Southern Oregon
Early Learning Services

Agency Advisory Council
Meeting Agenda
March 10, 2017
10:00 am – 12:00 pm
Southern Oregon ESD
Downstairs Conference Room, Medford

10:00 - 10:10	Welcome and Introductions	René
10:10 - 10:20	Update on hub monitoring	René
10:20 – 10:40	Identify existing parent voice opportunities – group discussion	Chelsea
10:40 - 11:10	Trauma Informed Care: Review Standard III/Workforce Dev't	René
11:10 - 11:15	Request for program highlights for Appreciation Dinner	Teresa
11:15 - 11:40	System Mapping Opportunity	René
11:40 - 12:00	Program Announcements/Updates	All

SAVE-THE-DATE FOR OUR NEXT AGENCY ADVISORY COUNCIL MEETING:
April 14, 2017
AllCare
Community Meeting Room A
1701 NE 7th Street
Grants Pass

Southern Oregon Early Learning Services Hub
Agency Advisory Council

Date/Time: 2/10/17 10:00 am – 12:00 pm
Location: AllCare, Grants Pass

Members in Attendance: Jessica Allen (Advantage Dental), Cheré Brown (Josephine Community Library), Michelle Gallas (Imagine That..), Mary-Curtis Gramley (Family Nurturing Center), Patty Gutierrez (Listo), Rhonda Schock (Great Beginnings Child Care), Celia Siemer (DHS-SSP), Geoffrey Lowry (OCDC), Eileen Micke-Johnson (RCC), Cathleen Price (CCRN), Heidi Schultz (Douglas ESD EI/ELSE), Belle Shepherd (OHA), Felicity Elworth (Southern Oregon Head Start)

SOELS Staff Members Present: Rene Brandon, Teresa Slater, Sheila Fortman-Craun

Guests: Peter Buckley (Southern Oregon Success) via phone

CALL TO ORDER/WELCOME AND GREETINGS
10:15 am Rene Brandon called meeting to order. Introductions were made.

APPROVAL OF MINUTES

Agenda Updates/Changes

DATA ELEMENTS FROM DHS AND OHA: DISCUSSION FROM GROUP: WHAT DO WE WANT TO KNOW?
René met with Belle Shepherd (OHA) and Rosemary Jernigan (DHS-Self Sufficiency) regarding using data to make early learning investment decisions and build new partnerships. DHS & OHA can offer the largest amount of data as a starting point. AAC to brainstorm what is needed from data such as child level/parent data, what is the long term effect, how school districts are protective of data, can data be retrieved from the state, FNC, preschool promise, other entities. Below is the raw data brainstormed during the meeting. The list will be edited and formatted prior to sending to DHS OHA. Once the data is available, a data subcommittee will be convened to begin analysis and make recommendations for next steps.

Children through age 8	Parents who are pregnant and/or have children 0-8
Number of Children in Foster Care by age: 0-2 3-5 6-8	Number of families served by DHS Self Sufficiency who are pregnant or who children of these ages: Pregnant 0-2 3-5 6-8
Number of open Child Welfare cases by age:	Number of families served specific to foster care

0-2 3-5 6-8	
Number in Social Services (?)	Number from Family Court
Zip Code Breakdown	Number of homeless families
Children in Early Learning	Kinship care families
Where are children prior to starting Kindergarten	Teen pregnancies
*From school districts: what do they do with the information when kids go into foster care	Drug/Alcohol dependency
Healthy Start programs – babies in NICU & low birth weight	Drug/Alcohol treatment programs
Race/ethnicity	Mental Health Diagnosis
Drug impacted	Mental Health treatment plan
	Parent Education

Subgroups for data collection requests may include OnTrack, Homeless data, ARC, SO Head Start, OCDC, EHS, LISTO, WIC, Project Baby Check and Healthy Families, Housing Authority data, home visiting data, Hallie E. Ford Center for Healthy Children and Families at OSU collects data, school districts, and other to be determined.

Head Start is using University of Chicago Parent, Family and Community Engagement Study. https://www.nhsa.org/our-work/initiative/parent-family-and-community-engagement-study for data.

Additional comments about this work included:

A primary goal of the early learning system is to find families who are not currently connected to any system partner but who would benefit from services.

We want to identify partner programs that are successful with thriving caseloads and success rates with low recidivism. Identify elements that make these programs successful to help the system learn.

