TRAUMA RESPONSIVE CARE FOR EMERGENCY DEPARTMENTS:

TOOLKIT

2024

VPQHC

Vermont Program for Quality in Health Care, Inc.

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I. INTRODUCTION

More children than ever are arriving in emergency departments across the nation and staying for longer while they await appropriate care. This intensifying problem requires an approach that targets both upstream and downstream processes. The Trauma Responsive Care toolkit for EDs is part of the effort to address the downstream need to improve care and support of children and families who find themselves boarding in the emergency department while they wait for psychiatric care to become available. **By providing Trauma Responsive Care, organizations create climates that are sensitive to individuals with trauma histories and foster inclusive settings where all feel welcomed, respected, and valued.** This toolkit will contribute to the system-wide efforts to ensure Vermont ED providers are equipped with the knowledge, tools, and resources they need to provide the highest quality of care for patients arriving to the emergency department with mental health conditions and substance use disorders.

VPQHC is partnering with the Department of Mental Health to offer Trauma Responsive Care trainings to emergency department staff across the state. This toolkit supplements the in-person trainings provided to Emergency Department staff across the state of Vermont and will serve as a centralized and structured source of information and resources for hospitals and providers.

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Thank you to the Trauma Responsive Care training team: Kristy Hommel, MEd; Matt Dove, NP, DUAL PMHNP, FNP Certified; and Peter Cudney, LICSW, for your passion and dedication to this work.

VPQHC
Vermont Program for Quality in Health Care, Inc.

VERMONT
DEPARTMENT OF MENTAL HEALTH

II. UNDERSTANDING TRAUMA

"I THINK THE MOST IMPORTANT THING IS THAT WE DISCOVERED THAT TRAUMA CHANGES THE BRAIN. A LOT OF PEOPLE STILL THINK THAT TRAUMA IS SOMETHING THAT HAPPENS TO YOU, THAT IS A STORY ABOUT THE PAST. ***WHAT REALLY IS A TRAUMA IS THAT YOUR BRAIN GETS CHANGED, AND YOU SEE THE WORLD DIFFERENTLY, AND YOU LIVE IN A DIFFERENT BODY, LIVE IN DIFFERENT WORLDS, WHERE YOU SEE THINGS DIFFERENTLY AND ARE EXPERIENCING DIFFERENTLY FROM OTHER HUMAN BEINGS."***

– Bessel van der Kolk (2016)

II. UNDERSTANDING TRAUMA

Trauma is a complex physiological phenomenon triggered by external, distressing events which overwhelm normal coping responses. Trauma can occur as a single acute event, cluster of events, or as chronic traumatic or toxic stress. Chronic traumatic stress can lead to physiological changes in a person's brain and body. Outcomes from exposure to trauma can range from mild to severe depending on many factors, including developmental status and the presence of supportive relationships.

When a person experiences trauma, physiological changes occur in both the brain and the body, increasing baseline stress and loss of sense of control. Examples of traumatic events include: physical, sexual or emotional abuse, early neglect, witnessing violence, serious accidents, refugee or war experiences, natural disasters, poverty, and discrimination.

A. THE IMPACT OF TRAUMA

- Physiological changes occur in the brain and body
- Fractured experience of the traumatic event
- Increased baseline stress and arousal
- Loss of sense of control
- Loss of sense of self, confusion, shame
- Disruptions to sleep, eating, digestion
- Relationships feel insecure
- Internal sensations may be unmanageable and unbearable
- Self-regulation is extremely difficult
- Heightened emotions, labile emotions, numbing, dissociation
- Misperceptions of the world and people as unsafe
- Triggers and flashback experiences
- Behavioral adaptations to manage unbearable sensations and relationships

B. CHILDHOOD TRAUMA

The more an individual is exposed to a variety of stressful and potentially traumatic experiences, the greater the risk for chronic health conditions and health-risk behaviors later in life. Adverse Childhood Experiences (ACEs) include a range of common, but preventable, events or circumstances that may be traumatic to children during the first 18 years of life. The CDC ACEs study demonstrated that over 60% of people have experienced at least 1 ACE, and 20% have experienced 3 or more.

II. UNDERSTANDING TRAUMA

C. DEFINITIONS

Adversity – Challenges we face in life.

Stress – Our physiological response to adversity, ranging from healthy, to tolerable, to toxic.

Toxic Stress – Acute stress that is beyond our current capacity to cope (especially when we fear for our safety), or chronic stress without time to recover and in the absence of supportive relationships.

Trauma – When stress is toxic it leads to changes in the brain and nervous system, which negatively impact functioning.

Complex Developmental Trauma – When stress is toxic during childhood, it leads to changes in foundational neurodevelopment, with potentially long-lasting impacts across multiple developmental domains.

D. RESOURCES & REFERENCES

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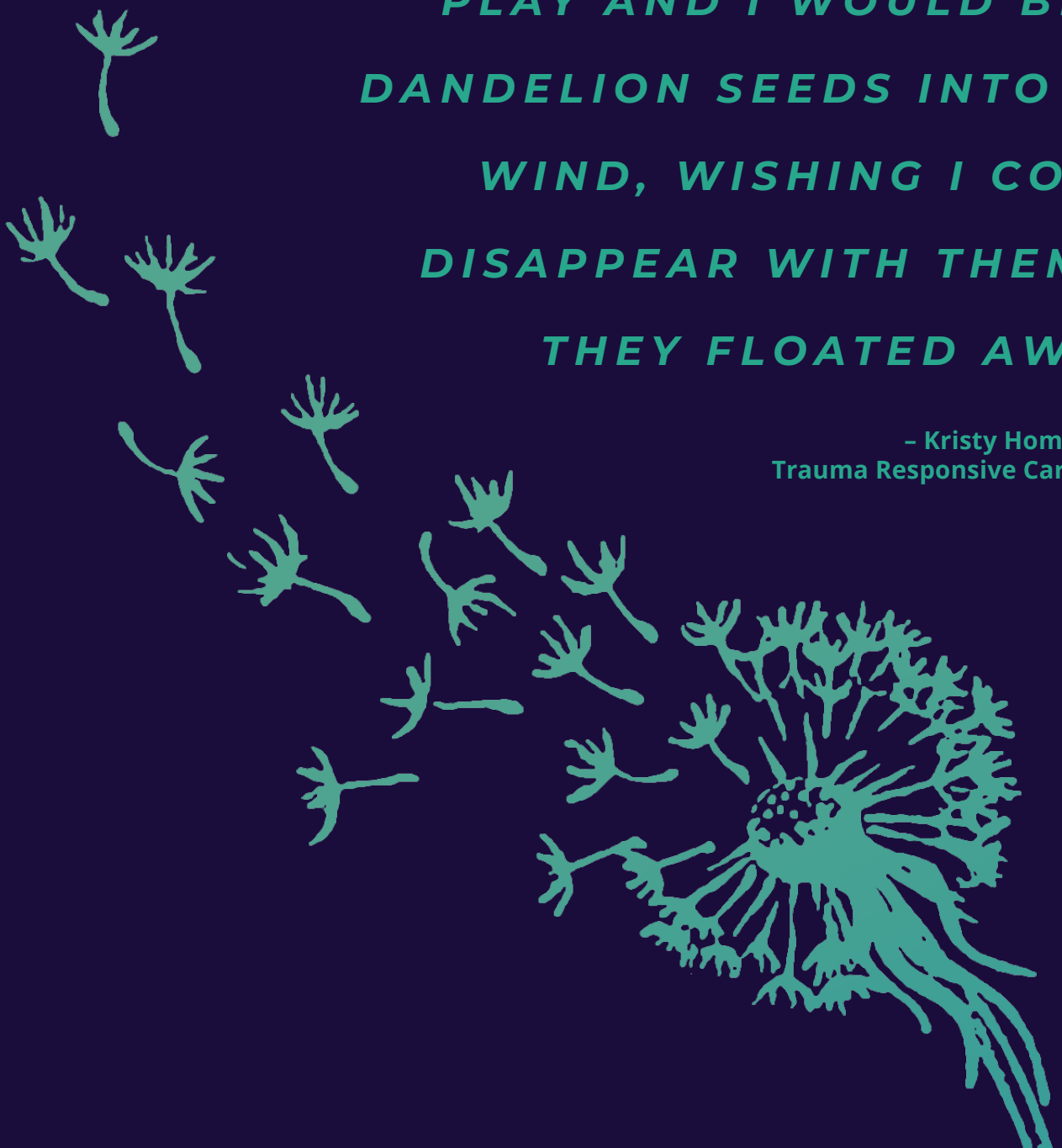
Substance Abuse and Mental Health Services Administration (SAMHSA). Understanding Child Trauma. Understanding Child Trauma - What is Childhood Trauma? | SAMHSA Child Maltreatment: Facts at a Glance (cdc.gov)

