

**A Publication of the National
Alliance for Direct Support Professionals**

Frontline Initiative

Volume 13 • Number 1 • 2016

**Trauma-Informed Care
Frontline Initiative**

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An introduction to Trauma-Informed Care

By Karyn Harvey

“Trauma” is a broad term for an event or series of events that make a person feel threatened. These events can range from less serious to quite severe. Either way, trauma can lead to a lifetime of fear and anxiety. For example, a child may feel threatened by a snarling dog. For decades after, he or she may have a negative reaction when placed in a similar situation. Generally, more traumatic events lead to more persistent fears and anxieties.

Many people with intellectual and developmental disabilities are considered “vulnerable”. That is, susceptible to injury—physical, emotional or financial—from another person. Many people with disabilities have been teased or bullied at some time in their lives. They are called the “R” word or much worse. They have been made to feel left out, ignored, or marginalized. We know that they are more likely than the general public to be physically or sexually abused. We also know that charging offenders is very difficult.

Continued on page 2



Recent research suggests that the effects of trauma are more widespread and damaging than previously thought. In a study of over 7,000 people with disabilities, over 70% reported they had suffered physically, sexually or financially. For many, the abuse was ongoing (for more information, go to <http://disability-abuse.com/>).

DSPs who understand trauma-informed care know how trauma can have profound effects on a person. Effects range from environmental sensitivities (loud noises, bright lights) to behaviors like distrust of others, despair, and powerlessness. To move past trauma, individuals need an ongoing sense of safety, connection to others they can trust, and a sense of empowerment. DSPs who provide quality support are perceived by the person as kind and safe. They have the persons' best interests at heart. They also help strengthen the person's connections to others.

DSPs can work to understand how trauma impacts the person's life and behavior. Then, they can work to create soothing, calm environments. They can convey respect, understanding, and provide ongoing opportunities for communication among people being supported and others in their lives.

Because of this, anxiety and fear can be reduced. DSPs can help the person feel a sense of control or power over their own lives. This can be as simple as having a real choice in their life. This is a very liberating feeling!

With these ingredients and staff that provide a sense of safety, connection and empowerment, people with disabilities who have experienced trauma have been able to heal. They have been able

Trauma-Informed Care vs. Traditional approaches to care

Trauma-Informed

- Symptoms or problem behaviors help the person deal with traumatic memories
- The person's choice, autonomy and control are central to healing
- The person defines primary goals for recovery, self-efficacy, and healing
- **Proactive** — focus on preventing further crisis and avoiding retraumatization

Traditional approaches

- Symptoms or problems are handled separately, without reference to previous experiences
- People providing services are considered experts
- Service provider defines primary goals, which focus on symptom reduction
- **Reactive** — services and symptoms are crisis driven, focusing on minimizing liability

Modified from <http://media-cache-ec0.pinimg.com/236x/60/69/a2/6069a2fa75439c0463b87d314ef98ae7.jpg>

to live meaningful and rewarding lives. This often comes down to the quality of support the DSP provides while working with the person. As a DSP, you are a key contributor to the person's quality of life.

Karyn Harvey, Ph.D., is the Assistant Executive Director (Quality Supports) at The ARC Baltimore, MD and the author of Trauma-Informed Behavioral Interventions: What Works and What Doesn't (available through the AAIDD Bookstore: <http://aaid.org/publications/bookstore-home/practice/page/2/#.VQHEZPnF98E>)

Symptoms of PTSD

When severe trauma occurs, it can cause post-traumatic stress disorder (PTSD). PTSD has three main symptoms: re-experiencing (or remembering), avoidance, and hyper-arousal.

Symptoms of re-experiencing can include continually talking about bad things that happened. This makes it difficult for the person to focus on the present. Re-experiencing may include repeated nightmares or flashbacks—vividly re-experiencing a traumatic event in the present, even though it happened long ago.

Avoidance can include what is known as "hyper-vigilance." The person may place too much attention on details of safety and day-to-day existence. They may repeatedly check on who is working or what is happening in their home or work environment. They may repeatedly perform such "safety rituals."

Finally, hyper-arousal can manifest as distress, property destruction, an impulse to fight, or actually fighting with others with very little reason. This can look like someone has a "chip on their shoulder" or some kind of ongoing issue to settle. However it is actually often based on the experience of past trauma. Strong startle responses and an inability to relax or settle down are also often common.

Frontline notes

Many people with intellectual or developmental disabilities have experienced trauma in their lives. Often they receive little or no treatment for the effects of this trauma. Traumatic experiences can lead to mental health problems and difficult behavior. However trauma is often not recognized as a source of a person's behavior. Therefore, little is done to get to the root of the depression, anxiety, paranoia, or aggression.