TRAUMA INFORMED PRACTICES DISCUSSION

The group reviewed and discussed Trauma Informed Oregon's Standards of Practice for Trauma Informed Care, Section II: Environment and Safety. There is demonstrated commitment to creating a welcoming environment and minimizing and/or responding to perceived challenges to safety [includes Physical Environment and aspects of Engagement and Involvement].

Elements reviewed included:

IIa. Physical Space (external environment, exits and entrances, waiting room, office, halls, lighting, restrooms, etc.) has been reviewed for actual and perceived safety concerns that may affect staff and individuals receiving services.

IIb. Physical environment has been reviewed for "welcoming" quality, e.g., cleanliness, odor, color, furniture (in good repair and arranged for comfort), access to water, etc.

IIc. Physical environment has been reviewed for cultural responsiveness.

IId. There is a designated "safe space" (permanent or temporary) for staff to practice self-care.

IIe. Physical safety and crisis protocols for staff and for individuals receiving services are in place and are regularly practiced.

IIf. Individuals who have received services from the agency have helped develop and/or have reviewed decisions about physical environment and/or safety protocols.
IIg. There is a process in place to hear and respond to safety concerns that arise.

DEBRIEF HUB TESTIMONY TO HOUSE EARLY CHILDHOOD & FAMILY SUPPORTS COMMITTEE ON 2/9/17

Six hubs were invited to share the good work happening around the Stat in early learning. Rene' was unable to attend in person but shared testimony electronically outlining how our AAC group is working together, as a community of practice, discussing how to move toward becoming trauma-informed organizations by accessing training, sharing resources, and discussing challenges and successes with implementation.

TRAINING OPPORTUNITIES

SOAEYC Together for Children is February 24 for professional track and February 25 for parent track. Parents need to pre-register. Professionals registering for the professional track can use KPI grant funding for professional development.

PAX Good Behavior Game – March 1-2, 2017

There is a waiting list. They have 27 participants from Eagle Point registered.

Strengthening Families Training Of Trainers – May 23-25, 2017

This is a Train the Trainer opportunity. Training is focused on building resiliency family resiliency by promoting protective factors. SOELS will be accepting applications from individuals interested in becoming a trainer to trainer other organziations. Please contact Chelsea Reinhart at SOELS for more information.

Kaleidoscope Facilitator Training – March 20-21, 2017

This is a Train the Trainer opportunity. This training teaches educators how to offer school-based parent-child play groups that engage elementary school teachers, early learning educators, and families. Please contact Teresa Slater at SOELS for more information.

CCRN Training calendar provided and all trainings are free. Purple handout shared at meeting.

PROGRAM UPDATES/ANNOUNCEMENTS

- Kindergarten launch week is February 27 – March 3. Flyers shared.
- Head Start is beginning recruitment. Felicity will send out information.
- Douglas ESD EI/ECSE is outgrowing their facility and are looking for creative outside the box ideas for a new building. They had 37 referrals in a week. They need office space and evaluation rooms. Rhonda Schock from Great Beginnings offered after hours space in Rogue River.
- Southern Oregon Success will host a workshop on Trauma Informed Practices on April 11. A flyer will be available soon.
- SOELS Coming Together for Children dinner on April 26 which will showcase hub funded programs and celebrate the great work happening in Southern Oregon.

Meeting adjourned at 12:04 pm
Submitted by S. Fortman-Craun

III. Workforce Development. Human Resource policies and practices reflect a commitment to trauma informed care for staff and the population served [includes **Training and Workforce Development***].

1= we haven't started yet **2= we've done a little** **3= we've done quite a bit** **4= we're stellar!**

Training **IIIa.** Employees have received core training in Trauma Informed Care. Check the content that staff has had: A= all staff; M = management/admin; DS= direct service staff. o The Adverse Childhood Experiences study ___ o The prevalence and impact of trauma on individuals in our agency ___ o The neurobiology of trauma___ o Issues of power and oppression related to the experience of trauma____ o Historical oppression; intergenerational trauma ___ o Principles and implementation of Trauma Informed Care___ o The role and benefits of peer support services___ o Trauma in the workforce; secondary trauma___ *If you provide (or make available) more in-depth training, please describe.* *Other trauma-related training regularly offered/required (including on trauma specific services)?*	1 2 3 4
IIIb. Core training is offered at least annually. *Which modules? How frequently? How many staff attend? How is annual training delivered, by whom?*	1 2 3 4
IIIc. Training is provided on supporting, managing, and responding to reactivity (e.g., de-escalation training). *Describe. How often is this training offered and to whom? How many staff have participated?*	1 2 3 4
IIId. Organization is building internal capacity to ensure that ongoing training and education for staff on trauma informed care is available. *How? What is the current status?*	1 2 3 4
IIIe. Alternative opportunities for staff to learn about TIC (e.g., webinars or videos, community events) are offered regularly. *Examples? How many staff have utilized?*	1 2 3 4