The National Childhood Traumatic Stress Network, About Child Trauma.
The National Child Traumatic Stress Network (nctsn.org)

"WHEN I WAS LITTLE I FELT DIFFERENT, DISCONNECTED, AND LONELY. ***AT RECESS I SAT ON THE PLAYGROUND WATCHING THE OTHER KIDS PLAY AND I WOULD BLOW DANDELION SEEDS INTO THE WIND, WISHING I COULD DISAPPEAR WITH THEM AS THEY FLOATED AWAY."***

– Kristy Hommel, MEd
Trauma Responsive Care Trainer



III. TRAUMA RESPONSIVE CARE

A. FOUNDATIONAL INFORMATION

Trauma informed care is a patient centered approach to medical care that acknowledges the widespread prevalence of trauma and encourages health care professionals to recognize the impact of past trauma on a patient's symptoms and behavior. A trauma informed individual can identify signs and symptoms of trauma, and understands how trauma may impact others' experience, both within and outside the medical system. It assumes that people are more likely than not to have a trauma history. This toolkit uses the term **trauma responsive** care to emphasize the importance of translating understanding into action. A trauma responsive person is not only informed, but feels competent and confident when responding to patients presenting with trauma-related symptoms. It seeks to reduce the anxiety of the healthcare setting and provide effective treatment while minimizing retraumatization. Trauma responsive care best practices should be embraced at both the clinical and organizational levels to create inclusive environments, improve patient outcomes, and increase safety and security for everyone involved. The National Child Traumatic Stress Network (NCTSN, 2016) describes a trauma-informed system as:

"One in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system including children, adults, caregivers, and service providers. Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies."

https://www.nctsn.org/trauma-informed-care/creating-trauma-informed-systems

A key tenet of trauma responsive care involves shifting from a judgmental stance to one of curiosity, from *"what's wrong with you?"* to *"what happened to you?"*

III. TRAUMA RESPONSIVE CARE

B. VALUES OF TRAUMA RESPONSIVE CARE

- Compassion in communication (active listening, open-ended questions, clarification, reflection, other techniques like humor or silence)
- Demonstrated understanding of the prevalence and impact of trauma
- Promoting safety
- Earning trust
- Embracing diversity
- Exhibiting dignity and respect for all
- Empowerment through patient-centered care

C. IMPLEMENTATION

Creating a trauma-responsive organization requires support from senior leadership and buy-in from the patient-facing workforce. More details and resources for organizational implementation are included below. Implementation components include:

- Training on the prevalence and impact of trauma.
- Integrating knowledge about trauma into policies, procedures and practices.
- Recognizing risk factors, signs and symptoms of trauma for patients, families, and staff.
- Creating welcoming physical environments that promote calm and safety, to prevent retraumatization.
- Maintaining communication that is open, consistent, respectful and compassionate.
- Promoting transparency, mutuality, collaboration and choice in patient interactions.
- Supporting a culture of staff wellness.
- Creating space for dialogue about traumatic stress.
- Engaging patients in organizational planning.

D. RESOURCES & REFERENCES

Maul, Alexandra; Menschner, Christopher. Center for Health Care Strategies. (2016). Key Ingredient for Successful Trauma-Informed Care Implementation: Key Ingredients for Successful Trauma-Informed Care Implementation (samhsa.gov)

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The National Child Traumatic Stress Network. (2016) What is a Trauma-Informed Child and Family Service System? https://www.nctsn.org/sites/default/files/resources//what_is_a_trauma_informed_child_family_service_system.pdf

IV. VERBAL DE-ESCALATION

A. FOUNDATIONAL INFORMATION

De-escalation is a process or strategies used to prevent, reduce, or manage behaviors associated with conflict. This includes verbal agitation, aggression, and violence during an interaction between two or more individuals. Verbal de-escalation can be a powerful tool to reduce a patient's level of agitation, mitigate violence, and ensure that patients feel seen, heard, and believed. De-escalation skills are necessary to support the safety of patients and staff.

B. RECOMMENDATIONS FROM PROJECT BETA

Project BETA (Best Practices in Evaluation and Treatment of Agitation), has compiled de-escalation recommendations developed by experts in emergency medicine and psychiatric care. The recommendations from Project BETA focus on verbal de-escalation as an important initial treatment for agitation.

Project BETA Domains:

- Respect personal space.
- Don't be provocative (monitor body language).
- Establish verbal contact.
- Avoid overwhelming the patient with too many staff in the room.
- Identify wants & feelings.
- Listen closely to what is being said.
- Agree or agree to disagree.
- Set clear limits.
- Offer choice.
- Debrief with patient and staff.

