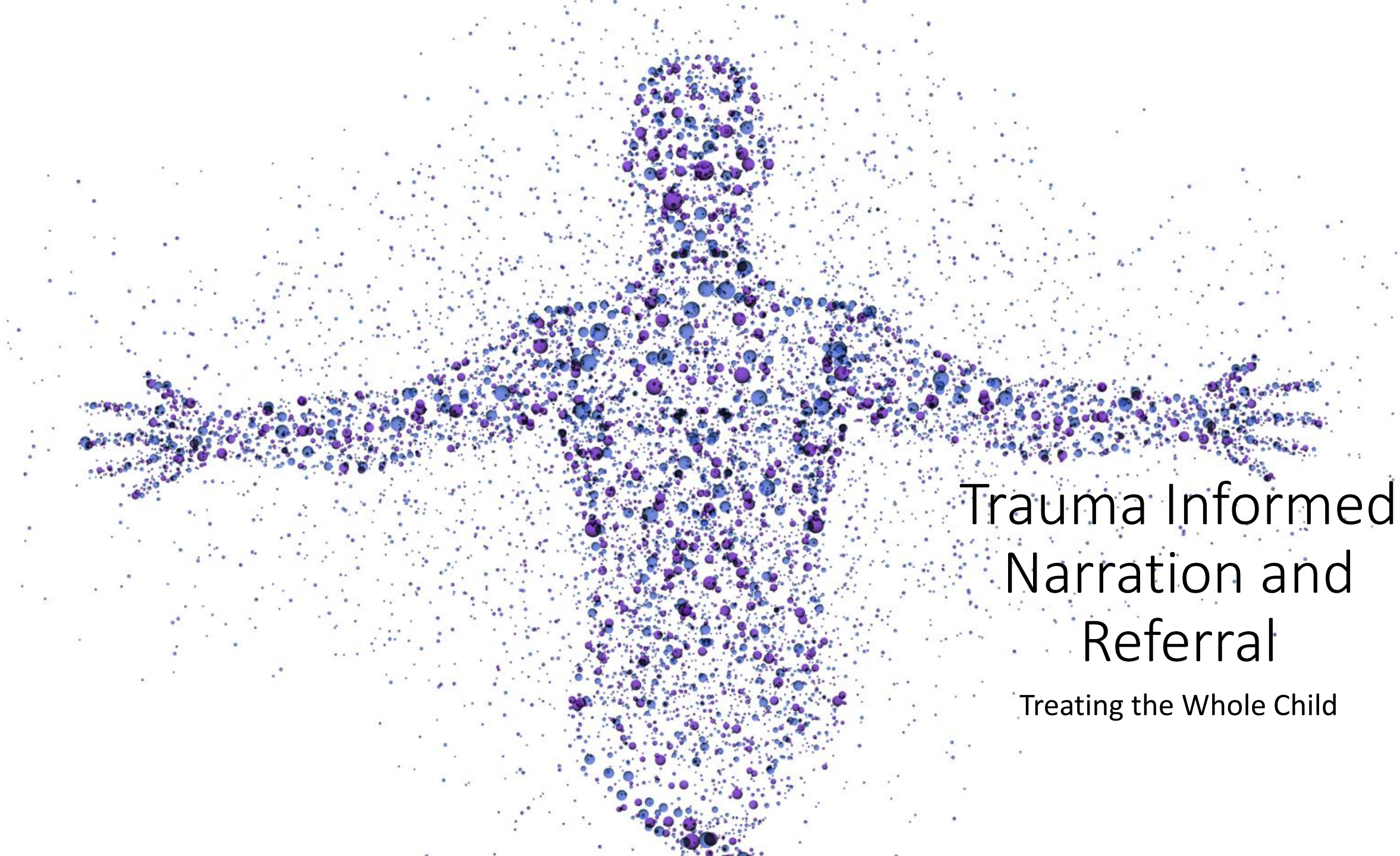

Trauma Informed Narration and Referral

Treating the Whole Child

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What does it mean to “treat the whole child”?