It is also widely accepted that most people who have lived in institutions experienced some form of trauma. As people moved from institutions, there was little understanding of how this would impact their transition and their future. Often service providers are unprepared to address the effects of trauma on the people they support.

Research shows how trauma-informed care can be a helpful approach to supporting someone

who has experienced trauma. Because of this, it is critical that direct support professionals (DSPs) have an understanding of trauma and its effects. DSPs need to know how to support individuals who have experienced trauma. This can include making connections with local resources, using positive support strategies, and seeking assistance when needed.

We encourage DSPs to spend time learning from the research and resources in this issue of Frontline Initiative. We encourage DSPs to become more comfortable with trauma-informed care through training and education. More can be done to support people who have had trauma in their lives. We hope that this issue of Frontline Initiative will move the discussion forward and improve the practice of DSPs.

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Frontline Initiative is supported through a cooperative agreement between the National Institute on Disability and Rehabilitation Research, U.S. Department of Education (#H133B080005) and the Research and Training Center on Community Living (RTC) at the Institute on Community Integration, University of Minnesota. The opinions expressed are those of the authors and do not necessarily reflect the views of the RTC, Institute, University of Minnesota, or their funding sources.

Frontline Initiative is available in alternate formats upon request.

NADSP update

The emerging role of DSPs

By Joseph M. Macbeth

Major changes are coming that effect how we will support people with disabilities. New regulations require all stakeholders to understand informed-choice and person-centered practices. For the most part, these changes are driven by the Centers for Medicare & Medicaid Services (CMS) through Federal Home- and Community-Based Services regulations. There is an even stronger emphasis on personal autonomy and a need for greater access to integrated settings.

New CMS rules address big issues. Of concern is, helping DSPs effectively support people to make informed decisions. Are they prepared? Do they have the tools, resources, and skills to take on this responsibility?

Soon, expectations for DSPs' work will be changing. Now more than ever, DSPs will be front and center in building social capital, helping to find and keep meaningful employment, promote social inclusion, and work closely with families. They will have to do all of this while still providing safe environments, assessing risk, and promoting choice. If the new CMS regulations open more doors for people with disabilities, how must DSPs help people move through them?

We hope there are many stories like this: I met Ed nearly twenty-five years ago while working as a DSP. Ed has cerebral palsy and needs a lot of technology and direct support throughout his day. At a young age, he was placed in an institution because his family

could not meet his needs. From there, he moved into a nursing home but he was still able to go to school, earning his high school and college degrees. Eventually, he moved to another part of the state and into an Intermediate Care Facility (ICF) with eleven others.

Around this same time, New York received its first Medicaid waiver that offered people with disabilities access to new opportunities. Ed seized these opportunities! It wasn't long before he was leading, sweet-talking, and challenging his team to find ways to support his move out of the ICF and into his own place. He was blazing new trails and getting people to think differently about choice, risk, and responsibility.

I can still remember the planning meeting where we had to talk about safety. The question that's always asked when anyone with a disability wanted to move from a safely staffed residential setting into a more "risky" one where staff wouldn't always be available; "What about a fire"? After a short pause and with a

familiar look in his eye, Ed said. "I'd rather die tonight in a fire in my own home, than live to be 100 years old living in an institution". The meeting room fell silent and it took us a few long seconds to see what Ed was telling us. At that moment, you could feel the energy driving us to help Ed get what he wanted for his life.

With an extraordinary commitment from DSPs, Ed is still living in his own place, getting tattoos and jumping out of airplanes. Ed has been living his life on his terms. His path has had some problems and heartache; but whose journey hasn't?

You see, in Ed's situation, the "system" didn't get him the life that he wanted. It only gave him the opportunity for that life. By the way, it was DSPs that helped Ed get the life he wanted. They continue to walk side-by-side with him every day.

Please stay in touch with NADSP. We want to support you through these ever-changing times.

Joseph Macbeth is the Executive Director of NADSP. He can be reached at jmacbeth@nadsp.org or 518-449-7551.

"The First One" NADSP conference: A resounding success

On May 30-31, 2015, DSPs from across the country gathered in Louisville, Kentucky for the first ever NADSP Annual Meeting and Conference. The conference was held right before AAIDD's Annual Meeting. Attendees to "The First One" came away with a renewed sense of the importance of their work. They were refreshed from encounters with other DSPs. They were encouraged by speeches and training sessions. Planning is already underway for **"The Second One" to be held in Atlanta, Georgia on June 4-5, 2016.**

I need Trauma-Informed Care and support

By Trent M. (A pseudonym)

I have long had goals and dreams. It is sometimes hard for me to believe but I have been able to overcome my difficult childhood and become a husband, a taxpayer, and a homeowner. I continue to use services and supports but they do not dictate who I am. I am in charge of my own life.