C. TECHNIQUES FOR VERBAL DE-ESCALATION

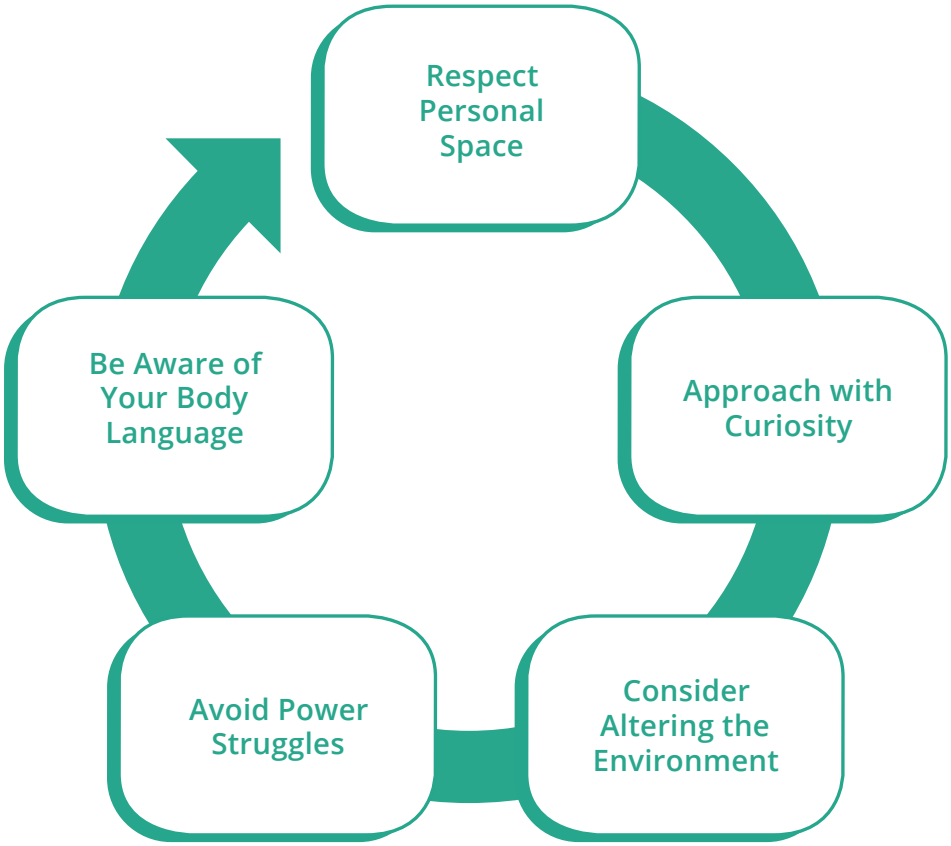
By adopting a **curious stance** we can collaborate toward healthier possible solutions. Problem behaviors frequently represent unmet needs or unmanageable emotions, and a lack of skills for meeting those needs or managing those emotions. They may also represent adaptive responses to past threatening environments. We want to understand the underlying needs and collaborate with the patient to meet those needs. We can validate how very real and difficult their feelings and needs are, and if we are genuinely trying to meet those needs and that is seen, the behaviors will often resolve.

- Approach with **curiosity.**
- Remember to treat every patient with **respect and empathy.**
- Remember they may be experiencing a flashback.
- Have appropriate number or staff available/within earshot.
- Monitor **body language.**
- Respect **personal space.**
- Know when to **tap out.**
    - Escalated Patient + Personal Trauma Activation = Tap Out
    - Co-regulation Attempt + Negative Patient Response = Tap Out

IV. VERBAL DE-ESCALATION

C. TECHNIQUES FOR VERBAL DE-ESCALATION (CONTINUED)

- Provide options for a patient's **healthy control** over circumstances and interventions.
  - *"Which arm would you like me to use?"*
  - *"How can I make you more comfortable with this procedure?"*
  - *"Please ask me any questions that arise for you as I explain the next steps."*
  - *"We can go for a walk around the department after 30 minutes of calm behavior."*
- Set **boundaries**.
- Validate experiences and feelings.
  - *""That sounds really hard. Tell me more."*
  - Try your hardest to do so from a place of truth and authenticity.
  - *"I noticed you haven't eaten today. Would you like help ordering food?"*
- Clearly **communicate** procedures, processes and expectations.
- Provide **coping skill** coaching.
- Identify the need being expressed – read between the lines.
- Coping strategies
  - *"Would you like a stress ball?"*
  - *"Do you think going for a walk would help?"*
  - *"Let's do deep breathing together for two minutes. I'll lead."*
  - *"Can I bring you a warm blanket?"*



IV. VERBAL DE-ESCALATION

D. COMMON BARRIERS TO EFFECTIVE DE-ESCALATION

Do your best to avoid these common barriers to de-escalation:

- Engaging in unnecessary power struggles. Avoid power struggles unless it is a MUST to maintain safety.
- Minimizing or trivializing a patient's experience or feelings. Well-meaning people often attempt to immediately fix the problem, and this can be counterproductive.
- Ordering, threatening, arguing. Example: Instead of *"Don't do that,"* try *"Help me understand why you made that choice."*

E. CONSIDERATIONS FOR REGULATION WITH CHILDREN

- Make changes to the physical environment. (Going for walks, windows and daylight, reduce noise, diversionary activities, wearing own clothing.)
- Consider soothing sensory experiences. (Music, noise canceling headphones, rain sounds, pleasant aromas, tea or hot cocoa.)
- Consider soothing rhythmic motor activities. (Stretching, yoga, weighted blankets, body socks, coloring books.)
- Consider co-regulating physical contact with family members. (Holding hands, hugs, back rubs, reading a book together.)
- Always prioritize verbal de-escalation over chemical or physical restraints, even if it is time consuming.
- Consider posting schedules, ideally with simple visuals, and help youth to track time and anticipate transitions.
- Use grounding techniques, breathing, observing with senses. (Breath work, body scans and progressive relaxation, tracking of the senses, drinking water, stretching and yoga).
- Use the **PACE** strategy to set a positive and accepting tone from the start.
    - **Positive** – Your energy, body language, facial expressions, tone of voice, and optimism. Signal to the child and family that you are safe and pleased to connect with them.
    - **Accepting** – Choose to believe that "they are doing the best that they can." Hold faith that children and youth are not intending to fail or to make our lives difficult. It is much more complex than that.
    - **Curious** – Adopt a "curious, not knowing stance." Ask what might have happened to this child and family, and what might they be experiencing now as a result?
    - **Empathetic** – Seek to understand the child and family. Broaden your understanding beyond the "single story" of trauma.

F. CAREGIVER CONSIDERATIONS

- If a child's parent is overwhelmed, it is likely the child will be as well.
- Partner with the parents, or whoever is present with the child and who has some degree of established relationship.
- Co-regulate the parents and ask them to help co-regulate their child.
- Keep the parents informed of next steps, time frames, decision points, and ask them to help keep the child informed.

IV. VERBAL DE-ESCALATION

F. CAREGIVER CONSIDERATIONS (CONTINUED)

- Invite community partners who may have an established relationship with the child to be present.
- Identify the ED staff who will be the primary contact for the child and family. Establish a deliberate connection with the child and family, and periodically check in.
- Educate and ask families about stress:
  - The ED can be stressful, and it can remind us of stress from our past.
  - We can keep you most comfortable if we know what stress is like for you, so we can plan ahead.
  - What happens for you/your child when they're really stressed? Any particular behaviors you would want us to know about?
  - Are there any particularly stressful things from your/your child's past you would want us to know about?
  - What helps you/your child feel more comfortable when they are stressed? Can we plan some activities that might help?

G. RESOURCES & REFERENCES

- Appendix A: Emotional Regulation: Body Based Experiences
- Appendix B: Emotional Regulation: Breath Work and Mindfulness
- Appendix C: Zones of Regulation
- Appendix D: Daily Schedule
- Appendix E: My Personal Support Plan
- Appendix F: "You are in the Emergency Department with Your Child in Crisis, Now What?"