- Addressing all aspects of the client’s life
- Remembering that behaviors are symptoms and manifestations of a deeper level of concern that is not always treated by only targeting the symptoms
  - Focusing on the “right problem”
- Be strength driven, not symptom driven
  - “Do no harm”
- People will forget what you said, but remember how you made them feel

What does it mean to case manage the whole child?

- The goal is to create a response to youth that restores and enhances dignity and provides opportunities for ***connection, healing*** and ***transformation.***
- An integral role in connecting youth with resources, developing their competencies and enhancing their capacities, all of which help the youth transition out of congregate care (i.e. residential care, detention, group home, foster care, etc.)
- Identifying more than just the recent behaviors, creating a greater picture of their past, potential, and strength-based needs.
  - **Identifying not what is wrong with the child, but what has happened to them**

Let’s make sure we are on the same page…

- ***Traumatization occurs when both internal and external resources are inadequate to cope with external threat.*** (Van der Kolk, 1989)

- Trauma disrupts attachment (and everything else)

- The more threatened we become, the more regressed our style of thinking and behaving become

Traumatized Children are:

- Two-and one-half times more likely to fail a grade in school
  - Score lower on standardized achievement tests and have more struggles in receptive and expressive language
  - More frequently designated to special education (Kessler et al., 1995)
- Suspended and expelled more often (also more truant)
- Engage more frequently in high-risk and delinquent behaviors
- Greater court/legal involvement and required supervision
- More likely to be diagnosed with co-occurring mental health disorders

What Does The Research Tells Us?

- One out of three adolescents have been physically or sexually assaulted by the age of sixteen (Boney-McCoy & Finkelhor, 1995).
- Child and youth trauma survivors at increased risk for substance abuse, criminal activity, homelessness, and re-victimization (Boney- McCoy, et al., 1996; Krahe, 2000; Flannery et al., 2001; Anderson, et al., 2003).
- Childhood trauma exposure consistently associated with a wide range of serious mental health, health risk & physical health disorders in adults (Felitti, et al., 1998;Schwartz & Perry, 1994; Dube, et al., 2003, Chapman, et al. 2004).

What are you case managing?

Limitations of Traditional Case Management

- Aligned developmentally, more with adults who often have invested interest in receiving these services (i.e. employment training, housing connection, parenting education, etc.).
  - What about the 17 year old who acts like a 10 year old?
- Assumptions the client is capable of and/or want to follow through on the goals they develop and the solutions offered by their case managers.
- Belief that the client will not be retraumatized by your interventions.
- Rigid expectations and non-compliance consequences.
- Only applies to specific aspects of needs, not all encompassing.

Trauma-Informed Case Management

- Holistic approach to delivering case management services and awareness of impacts of reports and recommendations.
- Connects theory to practice for case managers, infusing principles of trauma-informed care, attachment theory, youth development and social justice into case management practice.
- The intention is that the trauma-informed case management can be used as part of the larger response in addressing youth from an individual, community, societal, and policy perspective.
- Interventions are based on trauma-informed and responsive principles including awareness of past, present, and future trauma

What are your limitations?

- Challenging and repetitive behaviors (trauma responses)
- Limited community resources
- Lack of awareness of services
- Denial of applications/referrals
- Time limitations
  - Upcoming court date, aging out of care, service availability
- Clients not being clinically appropriate for desired services
- Resistance/Sabotaging

What are agencies looking for?

- Clear clinical rationale for treatment (medical necessity)
- Programmatic alignment (what role will they have in the milieu)
- Therapeutic amenability (how successful can their program be)
- Level of community support (family, natural supports, case management)
- Realistic and tangible discharge goals (where can they transition)
- What barriers are there for success (why hasn’t interventions been successful previously)

What are agencies avoiding?

