When a Culture of Trauma-Informed Care Breaks Down

This document addresses the situation in which a program has become demoralized and overwhelmed, and is just trying to make it through the day or night. Signs that this has happened include: programs relying excessively on the use of force, restraint, or intervention teams; structure and programming losing their mooring; staff are in survival mode, moving from one crisis to another.

When this happens, staff are often responding to their fear of what could happen if the situation got worse, rather than what is happening at the moment. When clients are not feeling safe, the disruption of safety shows up in their behavior. For both the staff and the kids there is a sense of imminent catastrophe.

Contributing Factors

There are many factors that can contribute to the development of a crisis mentality in a program. The process is cyclic and can start with any combination of these factors:

- Influx of a new population
- A new type of client for the agency, without enough need-specific training
- Significant staff turnover – in child care staff, therapists and/or leadership
- Not enough training for new staff
- Understaffing and resultant over-working of current staff
- A change in available resources
- Implementation of a new treatment approach
- Lack of integration of therapists into the treatment program
- Changes in regulations governing care, such as limits on the use of restraint and seclusion
- Serious incidents of staff assaults

Signs that Trauma-Informed Culture is Breaking Down

- Staff injuries increase
- Child injuries increase
- Lack of structure, few activities planned or carried out
- Inconsistent application of limits
- Increasing numbers of power struggles leading to restraints
- Over-reliance on control.

- Overuse of calls for assistance, relying on a paging system the clients can hear
- Living areas look unkempt, damage is not repaired, areas are not clean
- Treatment plans are not communicated or followed through on
- Staff do not feel they are part of the treatment. They do not see the connection between their work and the child's goals
- Therapists are staying in their offices and not interacting with child care workers or hanging out in program spaces
- High turnover
- Supervision does not take place
- Individual therapy does not reliably take place, as therapists are handling emergencies
- Routines are not followed
- Use of sick leave increases
- People speak of the clients in hopeless, blaming terms
- Splits occur and deepen between parts of the team, and staff sometimes blame each other or leadership for the problems that are occurring. There is a sense of "us vs. them"
- Staff reduce interactions with clients, stay in their offices more, or start texting their friends during worktime
- People are not sure how to intervene when problems begin (because they know they are trying not to use restraints or rely heavily on consequences), so they do nothing and feel helpless as they watch a client become more and more escalated

How Can the Program Regain Its Trauma-Informed Focus?

When an agency becomes aware that one (or more than one) of its programs has deteriorated towards a crisis mentality, there are roles for each group of people that the program may want to start immediately. Follow-through mechanisms should be established to track implementation. Data about restraints, staff and child injuries, hospitalizations, arrests, and negative discharges can provide reliable information to evaluate the impact of interventions.

Senior Leadership

- Begin the conversation – build a frame for is going on and the reasons for it
- Convey hope in the possibility of turning things around
- Establish contact with every staff member who is hurt
- Speak warmly and hopefully of the youth
- Recognize staff achievement
- Remind staff about their reason for doing this work, the mission, the positive impact they have on the youth

- Make resources available for change effort
- Articulate policy if there is confusion. Set program expectations, such as what is meant by a term like “imminent danger”, when restraint can and cannot be used, or at what point a call to the police is merited
- Acknowledge and reinforce team members’ efforts when progress happens, e.g. compliment a staff person’s stamina in sticking with a youth experiencing difficulties

Mid-level Leadership

- Lead change effort
- Establish clear expectations and methods to measure them, and regular review periods to evaluate progress, including who will be responsible. Be careful not to let sympathy for the difficult time staff is experiencing result in a relaxation of the expectations. If there are reasons an expectation was not met, engage in troubleshooting how this will be overcome the next time a similar situation occurs. If the administration just accepts the reasons and communicates, “Oh well, I guess there is nothing we can do,” they are replicating the paralysis felt by staff – and thus increasing it.
- The following table (next page) illustrates some areas in which expectations can be clear and monitoring mechanisms established. This is not an exhaustive list; it is just meant to illustrate the kind of clarity that is important.

Child Care Staff Expectations	Person Responsible for Implementation	Monitoring Mechanism
There will be two planned activities per weekday and three per weekend/vacation day.	Unit Supervisor	Schedules passed in, comments written on each activity, spot checks
Each child care staff member will have a chore towards the cleanliness of the unit and will complete it on each shift they work.	Unit Supervisor	Chore list passed in, spot checks
Each child care worker will be assigned three youth as their special responsibility. They will spend at least ½ hr. individual time with each of these youth per week.	Unit Supervisor	Progress notes
Therapist Expectations	**Person Responsible for Implementation**	**Monitoring Mechanism**
Therapists will attend staff meeting weekly	Clinical supervisor	Meeting attendance sign in
Therapists will make sure that the child care staff understand the children's goals and how that is translated into what the child care worker does	Clinical supervisor	Therapist and staff report
When a child is in crisis, therapist will connect with child and staff within 4 hours or will designate someone to do so	Clinical supervisor	Observation, progress notes

Further interventions for mid-level leadership:

- Add resources in a targeted way. For example, have a cleaning service do a thorough cleaning of a unit as soon as the staff and kids have created a cleaning schedule to maintain the cleanliness.
- Articulate and model the expected method of interacting with the kids – be involved, caring, flexible, and respectful.
- Clinical management can be clear with therapists – from the hiring onwards – that they are expected to be part of the team, not only doing outpatient therapy in their office. Teach and give examples of how to translate treatment goals into unit activities for staff.
- Clinical management can guide and model for therapists how to lead the team in clinical thinking. The therapists and clinical management establish clinical thinking by responding to every attempt to discuss a problem behavior by asking: How do we understand this behavior? When we understand the adaptive nature of the behavior, we can respond by helping the child to learn to meet these same needs in a more positive way. The clinicians also make sure to share the formulation/information with the team, to establish a treatment theme, to connect problem behaviors to past history, and to suggest restorative responses based on the team's understanding of the skills a child needs to learn.

The Child Care Workers and the Therapists

It is counter-intuitive, but it is essential that when a unit is in crisis, the staff must move towards the youth – not away from them. The natural human response to harmful behavior is to move away. This can manifest by emotional distance, by increased strictness, by lack of activities, by staff spending more time in their offices, or simply communicated through frowns and disapproving looks. By their behavior, the youth are telling the adults that they do not feel safe or connected. We have to make plans to increase their connection to adults. **How do we do this?**

- Schedule time for staff to spend with 1-3 clients doing a pleasurable activity.
- Organize team-building activities, using consultation from recreational therapists, if available.
- Have as many fun activities as possible.
- Use music, dance, singing, jump rope rhymes, hand games to knit the community together.
- Develop a cottage song, a mascot, a logo, or a saying.
- Celebrate anything good that happens, even if it's small.
- Have a box in which anyone can put a note about a good thing they saw a kid or a staff do, read it out at community meetings. Give awards, but not competitive ones, ones that anyone who meets some criteria can receive.
- Have community meetings. Have all participate. Talk about what is happening, what kind of place we want to live, what we can do about it.

- Decrease room time. Spend as much time together, doing activities.
- Do the kids' hair. Have a spa night. Feed them. Any activity designed to communicate the care staff have for them can increase their feelings of safety.
- Clean and decorate the unit. Involve the kids.
- Fix any damage. Involve the kids.
- In treatment team, talk about the kids that are the hardest to connect with. Review their history. Ask yourselves: Why did they have to learn to put up such walls? Encourage compassion. Discuss their strengths and interests. Can staff find a way to participate in these interests with them?
- Create "Moments of Hope" notebooks about the kids who are struggling and ask staff to write down any good things that happen with that child.
- Congratulate each other on the team's stamina in sticking with kids that are struggling.
- Make specific plans to support that stamina, like trading off who reaches out to the kids for whom anger is the default emotion.
- Remind each other about other kids you have known who seemed to reject all efforts and later came around.
- In treatment team, develop restorative ideas for each kid that are significant, require thought, and are related to their treatment.
- Teach specific feelings management skills.
- Model feelings management skills yourself and label out loud that you are doing so.
- Validate the feelings behind the behavior.
- Express an understanding that this is the best the kid knows at the time – and the hope and confidence that change is possible.
- Tell them, and show them – over and over again – all the good things you see in them and how delighted you are by everything positive (and even neutral) that happens.

Summary

Even this partial list of interventions seems like a daunting task. *It is.* What is more daunting, though, is not doing it and remaining in paralysis. A specific plan with clear responsibilities and methods of measurement will begin to create change. As people notice change, there will be an increase in hope. Hope brings the energy to make more changes. And fairly soon, people will be feeling pride in their workplace again, and the kids will be gradually getting better…slowly. There will be backslides, but they will be demonstrating that they feel more connected and relaxed. Then, finally, more effective treatment can happen.

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Signs that Trauma-Informed Care is Eroding

- Groundings are more frequent and longer
- Restorative tasks begin to look like punishments
- People start talking about clients “getting away with” things
- Behaviors are described as deliberate and attempts to get at staff
- Team members are not trying to understand behavior or figure out how it is adaptive for the client. Instead they focus on how to change it.
- Divisions start between team members, there is more blaming of each other
- Team members start asking for more rules to govern their interactions
- Staff stay in offices and interact less with clients
- The words “consistency” and “structure” are used more than usual
- Activities begin to have to be earned, and clients are not allowed to attend fun events or arts or recreation activities due to recent problem behaviors
- Clients are described in pejorative terms such as “manipulative” and “borderline”
- People say things like "she wants to be that way"
- Loss of hope; hearing more cynical statements
- Less laughter and fun
- People are talking about returning to points and levels or adding more severe consequences

What to look for as contributing factors:

- Client turnover
- Staff vacancies and over-work of remaining staff
- A new type of client, or a mismatch between new type of client and available supports/capacities to manage that change
- Administration being less available
- Any particular staff having severe problems/illness
- Personal issues and losses
- New reporting or oversight demands
- Difficult incidents and/or difficult discharges