Additional Resources:

Hughes, Daniel. (2017). Dyadic Developmental Psychotherapy: An Attachment-Focused Family Treatment for Developmental Trauma. https://doi.org/10.1002/anzf.1273

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V. IMPLEMENTING TRAUMA RESPONSIVE CARE: INDIVIDUALS

A. EMOTIONAL REGULATION

Emotional Regulation is the ability to manage an individual's emotional state. When providing care to someone experiencing a distressing emotional state it is important to regulate our own emotions before engaging with the patient. When you feel calm and regulated you can help patients learn skills to regulate themselves. Consider using the Three R's to prepare yourself before engaging with patients:

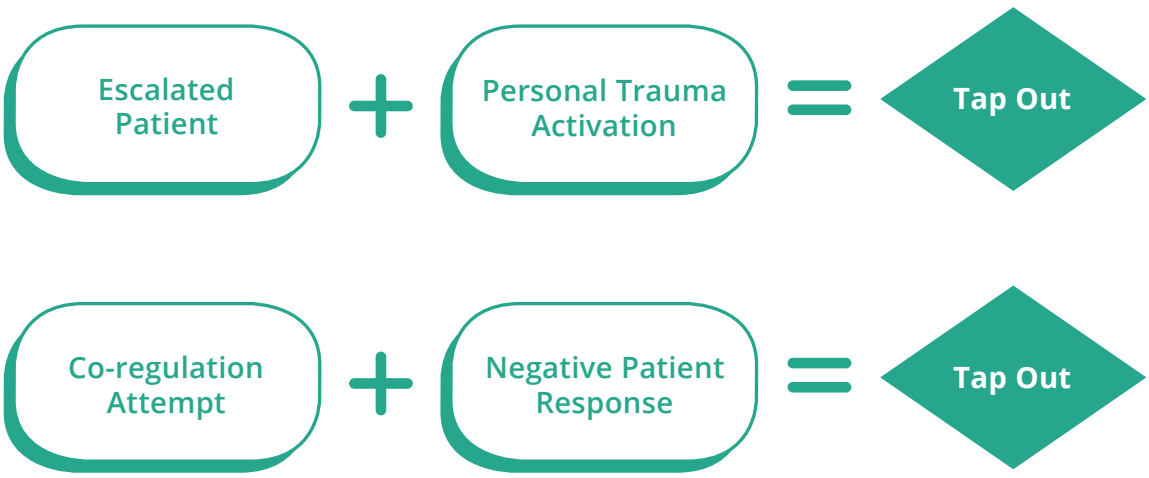
Remember the Three Rs
First assure a situation is safe, then...

- **Regulate** – First, regulate yourself. Breathe. Breathe again. Focus on your own calm energy, and your affect. Be settled as much as you can. Prepare for your energy and the child's energy to meet. Match the child's affect and body language, shifting then to positive, caring affect.
- **Relate** – Engage carefully, and with clear and deliberate respect. Use the right PACE (see page 13). Communicate your care and concern for the child. Offer your name, your role, and an explanation of what the next steps are. Continue to offer positive, caring affect.
- **Reason** – After you're both regulated and feeling connected, then move on to cognitive strategies like planning, problem solving, processing, etc.

See Appendix G: for a Model of The Three R's: Reaching The Learning Brain. By Dr. Bruce Perry and the Beacon House.

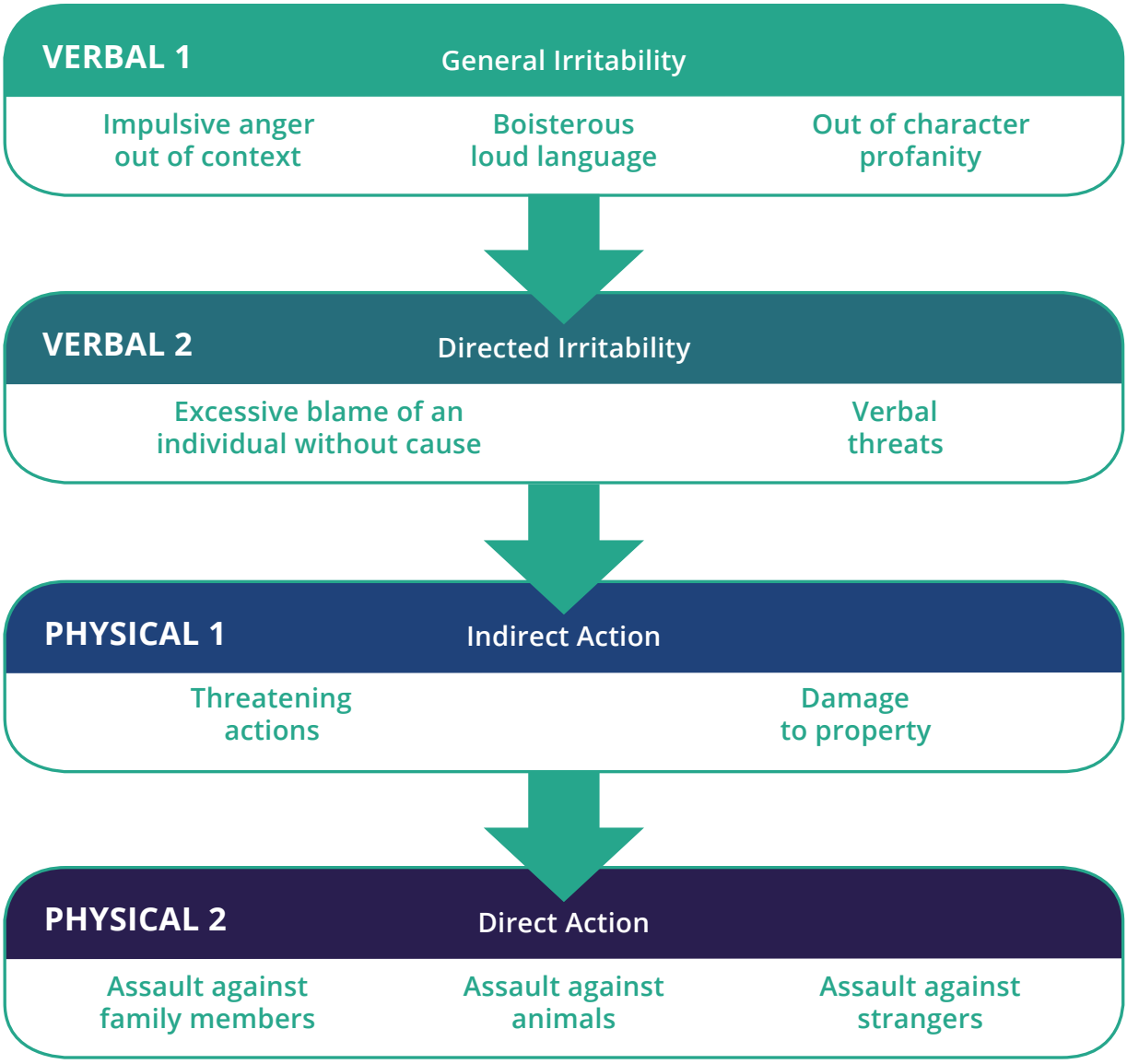
B. WHEN TO TAP OUT

If you find yourself in a power struggle or feeling overwhelmed by a patient or situation, this is a good time to try to switch out with a co-worker. Remind yourself that these cases can be hard and emotionally taxing. Everyone needs breaks and that is okay. Feeling stressed, anxious, elevated, triggered, impatient, reactive, powerless, or stuck are all signs of needing a break.



V. IMPLEMENTING TRAUMA RESPONSIVE CARE: INDIVIDUALS

C. RECOGNIZING WHEN A PATIENT IS ESCALATED



VI. IMPLEMENTING TRAUMA RESPONSIVE CARE: ORGANIZATIONS

A trauma responsive organization supports staff to feel competent and confident when responding to patients presenting with trauma related symptoms. Organizations that are trauma responsive seek to reduce the stress that can be experienced in a health care setting and provide effective treatment. Trauma responsive care best practices should be embraced at both the clinical and organizational levels to create inclusive environments, improve patient outcomes, and increase safety and security for everyone involved.

A. IDENTIFY CHAMPIONS

Work with leadership to build commitment and support and find staff members who are motivated and passionate about implementing Trauma Responsive Care strategies at your organization. Designate an individual or team to coordinate and guide the work.