- Significant aggression/opposition (recent acts and significant instances of harm)
- Developmental/Cognitive Concerns (autism, intellectual disability, etc.)
- “Dumped” Children
- Pervasive behaviors/conditions that are not treated at the agency (sexual acting out, personality disorders, pregnancy, medical concerns)
- Extensive history of failed placements at same level of care

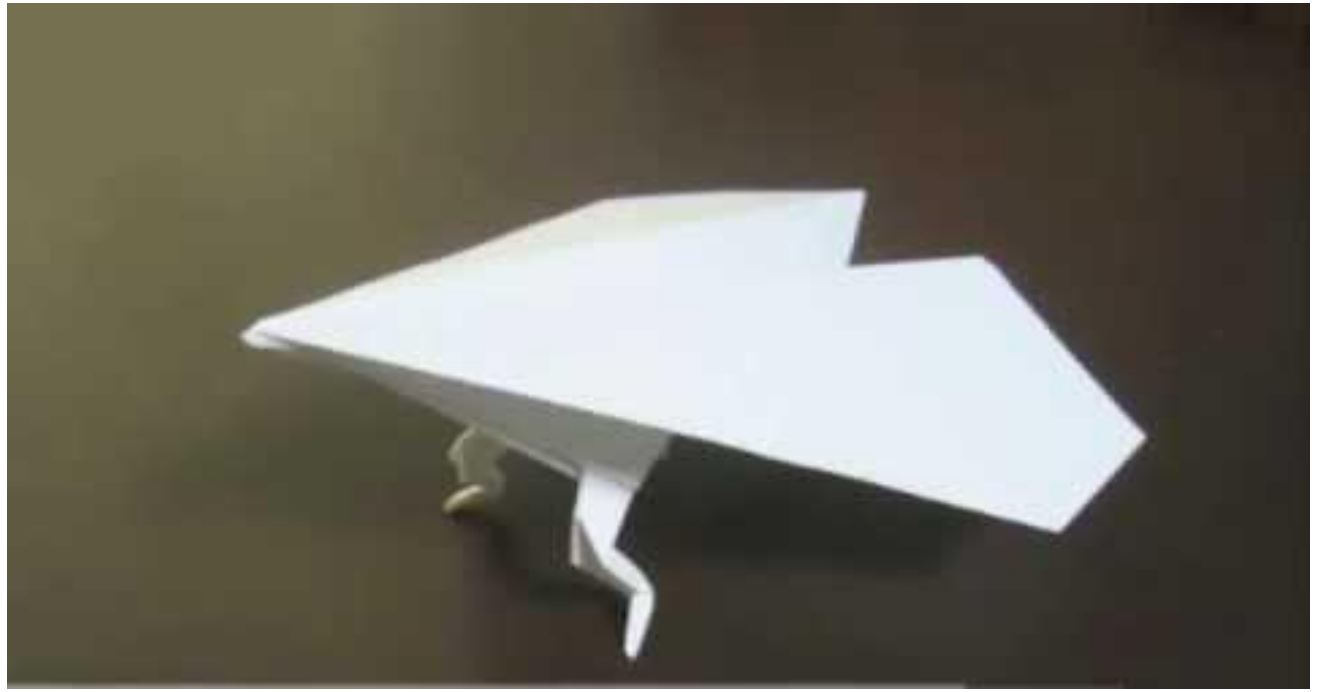
What are your clients doing to impact acceptance?

- Self-sabotage (both conscious and subconscious)
- Resistance to treatment
- Minimization of behaviors
- Highly reactive/oppositional tendencies
- Refusal to engage or comply
- Long history of placement disruptions
- History and exposure to trauma
- Legal involvement

What are you doing to impact placement?

- Lack of trauma-awareness
- Minimization of strengths
- Lack of connection between past experiences and current behaviors
- Use of legal terms or platonic descriptions of behaviors
- Focus on most recent behaviors at the start of reports instead of introduction of strengths or recent success
- Fear of “oversharing” information
- Impact of your own transference/burnout on hopefulness and investment in client

How does history impact placement?