Let me tell you more. I was born with intellectual and developmental disabilities. Most of my family did not understand this—they treated me badly both emotionally and physically. I was abused from the time I was little to my late teens. School was better than home but only a little. I had heroes along the way—my grandma, some teachers, and my high school principal—but generally, I struggled. I lived in many homes back then—some of them “group homes.” I was in family court more than once; judges were sympathetic but limited in how they could support me.

My behavior was uneven. I could be charming and get along but other times I was high-strung and anxious. I heard the “R word” hundreds of times, usually as a slur. My response to abuse or bullying was rarely healthy. I would lash out, run, withdraw, hit. I rarely felt safe.

In my twenties, things got better. I got connected to an agency that provided safe housing and supports. I had an advocate that helped me do a person-centered plan. I began to recruit, interview, and hire my own disability support providers.

I got some distance from family and I made better decisions when things weren’t going well. Some changes took a long time but they began to add up. Those individuals who supported me well generally stayed on. Others didn’t last a month.

I recently heard the term “trauma-informed care.” I am not sure what it means but I think I need it. I need supporters who understand me and listen to me. Supporters who let me take risks. Supporters who have diversified thinking—

they can look at more than one way to solve a problem and can accept different approaches to address issues. Supporters who respond to my daily ups and downs. Supporters who know about how my disabilities impact my life. Most of all, supporters who accept me for who I am.

If you read the rest of this issue, I think you will be a better supporter—it will be great if you understand trauma and trauma-informed care.

Statistics about trauma

By Ann Carrellas, L.M.S.W.

- Children and adults with disabilities are physically and sexually abused much more often than those without disabilities.
- Children with disabilities are 2–3 times more likely to be maltreated than children without disabilities.^{1,2}
- Children with disabilities are less likely to report abuse.³
- Between 26–90% of women with disabilities have experienced at least one instance of sexual or physical violence.⁴
- Between 29–87% of men with disabilities have experienced at least one instance of sexual or physical violence.⁴
- People with disabilities are 4–10 times more likely to be victims of crimes than people without disabilities.⁵
- Most abusers are close to the victims, such as family members and paid caregivers.⁶

1 Goldson, E. (2001). Maltreatment among children with disabilities. *Infants and Young Children*, 13(4), 44-54.

2 Sullivan, P.M., & Knutson, J.F. (2000). Maltreatment and disabilities: A population-based epidemiological study. *Child Abuse and Neglect*, 24(10), 1257-1273.

3 Hershkowitz, I., Lamb, M.E., & Horowitz, D. (2007). Victimization of children with disabilities. *American Journal of Orthopsychiatry*, 77(4), 629-635.

4 Hughes, R.B., Lund, E.M., Gabrielle, J., Powers, L.E., & Curry, M.A. (2011). Prevalence of interpersonal violence against community-living adults with disabilities: A literature review. *Rehabilitation Psychology*, 56(4), 302-319.

6 Sobsey, D., Doe, T. (1991). Patterns of sexual abuse and assault. *Sexuality and Disability*, 9(3), 243-259.

5 Sobsey, D., Lucardie, R., & Mansell, S. (1995). *Violence and disability: An annotated bibliography*. Baltimore, MD: Paul H. Brookes Publishing.

Trauma-Informed Care and the START Model

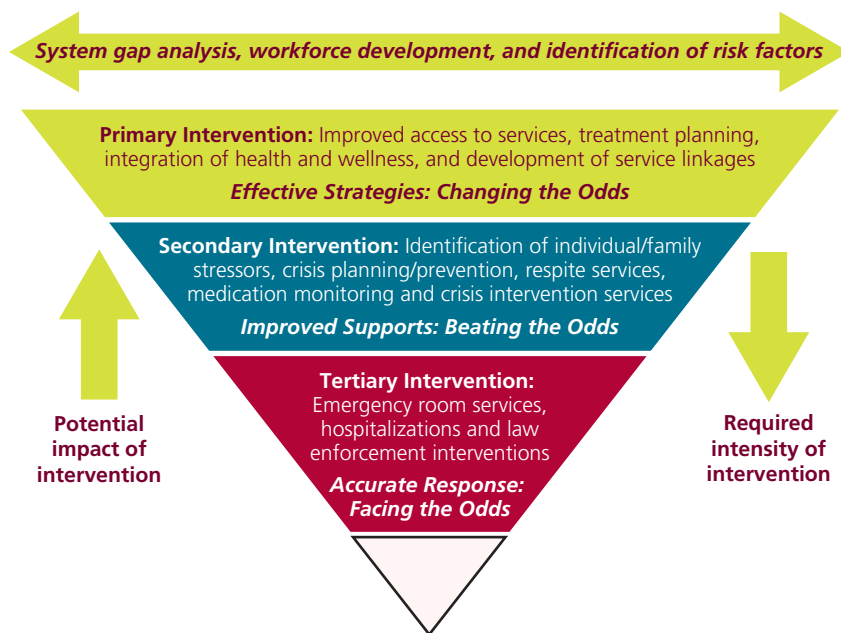
By Lacey Eaton

The START (Systemic, Therapeutic, Assessment, Resources and Treatment) Model is used in many parts of the country. It enhances and supports existing care systems. It is specifically for people with IDD who also have mental health concerns or a behavioral concern. It often utilizes trauma-informed care. The goal is to identify barriers and bridge gaps in services and supports to people we serve. Primary and secondary interventions are intended to reduce emergency calls. Using a positive, person-centered approach, START works to improve current systems of support, both natural and paid. It can also help identify new, appropriate resources.