B. ORGANIZATIONAL ASSESSMENT

When implementing changes at any organization it is important to use an organizational assessment to determine the organization's readiness and capacity to begin the change process. An organizational assessment establishes baseline competencies, capacity for making systemic changes, and identifying needs.

Resources & References:

Sample Trauma Responsive Care Organizational Assessments:
https://traumatransformed.org/documents/tia_orchard.pdf

Vicarious Trauma-Organizational Readiness Guide for Victim Services:
https://ovc.ojp.gov/sites/g/files/xyckuh226/files/media/document/os_vt-org_victim_services-508.pdf

NCTSN Trauma-informed Organizational Assessment (TIOA):
https://www.samhsa.gov/resource/dbhis/nctsn-trauma-informed-organizational-assessment-tioa

Trauma-Informed Care Organizational Assessment, Traumatic Stress Institute: https://www.traumaticstressinstitute.org/resources/trauma-informed-care-organizational-assessment/

C. DETERMINE PRIORITIES & CREATE AN ACTION PLAN

Using the results of your organizational assessment determine your priorities and build a timeline for addressing each priority. Identify areas of strength to maintain and gaps that need to be addressed. Ensure your action plan is specific and realistic.

Resources & References:

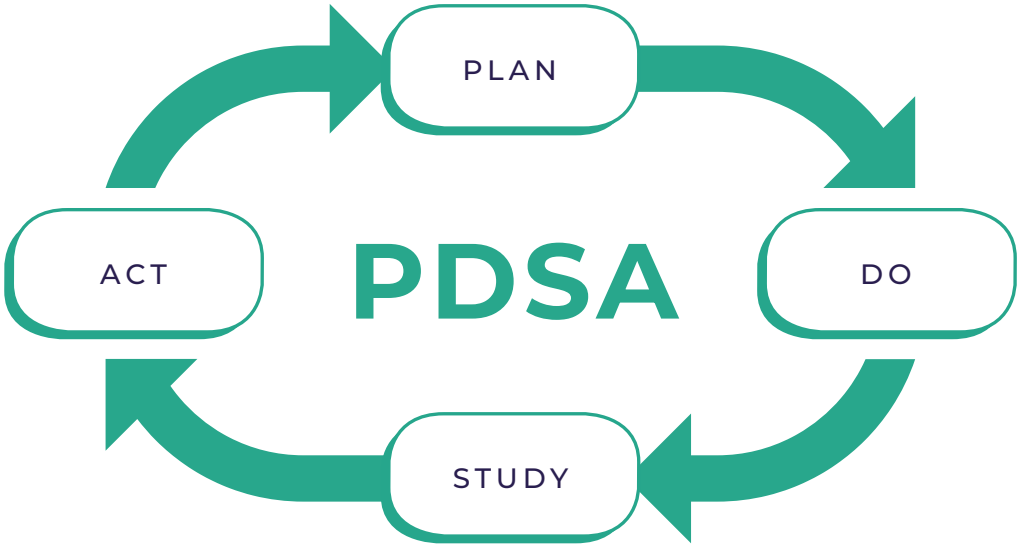
Office for Victims of Crime, Blueprint for a Vicarious Trauma-Informed Organization: Step 3: Determine priorities and develop an action plan.
https://ovc.ojp.gov/program/vtt/where-do-we-begin-contd/step-3

How to Improve: Model for Improvement | Institute for Healthcare Improvement (ihi.org)

VI. IMPLEMENTING TRAUMA RESPONSIVE CARE: ORGANIZATIONS

D. IMPLEMENT CHANGES

Use the Plan, Do, Study, Act model to implement and test small changes within the care your team provides. Weave trauma responsive care concepts into patient rounds, provider rounds, and team debriefs. Measure outcomes.



Resources & References:

How to Improve: Model for Improvement | Institute for Healthcare Improvement (ihi.org)

Quality Improvement Essentials Tool-kit:
https://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx

E. TRAIN STAFF

Provide regular opportunities for staff to receive training in Trauma Responsive Care and de-escalation strategies. Teaching staff to understand secondary traumatic stress and providing opportunities for teams to support each other and debrief challenging situations can reduce burn out and help staff experience compassion satisfaction.

VII. SECONDARY TRAUMATIC STRESS

A. UNDERSTANDING SECONDARY TRAUMATIC STRESS FOR HEALTH CARE PROFESSIONALS

Secondary traumatic stress is frequently experienced by health care providers when they are directly exposed to the trauma of others. Recognizing signs of secondary traumatic stress is essential to maintaining the wellbeing of healthcare professionals.

Secondary traumatic stress can happen to anyone and is particularly common in the health care field. It is important to support self-care for yourself and team members and to recognize when your level of stress is increasing.

> *"SECONDARY TRAUMATIC STRESS* ***IS A NORMAL RESPONSE TO ABNORMAL EVENTS."***
>
> **– Laura Vega, DSW, LCSW**

COMPASSION SATISFACTION

- Postive feelings from competent performance and relationships with colleagues
- Work that makes a meaningful contribution

SECONDARY TRAUMATIC STRESS

- A normal response to the exposure of another person's trauma
- Other Terms: Compassion Fatigue, Vicarious Trauma

BURNOUT

- Emotion exhaustion and depersonalization
- Reduced feelings of personal accomplishment

VII. SECONDARY TRAUMATIC STRESS

B. SECONDARY TRAUMATIC STRESS: MANIFESTATIONS

- Irritability
- Difficulty concentrating
- Feeling angry/cynical
- Intrusive or recurrent disturbing thoughts
- Sleep problems
- Feeling emotionally detached
- Overly aware of any signs of danger
- Hopelessness
- Guilt
- Avoiding reminders of difficult experiences
- Social withdrawal
- Chronic exhaustion
- Physical ailments
- Diminished self-care
- Feeling ineffective
- Feeling down or depressed
- Feeling apathetic

C. ORGANIZATIONAL STRATEGIES FOR CREATING A SECONDARY TRAUMA-INFORMED CULTURE

The Office for Victims of Crime provides improvement strategies specifically focused on shifting a work culture into one that is trauma responsive both for patients and staff. Effectively managing secondary trauma in the workplace is essential for employee retention, wellbeing, and quality care for patients. The **Vicarious Trauma Toolkit (VTT)** defines a "vicarious trauma-informed organization as one that proactively assumes the responsibility to recognize and address the needs of staff in these five evidence-informed areas of organizational health:

- Leadership and Mission
- Management and Supervision
- Employee Empowerment and Work Environment
- Training and Professional Development
- Staff Health and Wellness"

Resources & References:

The links below include steps for becoming vicarious trauma informed, and resources for implementing changes:

Blueprint for a Vicarious Trauma Informed Organization:
https://ovc.ojp.gov/program/vtt/blueprint-for-a-vicarious-trauma-informed-organization

The National Child Traumatic Stress Network: Creating Trauma-Informed Systems:
https://www.nctsn.org/trauma-informed-care/creating-trauma-informed-systems

VII. SECONDARY TRAUMATIC STRESS

C. ORGANIZATIONAL STRATEGIES FOR CREATING A SECONDARY TRAUMA-INFORMED CULTURE (CONTINUED)

According to the CDC, the implementation of stress prevention programs in hospital settings has resulted in a 50% reduction in medication errors and a 70% reduction in malpractice claims. (Stress At Work, The National Institute for Occupational Safety and Health (NIOSH). Centers for Disease Control and Prevention. 1999 DHHS (NIOSH) PUBLICATION NUMBER 99-10)

Stress prevention programs may include:

- Policy changes
- Psychoeducation
- Skills training
- Staff retreats
- Clinical group supervision
- Case conferencing
- Self-report screening
- Workplace self-care groups
- Work/life balance
- Flexible scheduling
- Employee assistance programs
- Use of evidence-based practices

D. SELF-CARE STRATEGIES AND TOOLS

Organizations are encouraged to support the health and wellness of their staff by devoting time and resources to employee self-care, prioritizing employee health, and building employee wellness into policies and procedures. In addition to organizational level changes, there are steps individuals can take to support themselves.