REPORTS GROW LEGS!

What happens to a report?

- Becomes the natural and document history of a client
- It becomes the letter of the law not the flavor
- It can be used both against and for the child
- Creates a dated snapshot that is often misused and not time appropriate
- Impacts future placements and perceptions
- Becomes a living document that can follow your client, their family, and clinicians for years to come
- Not always accurate!

So what now? How do we find a solution?

- Create connections, link current behaviors to past experiences so that the referral source is immediately aware rather than hoping they see some link.
- Lead with a strength-based approach and the specific needs of the client
- Investigate old reports, confirm history, and update/assess when necessary (don’t go with convenient, go with accurate)
- Don’t take no for an answer, find out what limitations they are and what recommendations they have for other placement or for clarification of behaviors/needs

Basics of Trauma-Informed Case Narration and Referrals

- Trauma-informed (and responsive)
- Strength-based
- Evidence based and accurate (facts are checked)
- Personal and Narrative (create the story)
- Knowledge of services needed and awareness of appropriateness of referral
- Identification of mid-way steps/services that could lead to successful acceptance and placement
- Transitional goals/supports are clear or supports to make it happen

It is time to change the fundamental question…

“What’s wrong with you?”

- Implies that the cause of the problem is within the sufferer
- Implies weakness or defect
- Denies personal and social accountability
- Who wants to feel broken or unfixable?
- Most behaviors directly relate to past experiences and may not be a conscious choice

“What has happened to you?”

- Includes physical, psychological, social and moral forms of injury
- Implies rehabilitation process and removes stigma and shame
- Creates an understandable framework for change and an increase in self-awareness/change

How can we practice this?

Questions

- What details stand out to you?
- What follow-up questions do you have?
- What impact has trauma potentially played in their current situation?
- What services does this client need?
- What barriers do you foresee?
- How would you write an initial referral?

Johnny

- Johnny is a 15 year old male who has had multiple residential placements including two acute hospitalizations for suicidal ideation. Johnny is currently residing in detention following a recent episode that lead to charges for property destruction and assault. Johnny has a history of school issues, exposure to domestic violence, witnessed the overdose of his uncle, and enjoys playing basketball at his local Boys' Club.

Sarah

- Sarah is a 13 year old Hispanic female who was referred to the courts following a CHINS petition for truancy. Sarah was required to meet with a school Resource Officer, however she refused and then began to skip school and would often leave home for 3-5 days at a time without her mother knowing her whereabouts. Sarah lives in the home with her maternal aunt, grandmother, 3 cousins, and shares a room with her older sister. Sarah was found by local police after they suspected drug distribution and gang activity in a nearby neighborhood. Sarah was also found in bed with an 18 year old boy who ran from the scene.