Typical referrals to START may be individuals who are displaying aggressive behaviors. In the START model, we see aggressive behaviors as a form of communication. When a person is unable to communicate effectively with words, we have to listen to their behavior. When we listen to behaviors, we find that many people we serve are trying to communicate that they are in pain, are depressed or anxious, or are not happy with something. Presenting symptoms may be attributed to IDD/ASD rather than a mental health component that may stem from trauma. Mental illness does exist in people with IDD/ASD; it just may manifest differently.

People we serve may be more vulnerable to stress and have more limited coping skills. Many have suffered one or more traumatic experiences in their

Public Health Model & START: Numbers benefitting from intervention



Center for START Services, 2015. <http://www.centerforstartservices.com/about/default.aspx>

lives. A traumatic event may be a “simple” change in residence. It may be a death in the family. It can be more serious physical or emotional abuse. We must pay attention to signs of trauma exposure. The START model encourages continued education and training in order to serve as a resource to the community.

Since trauma is common to the people we serve, it is important that we understand what trauma looks like. Different approaches may help support a person and their system. It is important to understand that early trauma can physically affect the chemistry of the brain and can affect the cognitive function of an individual. If you combine mental illness with an IDD, the ability to identify and cope with the trauma can be very difficult. When it comes

to experiencing trauma, it is important that the entire support system is involved.

START helps in a way that brings the whole system together and shares with the team everything that has been observed and discovered about the individual. Ideally, DSPs are included on this team. The START team works together to make recommendations for services and supports based on client needs. DSPs can play an important role on the team because of their work with the individual. They also play an important role in carrying out intervention and prevention activities determined by the team. The team meets regularly to keep the system communicating effectively. The team can also provide support for the DSP.

The Center for START Services provides technical support, clinical expertise, and training and consultation services that support the development of —

- Comprehensive evaluation of services and systems of care (local and state)
- A systems linkage approach to service provision
- Expert assessment and clinical Support
- Outcomes-based research and evaluation
- Short-term therapeutic resources and opportunities
- Cross systems crisis prevention and intervention planning
- Family support, education and outreach
- Interdisciplinary collaboration

By supporting development of the cornerstones of the START model as outlined above, START programs and their participants experience an array of benefits including —

- Reduced use of emergency services and state facility/hospital stays
- High rates of satisfaction by families and care recipients
- Cost-effective service delivery
- Increased community involvement and crisis expertise in communities
- Strengthened linkages that enrich systems, increase resources, and fill in service gaps

Resources can be found at www.centerforstartservices.com

Lacey Eaton, MA, LPC-I, is assistant director and team lead for the START program at MHMR Tarrant in Fort Worth, Texas. She can be reached at 817-569-5656.

Trauma-Informed Care

Resources and initiatives in the state of Michigan

By Ann Carrellas, L.M.S.W.

As in every state, Michigan DSPs deal daily with the aftermath of the abuse of persons with disabilities. Persons we serve may not be able to say if they were abused or are currently experiencing trauma. However we may detect when someone we work with shows signs of trauma. These may include significant changes in mood, behavior, sleep patterns, eating, and difficulties in relationships with others. People who are providing direct, daily supports are in a unique position to use trauma-informed care.

The Michigan Department of Community Health focuses on integrating trauma-informed care in the provision of mental health services. This includes understanding how to best support people with IDD. The Michigan Department of Human Services has also infused trauma-informed practices in their services to children who are served in child welfare agencies.

The Children's Trauma Assessment Center (CTAC) at Western Michigan University is a major player. Their staff assesses children entering foster care and also other children exposed to traumatic events. CTAC currently has federal grants to work with Michigan communities including Detroit, Flint, and Kalamazoo to develop evidence-based practices. These are designed to reduce the impact of violence and trauma on children and youth and to increase their resiliency.



Finally, we note a collaborative with the Arc Michigan, the Developmental Disabilities Institute at Wayne State University, the Michigan Coalition to End Domestic and Sexual Violence, and the Michigan Disability Rights Coalition. They use a trauma-informed approach. Their mission is to develop safe and effective service delivery for individuals with disabilities who have experienced domestic and sexual violence.