See Appendix H: For Self-Care Strategies and Tools, as well as the ABCs of Provider Self-Care: Awareness, Balance, Connection

E. RESOURCES & REFERENCES

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VII. SECONDARY TRAUMATIC STRESS

E. RESOURCES & REFERENCES (CONTINUED)

- Perry, Bruce, M.D., Ph.D. (2014). The Cost of Caring: Secondary Traumatic Stress and the Impact of Working with High-Risk Children and Families. Child Trauma Academy. (ojp.gov) https://ovc.ojp.gov/sites/g/files/xyckuh226/files/media/document/sts_impact_on_child_advocates-508.pdf
- The Center for Victims of Torture. (2021). Core Concepts – Handouts. Professional Quality of Life (ProQOL). https://proqol.org/self-care-tools-1
- The National Child Traumatic Stress Network. (2008). Child welfare work & secondary traumatic stress. Child welfare trauma training toolkit, module 6: Managing professional & personal stress – Activity 6C: Supplemental handout. https://tnchildren.org/wp-content/uploads/2014/11/Secondary-Trauma.pdf

APPENDIX A: EMOTIONAL REGULATION: BODY BASED EXPERIENCES

Consider what is needed: up-regulation and energizing, or down-regulation and calming? Offer guidance and do the activity with the child.

Rhythmic, Repetitive, Motor Activities: Walking, rocking or swinging, standing and swaying, dancing or just listening to music, drumming or tapping, coloring, rolling or gently tossing a ball back and forth, butterfly tapping.

Proprioceptive Experiences: Yoga or stretching, jumping on a trampoline, pressing hands together, pulling hands against one another, self-hugs, pressing hands against skull, jumping jacks, running in place, push-ups, planks, crunches, resistance/exercise bands, weighted blankets, body socks…

Sensory Experiences: Aromas, tastes, savoring a food, tea/warm drinfks, ice water/cold drinks, moving air (fans), music or white noise, brighter or dimmer lighting, warm blankets, sunshine, hands in ice water or holding an ice cube, cold compress…

APPENDIX B: EMOTIONAL REGULATION: BREATH WORK & MINDFULNESS

Mindful Breathing: Begin breathing and focus on the physical sensations. Rise and fall of chest, air through nose/mouth/throat, heartbeat, whatever arises. When distracted, simply return to focus. 3-10 minutes. Reflect on experience at the end.

Belly Breathing: Same as above, with hand on belly. Deliberately inhale by expanding belly (vs chest), and exhale by contracting belly. When distracted, simply return to focus. 3-10 minutes. Reflect on experience at the end.

Count Breaths: Begin breathing and count each exhale, 1-5, then begin again. When distracted, simply return to focus. 3-10 minutes. Reflect on experience at the end.

Box Breathing: Inhale for a count of 4, hold breath for 4, exhale for 4, hold empty for 4. Repeat at least three time. Reflect on experience at the end.

4-7-8 Breathing: Inhale for a count of 4 through the nose, hold breath for 7, exhale for 8 through the mouth with "whoosh" sound. Repeat at least three times. Reflect on experience at the end.

Observing an Object: Choose an object with neutral meaning. Spend 3-5 minutes using your senses to observe the object in as much detail as possible. What does it look like, how does light and shadow play out? What does it feel like? What sounds does it make? What might it smell or even taste like? Reflect on experience at the end.

Observing the Environment: What sounds can you hear in the environment? What do you see if you really focus your gaze? What does the environment feel like physically? Can you smell or taste anything? 3-5 minutes. Reflect on experience at the end.

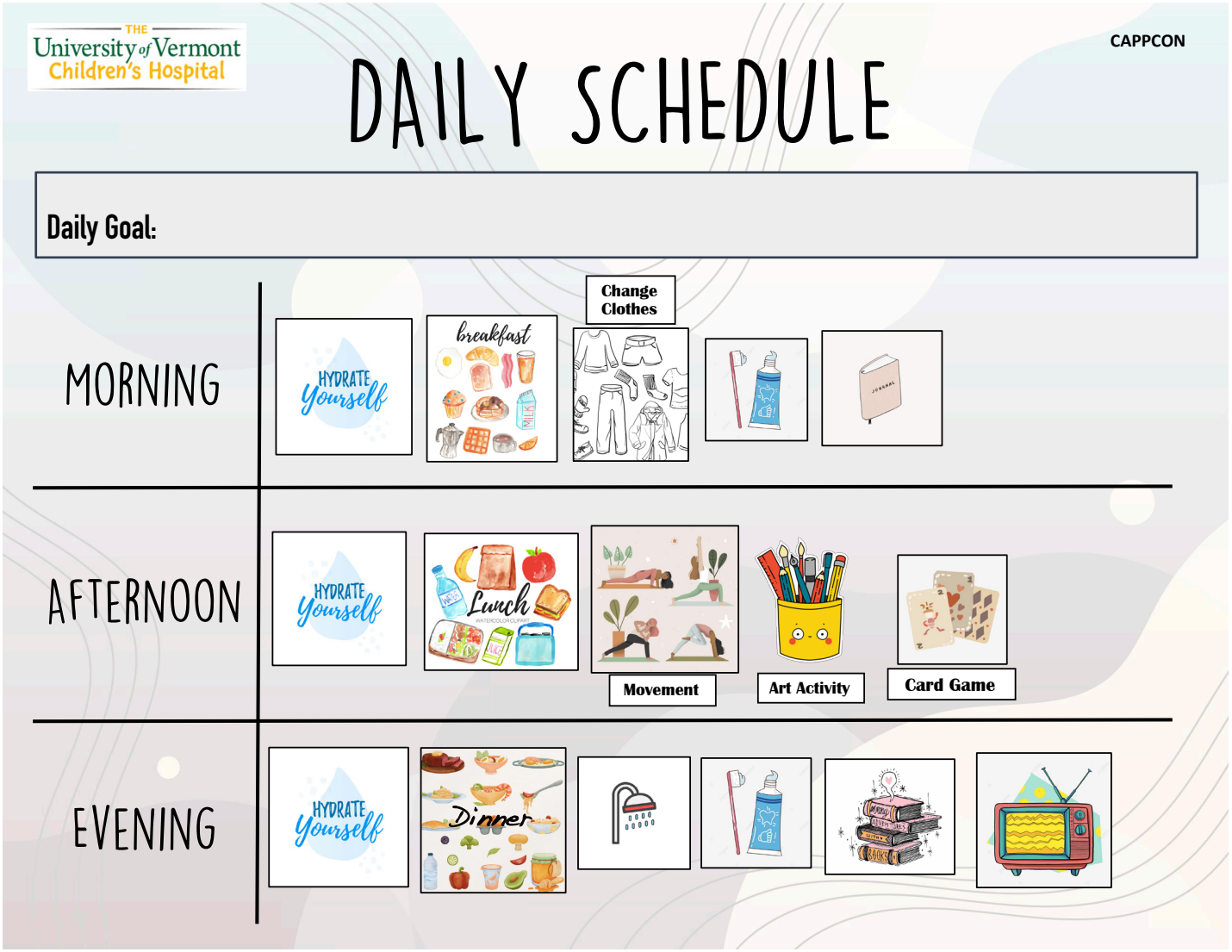
5-4-3-2-1: Carefully notice 5 things you can see, 4 things you can hear, 3 things you can touch/feel, 2 things you can smell, and 1 thing you can taste (or take 1 slow deep inhale and exhale). Repeat until feeling calm. Reflect on experience at the end.