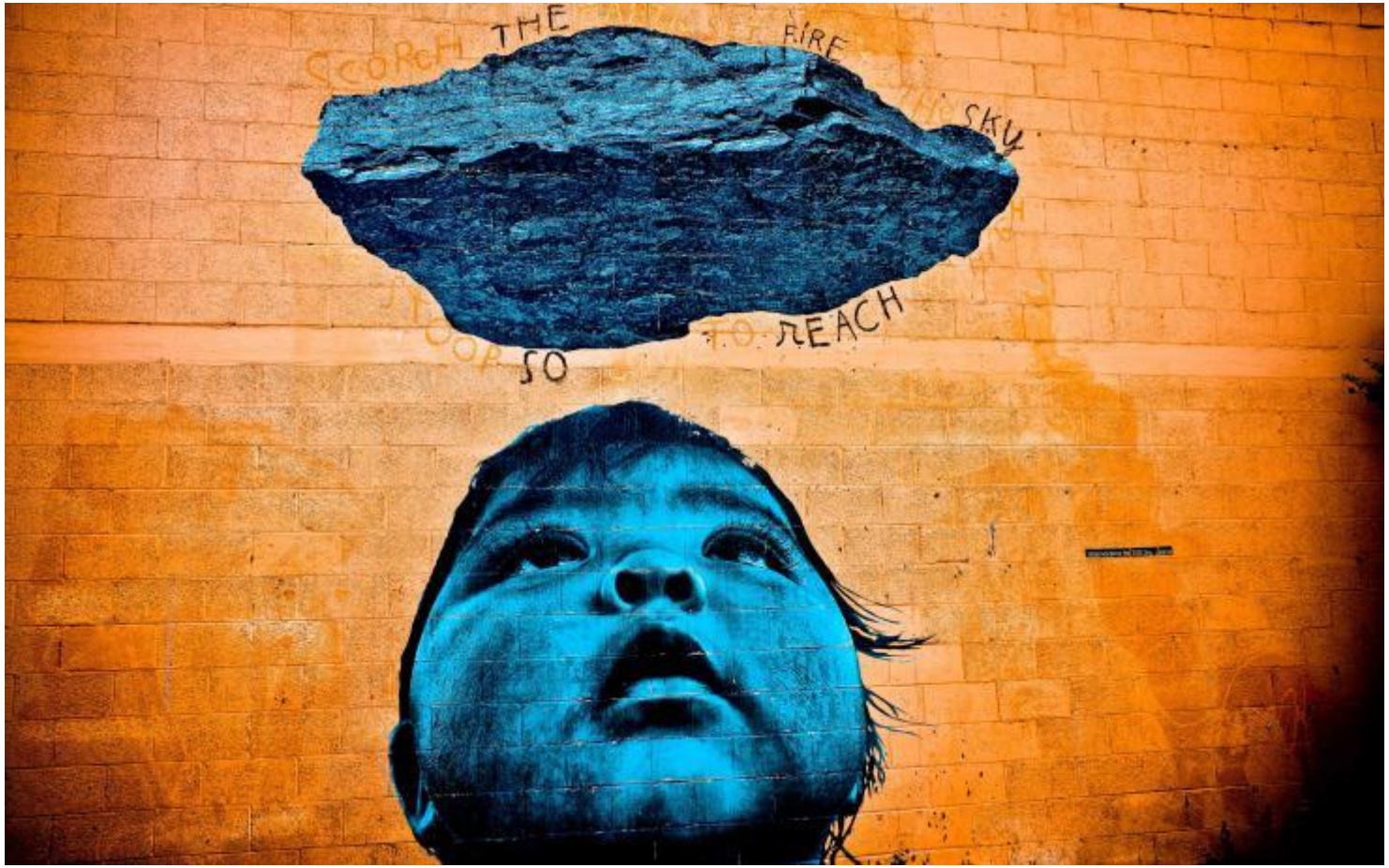
Joey

- Joey is a 15 year old male who is currently detained after he broke curfew and violated his probation. Joey was originally detained after he attempted to stab a neighbor. Prior to this incident Joey had returned home from school and learned that his mother had been assaulted. Joey was highly aggressive in detention and required close observation due to threats of self-harm. Joey was an honor roll student, enjoyed playing JV football for this high school, and loves to draw.

Emily

- Emily is a 16 year old female with a long history of acute hospitalization due to suicidal ideations, self-mutilation, depression, sexual promiscuity, and identify issues. Emily was sexually abused by her uncle from age 3-7 and was removed from her home after her parents failed to intervene. Emily has been in 5 foster homes, 3 group homes, and has been in 2 long-term residential settings. Currently, Emily is in an acute hospital after she was caught shop lifting and threatened to kill herself when police became involved.

So what now?



We Change The Question

“What’s Wrong With You?” ***to*** ***“What’s Happened To You?”***

We Create a Trauma-Sensitive Culture

Recognizing symptoms as survival skills and communicating needs in more informed ways.

We Give Them A Different Experience

We create the compassionate and trauma-informed environment they need and work to refer them to services that can do the same.

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