
- Recognizing the impact of coercion, bullying, and inappropriate uses of power on human capital
- Moving beyond managing diversity to addressing stigma
- Incorporating what is known about the impact of trauma on specific realms into leadership, management, and supervisory processes

About Trauma-Responsive Systems, continued

- Increasing the focus on boundaries that are life-giving instead of income-demeaning
- Adjusting policies and processes to reward symptoms of restorative process and respectful relationships
- Developing genuine respect for and positive appreciation of differences in culture
- Metrics that measure the impact of improved personal effectiveness on productivity, benefits usage

If your organization is one that provides physical or mental health care, or social services, your constituents' histories certainly include traumatic events. For you, **Trauma-Informed Care (TIC)** is only part of the process: the service delivery. **Trauma-Responsive Systems** include service delivery, operations, finance, administration and marketing; the policies as well as the process, of which Trauma-Informed Care is a part.

Trauma-Responsive Systems reflect first and foremost a way of **thinking about** and **relating to others**. This changes the game, so to speak, by focusing on behavior as a consequence of history rather than on the labels used to describe that behavior and to access reimbursement for services in different health care settings.

Such a shift impacts the mindset of every person who interacts with the person receiving services. It engages the world of the front desk, finance, medical records, payment and reimbursement, scheduling, management, administration, environmental services, security and the community of people involved with those who receive services.

It also impacts the people who provide services and who interact with those who receive services. Trauma-informed processes recognize that everyone is at risk for experiencing traumatic events, and for interacting with people whose reactions and responses are shaped by trauma. Trauma-Informed Care is the beginning, and without larger systems change to Trauma-Responsive, it is insufficient.

This document discusses Trauma-Responsive Systems and within that, Trauma-Informed Care as an industry-specific application. Additional details about the nature and characteristics of Trauma-Responsive Systems are embedded in the section on Trauma-Informed care to provide context.