Body Scan: Begin with lower half of body for a couple minutes. Working up from your toes, what do you notice? If there is stress/muscle tension, can you let it relax a bit? Next, focus on your torso, arms and hands for a couple minutes. Finally move to your shoulders, neck, head and face for a couple minutes. Reflect on experience at the end.

APPENDIX C: THE ZONES OF REGULATION

The Zones of Regulation | A Curriculum For Emotional Regulation: https://zonesofregulation.com

APPENDIX D: DAILY SCHEDULE EXAMPLE



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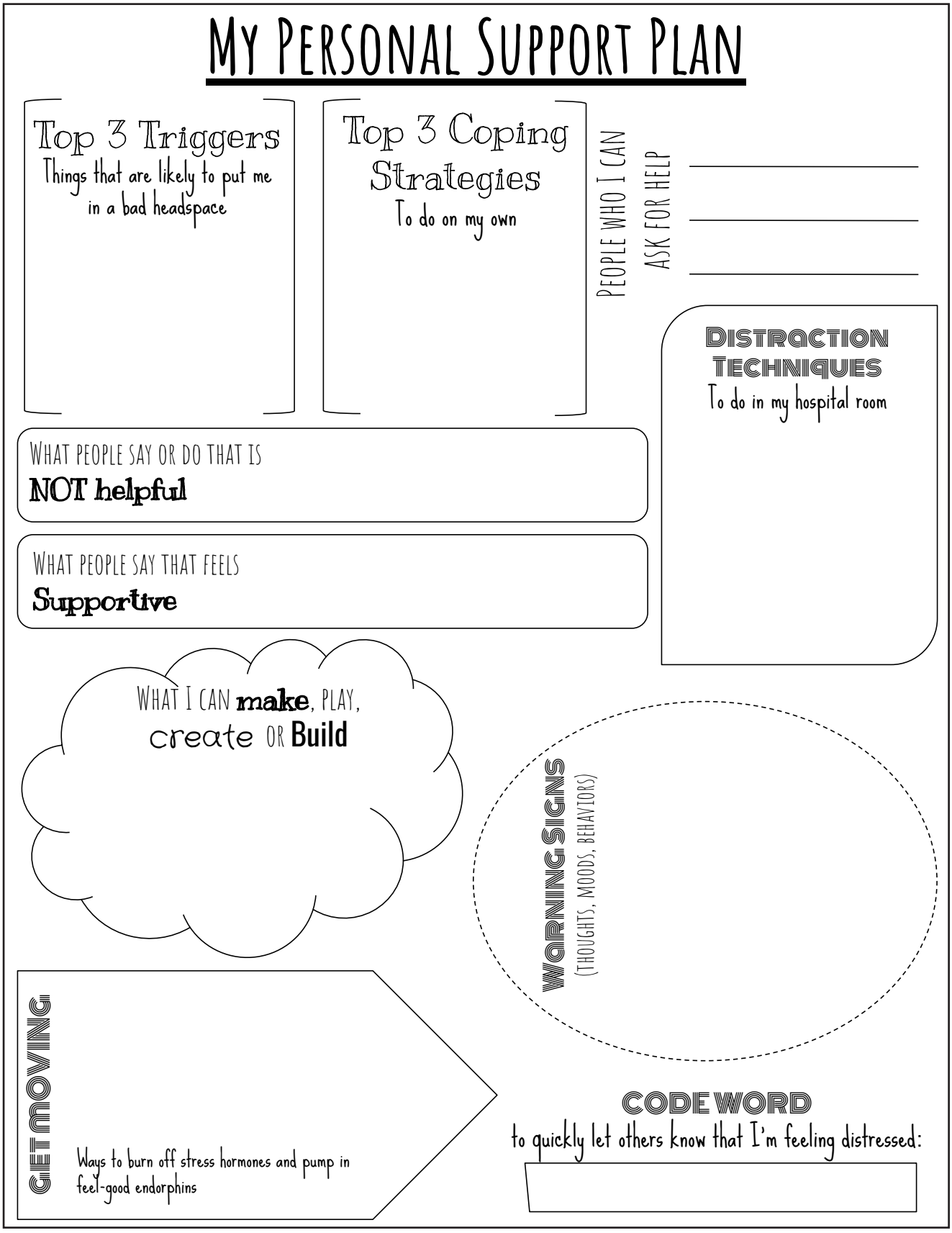
APPENDIX E: PERSONAL SUPPORT PLAN (FOR YOUTH)



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APPENDIX F: "YOU ARE IN THE EMERGENCY DEPARTMENT WITH YOUR CHILD IN CRISIS, NOW WHAT?"

https://mentalhealth.vermont.gov/services/children-youth-and-family/services-and-supports-children-youth-and-family

Remember to Take Care of Yourself

It is important to take care of yourself in this stressful situation. Some things you may find helpful are to:

- call family or friends who can be with you or support you over the phone
- take a break and go for a walk or get something to eat or drink (ask about vending machines or a café available to you)
- ask whether there is a quiet space such as a chapel or meditation area that you can use
- request to speak to a patient advocate at the hospital who may be able to help you
- seek out a place you can shower or attend to your personal hygiene
- consider asking family or friends to bring cards, games, or books to help pass the time

We hope you find this brochure to be helpful as you navigate this difficult journey. The brochure is a collaborative effort of the Vermont State Interagency Team, families, and providers.
http://ifs.vermont.gov/

NOTES

For Information and/or Support about Mental Health

Vermont Department of Mental Health
at 1-802-241-0090,
https://mentalhealth.vermont.gov/individuals-and-families

The DMH works with private nonprofit agencies in Vermont to provide mental-health care through our Designated Agencies. The DMH website offers resources, information about each local area Designated Agencies, and information about how to access services.

Vermont Federation of Families for Children's Mental Health at
1-800-639-6071,
https://www.vffcmh.org/

The Vermont Federation of Families for Children's Mental Health supports families and children and youth, ages 0-22, experiencing or at risk to experience emotional, behavioral, or mental health challenges.

National Alliance on Mental Illness Vermont (NAMI-VT) at
1-800-639-6480,
http://namivt.org/support/family-groups/

NAMI-VT provides information about mental health and offers supportive resources to families, including a free family support group in different areas of the state.

Vermont Family Network (VFN) at
1-800-800-4005,
https://www.vermontfamilynetwork.org/

VFN has been helping families of children with special needs or disabilities for more than 25 years. They listen and help with any needs or concerns you may have related to you or your child's health, education, or well-being.

You Are In The Emergency Department With Your Child In Crisis

NOW WHAT?

Being in the Emergency Department with your child can be scary and confusing. Please remember you are the expert on your child and you know their strengths and what works best for them. It is important to share this with others. You may feel worried, overwhelmed and alone. Please know there is support for you.

It is OK to Reach Out.
It is OK to Ask Questions.