Ann Carrellas, L.M.S.W. is a Research Associate at the Developmental Disabilities Institute at Wayne State University in Detroit, Michigan. Her work focuses on practices that reduce the risk of violence for persons with disabilities and she is the chair of the State of Michigan Fetal Alcohol Spectrum Disorders (FASD) Task Force and is currently working toward a Ph.D. in Social Work at Wayne State.

The Adverse Childhood Experiences (ACE) Study

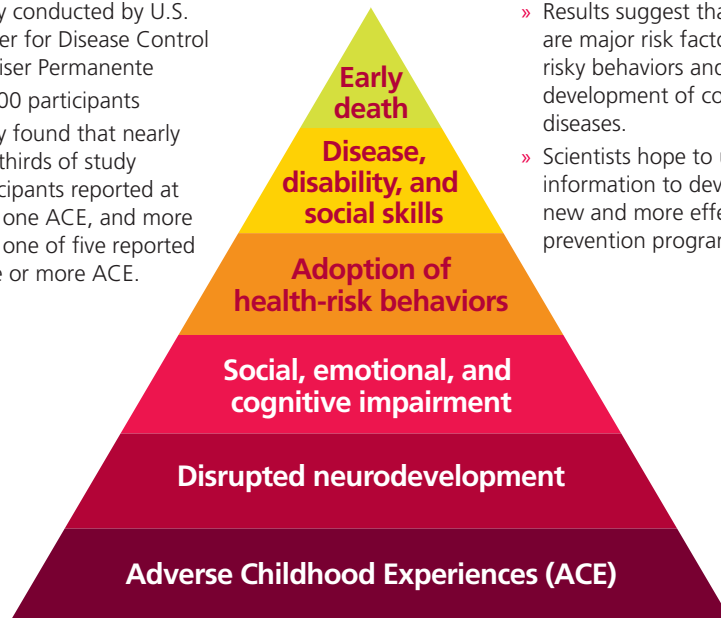
The Adverse Childhood Experiences (ACE) study is one of the largest investigations ever conducted to assess associations between childhood adverse experiences, and health and well-being later in life. The study was conducted by the Centers for Disease Control and Prevention and Kaiser Permanente's Health Appraisal Clinic in San Diego.

More than 17,000 Health Maintenance Organization (HMO) members provided details about childhood experiences during comprehensive physical examinations. They reported information about abuse, neglect, and family challenges. The results showed that childhood abuse, neglect, and exposure to other traumatic stressors are common. Nearly two-thirds of study participants reported at least one adverse childhood experience (ACE), and more than one of five reported three or more ACEs.

The results also suggested that certain early experiences are major risk factors for negative short- and long-term outcomes. Risk factors such as smoking, alcohol abuse, and certain risky sexual behaviors in adulthood were strongly associated with ACEs. Additionally, risk factors for many common diseases were not randomly distributed in the population. They tended to concentrate in the population that reported ACE. Risk factors for many chronic diseases tended to cluster: persons who had one risk factor tended to have one or more other risk factors too.

The ACE Pyramid

- » Study conducted by U.S. Center for Disease Control & Kaiser Permanente
- » 17,000 participants
- » Study found that nearly two-thirds of study participants reported at least one ACE, and more than one of five reported three or more ACE.



- » Results suggest that ACE are major risk factors for risky behaviors and the development of common diseases.
- » Scientists hope to use this information to develop new and more effective prevention programs.

<http://www.cdc.gov/violenceprevention/acestudy/pyramid.html>

The ACE Pyramid represents the conceptual framework for the study. The information collected helps to bridge some of the gaps identified in previous research. Researchers hoped to identify influences of disease, disability and early death among those who report ACE. By providing this information, scientists hoped to develop new and more effective prevention programs.

The information from the ACE study regarding the impact of adverse childhood experiences can improve efforts towards prevention and recovery. This research has informed development of public education and prevention programs. The Centers for Disease Control and Prevention has also suggested some paths to encourage

recovery. These are reported below. Importantly, safe, stable and nurturing relationships for those who have experienced one or more ACE is key in this process. DSPs are in a unique position to provide such relationships to the individuals they support.

This text is adapted from the Centers on Disease Control (<http://www.cdc.gov/violenceprevention/acestudy/index.html>).

While it is unclear how many of the study participants have an intellectual or developmental disability, the study highlights how prevalent and destructive childhood trauma can be.

Trauma-Informed Care

Taking action

By Lynn Winters

Years ago, I was sitting through my umpteenth workshop on trauma. I could barely contain my frustration. Eight hours of describing what trauma is, and not a minute on how to help or what to *do*. More recently, amazing information is coming out on trauma-informed care and I finally feel like I have some practical tools to help.