*Substance Abuse and Mental Health Services Administration, *SAHMSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* HHS Publication NO. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014

Hiring and Onboarding Practices **IIIf.** Screening and interviewing protocols include applicant's understanding and prior experience/training regarding the prevalence and impact of trauma and the nature of trauma informed care. *What questions are asked during the interview process? How do you gauge an applicant's ability to respond in a trauma-sensitive way to the individuals you serve (some organizations are hiring for 'warmth and emotional intelligence')?*	1 2 3 4
IIIg. Individuals with lived experience of our service system participate in the hiring process. *How? How is their feedback utilized?*	1 2 3 4
IIIh. New employee orientation and training includes the core principles of trauma informed care and affirms the agency's commitment to ongoing trauma awareness and education for staff. *Describe.*	1 2 3 4
Supervision and Support **IIIi.** Staff receives regularly scheduled supervision. *Which staff? How often does this process happen?*	1 2 3 4
IIIj. Peer Support personnel, whether contracted or on staff, also receive regular support and guidance. *What is the process?*	1 2 3 4
IIIk. Supervision includes discussion of staff care and wellness. *Describe or provide example.*	1 2 3 4
IIIl. Supervision includes learning and application of knowledge about Trauma and TIC. *Example of how this happens?*	1 2 3 4
IIIm. Supervisors have had training/consultation on supervising for TIC. *When and how does this occur?*	1 2 3 4
IIIn. Performance reviews expect increased awareness, understanding and practice skills related to trauma informed care. *Describe.*	1 2 3 4
IIIo. Supervisors and staff can explain personnel policies; disciplinary actions reflect principles of transparency, predictability, and inclusiveness insofar as possible, given legal or contractual considerations. *Examples of how this is ensured?*	1 2 3 4

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Southern Oregon Early Learning Hub

A Trauma Informed Workforce:

An introduction to workforce wellness

Purpose. This document provides foundational information about workforce wellness. It is intended for those who are beginning to consider ways to address workforce wellness in their programs and organization by providing background and definitions.

Background. Working with survivors of trauma can be extremely rewarding, but can also be challenging. Without direct attention to the needs of care providers, providing services to trauma survivors can increase the risk for burnout, vicarious trauma, and secondary traumatic stress. External factors and stressors, as well as workers' personal trauma histories can add to the risk.

Whether or not someone has a history of trauma, bearing witness to human suffering and adversity can be deeply impactful. Reactivity related to unresolved trauma among workers and those they serve can make working conditions more difficult and can undermine health and safety. Providing effective and sensitive care to survivors (trauma-informed care), requires an emotionally healthy, competent, and well supported workforce.

Definitions. The terms burnout, secondary traumatic stress, vicarious trauma, and compassion stress or fatigue are often used interchangeably. There are, however, important distinctions to consider when developing resources. It is important when addressing workforce wellness that organizations identify what resources and strategies the organization will provide. Workforce wellness strategies need to not only address the importance of self-care but identify how the organization will work to reduce stress, address vicarious trauma, and support self-care activities. For example, for an employee who is experiencing secondary traumatic stress, the organization would make trauma specific services available (e.g. counseling, EMDR). In addition to providing access to services organizations will likely need to accommodate employees' schedules.

Burnout: The term "burnout" has been applied across helping professions and refers to the cumulative psychological strain of working with many different stressors. It often manifests as a gradual wearing down over time.

Vicarious Trauma: Vicarious traumatization is the cumulative effect of working with survivors of trauma and includes cognitive changes resulting from empathic engagement and a change to your worldview.

Secondary Traumatic Stress: The term "Secondary Traumatic Stress" is used to describe professional workers' subclinical or clinical signs and symptoms of PTSD that mirror those experienced by trauma clients, friends, or family members. While it is not recognized by current psychiatric standards as a clinical disorder, many clinicians note that those who witness traumatic stress in others may develop symptoms similar to or associated with PTSD.

Compassion Stress: Compassion stress characterizes the stress of helping or wanting to help a trauma survivor. Compassion stress is seen as a *natural outcome* of knowing about trauma experienced by a client, friend, or family member, rather than a pathological process.