Questions You May Consider Asking

…About What Will Happen While We Are Here:

- What if English is not my first language?
- How will you engage with my child if they are non-verbal and/or they use a specialized communication device?
- Who oversees my child's care? Is this the person I should speak to if I'm concerned about my child's symptoms increasing or if my child is not safe?
- What does "meeting criteria" mean and how does this affect planning for my child?
- What does it mean to be voluntary or involuntary?
- How are you creating a safe space for my child while in the ED?
- Who do I contact at the hospital if I have concerns about the care my child is getting?
- Can I be with my child the whole time my child is here? Who else can visit my child?
- How can I call someone if I don't have a phone or my cell phone isn't working?
- What is the Wi-Fi password for the hospital?
- What items can I bring to comfort my child? Food? Stuffed animals? Music? Toys?
- Who is the attendant sitting outside my child's room and what is their role?
- If I need to leave for a while, who do I tell?
- Who do I ask to speak to if I'm calling to check on my child?
- If I have a community team, how can they connect to my hospital team?

…About Possible Options For My Child:

- If my child stays here at the hospital-what will happen? Who will my child see? Will my child be OK? How long can my child stay here?
- Could medication be helpful for my child? Who can I talk to about this?
- What services and supports can be put in place so my child can safely return home? Who do I need to talk to? What are things that I need to consider? Safety to me and my child and my family is _____ _____ _____ _____ and we need _____ _____ _____.
- If my child can't safely return home immediately what are the choices we have?
  - Where are the crisis beds that may be appropriate for my child?
  - What can the crisis beds offer?
  - How long can my child stay there?
  - Is there a minimum number of days? A maximum number of days?
  - What are the expectations there?
  - Can I visit them or talk to the people there before my child goes there?

People Who Can Help Me

Below is a chart you might find useful as you consider your child's care and needs. These are some of the people you may see, interact with or want to contact while in the Emergency Department. When you talk to people who are caring for your child you may find it helpful to keep notes of what you talked about and when. It is hard to remember details in stressful situations.

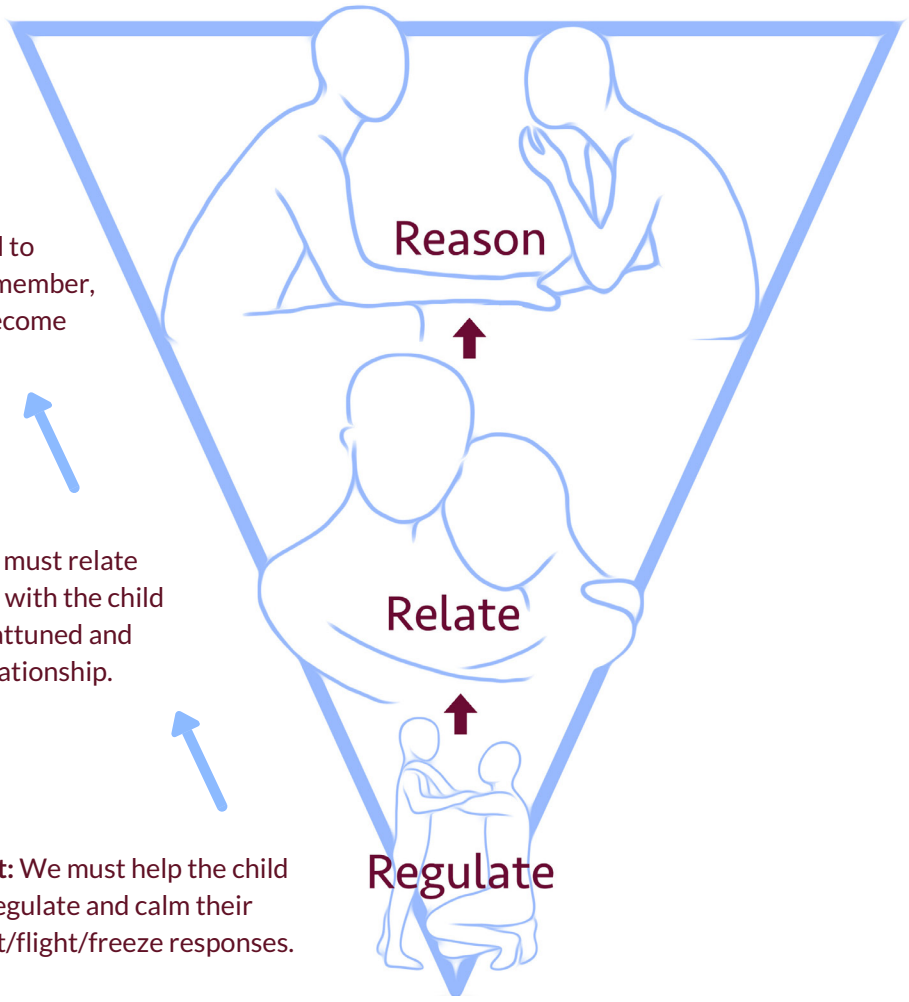
Who Can Help?	What is their name and contact information?	When did we talk?	What was said?
Crisis Screener/Emergency Personnel from mental health agency (Designated Agency)			
Hospital Psychiatrist			
My child's nurse			
My child's doctor or primary care physician			
Hospital Social Worker			
Vermont Federation of Families or other support organization			
Hospital Patient Advocate			
Emergency Personnel involved in bringing my child to ED			
My child's therapist or case manager (if applicable)			
My child's school			
Other:			

APPENDIX G: THE THREE R'S: REACHING THE LEARNING BRAIN

Beacon House
Therapeutic Services and Trauma Team

The Three R's: Reaching The Learning Brain

Dr Bruce Perry, a pioneering neuroscientist in the field of trauma, has shown us that to help a vulnerable child to learn, think and reflect, we need to intervene in a simple sequence.



Third: We can support the child to reflect, learn, remember, articulate and become self-assured.

Second: We must relate and connect with the child through an attuned and sensitive relationship.

First: We must help the child to regulate and calm their fight/flight/freeze responses.

Heading straight for the 'reasoning' part of the brain with an expectation of learning, will not work so well if the child is dysregulated and disconnected from others.

www.beaconhouse.org.uk

FOLLOW US @BeaconHouseTeam

APPENDIX H: SELF-CARE STRATEGIES FOR PROVIDERS

Here are several quick strategies that can be used when your stress level is high while on a shift.

2 Minute Strategies:

- Breathe
- Stretch
- Day-dream
- Step away from assignment
- Laugh
- Give yourself a compliment
- Look at the window
- Share a joke

5 Minute Strategies:

- Listen to music
- Chat with a coworker
- Step outside for some fresh air
- Have a snack
- Grab a cup of coffee or tea
- Mindfulness activity

FOR THE PROVIDER: WORKING WITH TRAUMATIZED CHILDREN AND FAMILIES (ABCs of Provider Self-Care)

AWARENESS	• Be aware of how you react to stress (overworking, overeating, etc.). • Monitor your stressors and set limits with patients and colleagues. • Talk to a professional if your stress affects your life or relationships.
BALANCE	• Diversify tasks and take breaks during the workday. • Eat sensibily, exercise regularly, and get enough sleep. • Engage in activities outside of work; use your vacation days.
CONNECTION	• Connect regularly with family, friends, and community. • Use meditation, prayer, or relaxation to connect with yourself. • When not at work, disconnect from professional role and email.

Adapted from Saakvitne, K. & Pearlman, L. (1996). Transforming the Pain: A Workbook on Vicarious Traumatization for Helping Professionals who Work with Traumatized Clients. New York, New York: W.W. Norton and Company.