When I was asked to write this article for *Frontline Initiative*, I went to my colleagues, Cynthia Alvarado, LBSW, and Jacqueline Valencia, BA, to brainstorm. Cynthia and Jacqueline run a family-based shelter program for homeless children and youth. They work directly with people receiving supports, their families, and the shelter parents that care for them. Often the children that come into their program have extensive trauma histories and are often in emotional crisis.

Here are a few items from the bag of tricks we've developed over the years working with children, youth, and their families.

1. Always look at a trauma survivor's challenging behavior as perfectly understandable given what he or she has been through.¹
2. If you don't know if the person you are supporting has a trauma history, it's better to assume he or she does. (This technique works great with anyone who is upset.)
3. Don't think, "What's wrong with you?" Instead, think, "What happened to you?"¹
4. People with trauma in their history tend to fear being rejected or pushed away. So, instead of "time out" try a "time in." Keep the person nearby. Stop what you're doing, and pay attention to the person (not the behavior). Speak quietly and calmly. If they respond well to touch and are not too escalated, try a hand firmly on the shoulder, or holding their hand. Always ask permission before touching. Sit quietly together.
5. Use the word "safe." Use it a lot. "I'm going to keep you safe. This is a safe place for you. Are you feeling safe?"
6. Help the person use their words if he or she has them. If the person doesn't have words, speak for him or her. Based on your observation, validate and normalize those feelings. "You seem to be very frustrated now, and that's OK. I would be too, if I were you."²
7. Check for sensory needs. Is the person too hot? Too cold? Hungry, tired? Is it too bright? Too loud? Adjust the environment.³
8. Offer an alternative activity; one that usually calms them. Try offering repetitive movement such as swinging on a porch swing, or rocking in a rocking chair.
9. Avoid the temptation to argue, lecture, nag, and remind. A trauma survivor in crisis cannot hear any of that, and it is likely to backfire.
10. After everyone is calm, look for the success. "Thanks for not hurting yourself," (even if they smashed all the plates). "You used your words really well!" (Even if they called you every name in the book).
11. First and foremost, take care of yourself.

Lynn Winters, Licensed Clinical Social Worker in Lacruse, New Mexico and Behavior Specialist for Bureau of Behavioral Support, Developmental Disabilities Division in New Mexico. She can be reached at (575) 556-1693 or lynnwinters@yahoo.com

1 National Council for Behavioral Health Learning Group. (2012). <http://www.thenationalcouncil.org/>

2 Forbes, H.T. (2012). *Beyond Consequences Live* [DVD].

3 Purvis, K.B., Cross, D.R., & Sunshine, W.L. (2007). *The connected child: Bring hope and healing to your adoptive family*. New York: McGraw-Hill.

Frontline resources

Treatment Improvement Protocol (TIP) 57, Trauma-Informed Care in Behavioral Health Services (Trauma TIP)

http://beta.samhsa.gov/samhsaNewsLetter/Volume_22_Number_2/trauma_tip/

SAMHSA's recently released publication offers behavioral health service providers and program administrators information and practices to assist people who have experienced repeated, chronic, or multiple traumas.

Changing Communities, Changing Lives SAMHSA'S National Center for Trauma-informed Care (NCTIC)

http://www.nasmhpd.org/sites/default/files/NCTIC_Marketing_Brochure_FINAL%282%29.pdf

Alternatives for Seclusion and Restraint National Center for Trauma-informed Care (NCTIC)

A technical assistance center dedicated to promoting alternatives to seclusion and restraint, and building the knowledge base on the implementation of trauma-informed approaches in programs, services, and systems.

<http://beta.samhsa.gov/nctic>

A Practical Guide for Creating Trauma-Informed Disability, Domestic Violence and Sexual Assault Organizations

<http://www.disabilityrightswi.org/wp-content/uploads/2012/05/Trauma-Informed-Guide.pdf>

What is Trauma-informed Care?

http://www.traumainformedcare.com/TIC_PDF/Sec_02-TReSIA-About_TIC.pdf

SIDRAN: PTSD and Dissociation Resources for Survivors

<http://www.sidran.org/>

AMBIT Network: Navigating research and practice in child trauma

<http://www.cehd.umn.edu/fsos/projects/ambit/>

The Risk and Prevention of Maltreatment of Children with Disabilities

<https://www.childwelfare.gov/pubs/prevenres/focus/focus.pdf>

Trauma-Informed Behavioral Interventions: What Works and What Doesn't

Karyn Harvey

Available through the AAIDD Bookstore:

<http://aaid.org/publications/bookstore-home/practice/page/2/#.VQHEZPnF98E>

NADSP's new train-the-trainer curriculum

Direct Support Professionals and informed decision making

Informed decision making is a process where an individual receiving supports has obtained information and knowledge about a situation, they understand the choices available and the outcomes possible, and the choices they make regarding that decision reflect their personal values. It is also the acceptance by that individual of the associated responsibility and risk of their decision. This decision is their decision alone and non-coerced.