Protective Factors. There are personal and organization strategies that mitigate the impact of working with survivors of trauma and adversity. Below are a few to consider:

- **Team spirit**. Feeling part of a team (per program, department, entire agency) and having social support on the job can buffer workplace stress.
- **Seeing change as a result of your work**. Having tangible evidence that their work is important and helpful.
- **Training.** Feeling competent to apply a trauma informed approach, as a result of effective training and education.
- **Supervision.** Receiving regular and predictable supervision as a way to prevent, monitor, and respond to stress.
- **Balanced caseload.** Having a diversified caseload based on the topics, intensity, length of service and balance between challenging and successful cases.
- **Stress Inoculation Training**. Practicing response to stressful situations in order to have the skills needed to regulate a stress response.

Ideas for Workforce Wellness

- Space for self care
- Staff shout outs or thank you cards
- Wellness plans
- Supervision
- Employee Assistance Programs (EAP)
- Workplace wellness rituals (Friday walks, Thursday lunches).

Risk Factors. The following factors are related to workforce stress and vicarious trauma.

- **Personal trauma history**. An employee's past history with adversity can mitigate or create challenges to doing this work. Employees who are aware of their history and have developed helpful coping skills are able to easily relate and support survivors.
- **Type of story.** The type of trauma stories an employee is hearing in their work can make a difference in the impact on the employee.
- **Length of employment.** Employees who are new in the field or new to hearing stories about trauma and adversity without warning or coping strategies are at greater risk for work related stress.
- **Always being empathetic**. Employees who feel like they have to always be empathetic or "always on" because at home they care for elders, children, or other family members or have more than one human service related job.
- **Isolation.** Isolation can be experienced because of the location of the worksite, because you are the only staff doing a particular job (e.g. only psychologist, peer support), or because you are not able to share details about your work with friends and family.

The content in this TIP has been adapted from the following sources:

1. Adams, R.E., Boscarino, J.A., Figley, C.R. (2006). Compassion fatique and psychological distress among social workers: A validation study. American Journal of Orthospsychiatry, 76(1).
2. Berzoff, J., & Kita, E. (2010). Compassion Fatigue and Countertransference: Two Different Concepts. *Clinical Social Work, 38.*
3. Cunningham, M. (2003). Impact of trauma work on social work clinicians: Empirical findings. *Social Work*, 48(4).
4. Cunningham, M. (2004). Teaching social workers about trauma: Reducing the risks of vicarious traumatization in the classroom. *Journal of Social Education, 40*(2).
5. Richardson, J.W. (2001). Guidebook on Vicarious Trauma: Recommended Solutions for Anti-Violence Workers. *National Clearinghouse on Family Violence*

Trauma Informed Oregon is funded through Oregon Health Authority, and is a partnership between Portland State University, Oregon Health Sciences University and Oregon Pediatric Society.

In writing these TIPs, Trauma Informed Oregon will strive for easy to read text, avoiding technical language and spelling out acronyms as needed. For TIPs that include information from other sources this may not always be possible.

WHAT YOU NEED TO KNOW: These questions were developed to review a specific policy about service exclusion through a trauma informed lens. Some of these questions may be helpful as you are developing or reviewing policies. (TIO, 2013)

Guide to Reviewing Existing Policies

Safety:

Does this policy put service recipients' safety at risk?

If so how? What precautions are in place to prevent, mitigate, or respond?

Does this policy put staff's safety at risk?

If so how? What precautions are in place to prevent, mitigate, or respond?

Is the policy clear and understandable to those who implement this policy?

Are all impacted parties trained on this policy?

Who, how, when, frequency?

Are service users informed of this policy?

Who, how, when, frequency?

Are partner agencies informed of this policy?

Who, how, when, frequency?

Is this policy carried out consistently across programs, staff, and agencies?

When it is not consistent is there an explanation given (consistent but flexible)?

Does this policy ask staff to work outside of their job or skill level? What support do they have?

Does this policy result in confidences being broken?

Can staff from one program explain another program's decision or have a way to find this out?

Are policy decisions communicated in a timely manner within the agency?

Restore Power:

Are policy decisions made in collaboration with other staff?

Do staff know what they can decide without approval?

Are staff trained in de-escalation so as to avoid unnecessary power struggles?

Are policies and procedures easily accessible (e.g. location, language)?

Are skills necessary to implement the policy provided and practiced (simulations)?

Is it clear how and why this policy was developed (transparency)?

Value Individuals:

Have staff been consulted about the policy?

Have service recipients been consulted about the policy?

Are mental health advanced directives in place where necessary?