Based on best practices and research, this dynamic training features information, role plays and practical skills for DSPs to use when supporting people in making informed decisions. Furthermore, the training also features the important developments in federal regulations that guide HCBS services throughout the country. The CMS "Community Rule" will directly impact DSPs and using the skills of Informed Decision Making as experienced in this training session will benefit both people receiving support and the DSPs who work in partnership with them.

For more information or to schedule a training, contact Joseph Macbeth, NADSP Executive Director at jmacbeth@nadsp.org.

Competency + ethics = Outcomes

Creating a culture of direct support competency

Did you know NADSP offers trainings and technical assistance?

Let NADSP train your managers, supervisors and training staff in the art of engaging adult learning seminars to advance the knowledge, skills and values of your direct support professionals (DSPs).

Competency + ethics = Outcomes: Creating a culture of direct support competency

This one-day training includes the following sessions —

CMS Community Rule and informed decision making: The emerging roles and expectations of the direct support workforce

This opening session offers a chance to reflect on the evolving role and expectations of DSPs. Many of these changes are driven by the Centers for Medicare & Medicaid Services (CMS) and its Federal Home- and Community-Based Services Community Rule. This is a radical departure from which we are accustomed and will ultimately create an emphasis on 'personal autonomy', greater access to 'integrated settings' and helping people to make 'informed choices'. The focus of this session addresses one important piece of the CMS Rule; how do we support people with disabilities to make informed decisions? What are the DSP's role in this process? What are the workforce demographics and projections to fulfill these? Do they possess the tools, resources and skills to uphold this responsibility?



The NADSP Code of Ethics encounter

NADSP faculty will share real examples culled from decades of practicing in the field of intellectual disabilities in a role play, unlike any other. In learning about ethical responsibilities, we will act out some real dilemmas and ethical decisions that confront DSPs on the job every day. Using NADSP's Code of Ethics, participants will consider ways that ethical practices can be incorporated into daily practice. The beliefs and attitudes that are associated with being an effective human service professional are critical to understanding this code — it is not the handbook of the profession, but rather a roadmap to assist us in staying the course of securing freedom, justice, and equality for all.

The great DSP competency connection

The cornerstone of every profession is a standardized set of competencies with which all practitioners carry out their craft. The NADSP assisted the state of New York in creating a standardized set of Core Competencies for DSPs. Since that time, we have provided

dozens of training sessions across the state as provider organizations begin to understand and roll-out the competency set. This session will introduce the national Direct Support Professional Competencies in an engaging, thought-provoking and fun manner. The audience will break into small groups and discuss the competencies...and then the fun and learning begins.

DSPs and informed decision making

A facilitated discussion that investigates how DSPs can use the ethical practices, professional skills and adept reasoning to assist people in making informed decisions and meeting the new CMS definition of "Community". This session will begin a deeper discussion by asking three questions that will identify ways that the spirit of the NADSP's Code of Ethics and Competencies will be incorporated in assessing Risk and balancing Safety. Part of the discussion will focus on how the organization can create a culture of competence with skilled, ethical and empowered DSPs that will lead the way to quality.

NADSP accredited training curricula

2015–2016

Academy for Direct Support Professionals

The Center for Disability and Development at Texas A&M University is a collaborative partnership between the two Texas Universities. Candidates pursuing entry-level recognition as a DSP are required by The Academy to take an introductory course in Person Centered Practices along with other requirements.

ARC Broward PATHS Certificate Program

The PATHS Certificate Program is designed to create a competency based and credentialed career path for DSPs. Coupled with mentorship, experiential learning opportunities and placement resources, PATHS will support students to find a career in this high demand field.

College of Direct Support

CDS is a multimedia, interactive, web-based curriculum. CDS offers training in content areas that have been identified as critical to successfully supporting people with disabilities to live self-directed lives in the community.

Human Services Credentialing Program Providers' Council

The Massachusetts Council of Human Service Providers, Inc. is a statewide association of health and human service agencies. The Credentialing Program is a set of curricula designed to develop and implement standards and competencies for DSPs.



North Dakota Community Staff Training Program

North Dakota has provided staff training through a cooperative effort of the North Dakota Department of Human Services, the North Dakota Center for Persons with Disabilities at Minot State University, and community agencies serving persons with developmental disabilities.

PATHS

PATHS is the credentialing program of the Ohio Alliance of Direct Support Professionals (OADSP). It provides a rigorous training and education program based on the principles of self-determination and ethical practice.

Relias Learning

This online curriculum offers staff compliance training and continuing education for organizations that serve people with developmental disabilities, as well as behavioral health, mental health, addiction treatment, community health, community action and child welfare.