Have service recipients been asked what is helpful and not asked about the implementation of this policy?

Are staff debriefed after events (exclusions, suicidal calls, police calls, aggressive behavior)?

How, when, by whom?

Have staff been asked what is helpful and not asked about implementing this policy?

Do all parties have a voice in decisions? How? If not, why not or when?

Mandy Davis, LCSW
Portland State University

Hosting a Meeting Using Principles of Trauma Informed Care

Preparing for the Meeting

- Have water and healthy snacks available- try to limit processed sugar
- Have fidget toys
  - Helps with focus
  - Have a few options- too many though can be a distraction
  - Basket on the table or few piles- Accessible to all
  - Options: Rubber bands, crayons and paper, stress balls, play dough, pipe cleaners
- Room Environment
  - Be mindful of space- too big or small?
  - Ensure there is access to the door
  - Seating- not too close
  - Temperature
  - Outside distractions
  - When variables can't be controlled- debrief the group on what things may come up

Starting the Meeting

- Description of expectations and reminders about caring for yourself
  - Length of meeting
  - Moving around to be comfortable- standing, walking, stretching
  - Directions to restrooms
  - Break times, however can leave when needed
- Right brain activity
  - Icebreaker or sharing
  - People can connect before moving into content
  - Remind people that they can "pass"
  - Model the game to set clear expectations
  - Activities should not include touching or revealing personal trauma information

During the Meeting

- Think about materials
  - Many formats as possible: paper, screen, etc.
  - Provide in advance
- Language
  - Explain acronyms
  - Have a list of frequently used acronyms on the wall
  - Reflect on the choice of words that you use
- Take breaks
  - Have scheduled breaks

IV. Services and Service Delivery. Service delivery reflects a commitment to trauma informed practice [includes activities related to **Screening, Assessment, Treatment Services,** aspects of **Engagement and Involvement,** and **Cross-Sector Collaboration** *].

1= we haven't started yet **2= we've done a little** **3= we've done quite a bit** **4= we're stellar!**

IVa. The first point of contact is as welcoming and engaging as possible for individuals seeking support or services. This includes reducing distress related to referral, self-referral, intake, etc. *Describe or provide examples of how this is achieved.*	1 2 3 4
IVb. Intake and all direct service staff are able to talk with individuals seeking services about the prevalence and impact of trauma and how it can affect engagement and involvement. *How is this information delivered in a trauma informed way? Do you have a script or coaching for staff?*	1 2 3 4
IVc. Direct service staff understand the heightened risk of suicide for trauma survivors and are able to respond appropriately and get appropriate help. *What is the protocol? What ensures that staff are able to implement?*	1 2 3 4
IVd. Intake forms and processes have been reviewed and modified to reduce unnecessary detail that might be triggering to individuals who are seeking or entering services. *What has been modified to improve the intake process for the consumer?*	1 2 3 4
IVe. Agency has written easy-to-read documentation for staff and service recipients that explain core services, key rules and policies, and process for concerns/complaints. *Describe or provide documentation. How it is available in the agency?* *Note if service recipients have reviewed.*	1 2 3 4
IVf. Policies related to treatment services (cancellations, no-shows, other rules) have been reviewed and modified as needed to reflect an understanding of trauma and its impact. *What was the review process used? What has happened as a result of these changes?*	1 2 3 4

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IVg. Individuals receiving services have the opportunity to provide input/feedback and/or to grieve policies that affect them. *What is the process or structure for this to happen?* *How is the process trauma informed?*	1 2 3 4
IVh. In organizations providing direct service, the importance of the primary relationship is recognized and supported through policy and practice. *How do you work towards continuity of care?*	1 2 3 4
IVi. In organizations providing direct service, trauma specific services are offered, preferably reflecting promising or best practices. *What services are offered?*	1 2 3 4
IVj. In organizations not providing direct services, staff has up-to-date information about trauma specific services available for referrals. *How do you ensure this information is available and used?*	1 2 3 4
IVk. Peer support is available and routinely offered to individuals receiving services. *If yes, what services are offered? What is the role of peers in the organization (paid staff, volunteer)?*	1 2 3 4
IVl. Individuals receiving services are not terminated without notice and direct contact (unless precluded by circumstances). *How do you ensure this? What's the protocol?*	1 2 3 4
Cross-Sector Collaboration **IVm.** Agency is working with community partners and/or other systems to develop common trauma informed protocols and procedures. *Describe efforts and progress in this area, including any shared or cross-training that occurs.*	1 2 3 4

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