Star Services

Star Services provides an engaging online and live curriculum for social service professionals, including photos, video, audio and story-based learning that requires the learner to interact with the content. STAR uses expert experience and examples from the field, person-centered philosophy and evidence-based content in areas of compliance, regulations, continuing education and skills development.

Training Collaborative for Innovative Leadership

This training is a shared venture developed by and for community based organizations. The programs are designed to promote quality excellence by focusing on strategies that enhance personal outcomes for individuals with disabilities.

U.S. Department of Labor

DOL now has a certified apprenticeship program for the occupational title of direct support specialist. Certified apprenticeship programs must meet the federal guidelines and be reviewed and approved by the NADSP.

NADSP membership 2015-2016

Affiliate members (\$200)

- Regis Ojijiski; Kingston, NY
- Patricia McKay and Family; Albany, NY
- The ARC of Tennessee, Inc.; Nashville, TN
- The GIL Foundation Inc.; Prospect, CT
- InterHab; Topeka, KS
- McComb Consulting and Government Relations; Annapolis, MD
- PAR; Harrisburg, PA

Sponsoring organizations (\$2000)

- American Network of Community Options and Resources (ANCOR); Alexandria, VA
- The Council on Quality and Leadership (CQL); Towson, MD
- RTC on Community Living, Institute on Community Integration, University of Minnesota; Minneapolis, MN
- New York State Association of Community and Residential Agencies (NYSACRA); Albany, NY
- The Leadership Consortium on Developmental Disabilities at the University of Delaware; Newark, DE
- Oregon Rehabilitation Association; Salem, OR
- NYSARC, Inc.; Albany, NY

Provider organizations Level one (\$500)

- Goodwill Industries of Greater Nebraska; Grand Island, NE
- J&J Independent Living LLC; Wasilla, AK
- Mill Neck Services; Mill Neck, NY
- Opportunities Unlimited; Lewiston, ME
- Pathway Enterprises; Medford, OR
- Transition To Independence; Contra Costa & Alameda Counties, CA

Provider organizations Level two (\$1000)

- Alvord-Taylor; Eugene, OR
- COARC; Hudson, NY
- Community Access Services; Beaverton, OR
- Community Support Services; Salem, OR
- Laura Baker Services Association; Northfield, MN
- Oahe; Pierre, SD
- Opportunities for Positive Growth; Indianapolis, IN
- Progressive Community Services; St. Joseph, MO
- Transitional Living Centers; Valley City, OH

Provider organizations Level three (\$2000)

- ARC of Orange County; Newburgh, NY
- Community Bridges; Concord, NH
- Jefferson Rehab Center; Watertown, NY
- Mount Olivet Rolling Acres; Chanhassen, MN
- New Horizons Resources; Pleasant Valley, NY
- Stone Belt ARC; Bloomington, IN
- Welcome House; Cleveland, OH

Provider organizations Level four (\$3000)

- AHRC New York City; New York, NY
- Bethesda Lutheran Services; Watertown, WI
- Cerebral Palsy Association of New York State; New York, NY
- Collaborative Industries; Lincoln, NE
- Dungarvin; Mendota Heights, MN
- ENCOR; Omaha, NE
- Ulster-Greene ARC; Kingston, NY



NADSP membership form

Individual membership categories

NADSP credentialed professionals – **FREE**

- DSP-R DSP-C level 1&2 DSP-Specialized Credentialed Frontline Supervisor

Individual membership if not employed by a supporting organization – **\$10**

- DSP Frontline Supervisor Self-advocate / family member

Provider organization membership categories

This level is for human service provider organizations that employ DSPs. Membership amount is dependent on the number of DSPs employed. **All DSPs employed by the organization also become individual members of NADSP.**

- Level one:** Employs up to 50 DSPs — **\$500** **Level three:** Employs 201 to 500 DSPs — **\$2,000**
 Level two: Employs 51 to 200 DSPs — **\$1,000** **Level four:** Employs more than 500 DSPs — **\$3,000**

Other professional membership

This level is for professionals working in community human services, such as social workers, administrators, and healthcare professionals.

- Community human services professional** — **\$50**

Non-provider membership categories

This level is for individuals or organizations that are **not providers or employers.**

- Affiliate:** Individuals or organizations that wish to demonstrate a commitment and to support the efforts of NADSP and its state chapters — **\$200**
 Sponsoring organizations: National or multi-state organizations, associations, businesses, and stakeholder groups that are dedicated to advancing the goals of NADSP and can help influence others — **\$2,000**

Total enclosed

Make checks payable to NADSP. To pay by credit card, visit www.nadsp.org/membership
(Discounts are not available with online payment)

Mail membership form and payment to:

NADSP, 240 Washington Ave. Ext., Suite 501, Albany, NY 12203-0305

Name

Organization

Address

City State Zip

Phone

Email