

Home Visiting Issues and Insights

Creating a Trauma-Informed Home Visiting Program

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The Impact of Trauma on Children and Families

Trauma affects a significant number of people in the United States (Gilbert et al., 2015; National Council for Community Behavioral Healthcare, 2011). According to one of the largest studies completed on childhood abuse and neglect, approximately 66 percent of adults have been exposed to at least one violent traumatic event in their childhood, and nearly one-quarter have been exposed to three or more categories of adverse events, including childhood abuse, neglect, and household substance abuse (Centers for Disease Control and Prevention [CDC], 2016).

While there is no standard definition of trauma, many organizations and studies agree that trauma is the result of an event (or a series of events) that is harmful or threatening to an individual and has long-term damaging effects on a person's well-being (Menschner & Maul, 2016; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Such traumatic experiences can include physical, emotional, or sexual abuse; substance abuse or mental illness in the household; parental separation or divorce; witnessing violence; neglect; and living with a mother who has been abused (CDC, 2016).

Trauma in childhood, including maltreatment and neglect, can affect the physical structure of a child's brain, which in turn affects the growing person's ability to regulate his or her behavior and emotions, as well as higher cognitive functions, memory, ability to learn, and overall physical and mental health (Child Welfare Information Gateway, 2015). People who are exposed to trauma or toxic stress in their childhood have a higher likelihood of smoking, substance abuse, risky sexual behavior, depression, anxiety, adolescent pregnancy, and intimate partner violence (American Academy of Pediatrics [AAP], 2014; CDC, 2010; Dube et al., 2003; Noll, Shenk, & Putnam, 2009; Ports, Ford, & Merrick, 2016; Raposo, Mackenzie, Henriksen, & Afifi, 2014). Exposure to trauma in childhood can also affect how a person raises his or her own children (Lomanowska, Boivin, Hertzman, & Fleming, 2015; Stevens, Ammerman,

Putnam, & Van Ginkel, 2002). Prolonged trauma can affect a person's relationships with others and is associated with high parental stress, severe parenting attitudes, a greater risk for child abuse, and disrupted attachment with the child (AAP, 2014; Ammerman et al., 2013; Lomanowska et al., 2015; McKelvey, Whiteside-Mansell, Conners-Burrow, Swindle, & Fitzgerald, 2016).

The Prevalence of Trauma in Families Served by Home Visiting Programs

Home visiting programs often reach families who have the highest level of need. For example, according to Stevens et al. (2002), approximately 70 percent of the women surveyed in a home visiting program had experienced at least one violent trauma in their lifetime. Mothers in home visiting programs have also been found to have more elevated rates of depression than those of the general population (Ammerman, Putnam, Bosse, Teeters, & Van Ginkel, 2010).

The [Mother and Infant Home Visiting Program Evaluation](#) (MIHOPE) is one of the largest random-assignment studies to date that assesses the effectiveness of home visiting programs in improving a variety of outcomes, including maternal health and child development (MDRC, 2016). Launched in 2011, MIHOPE plans to recruit more than 4,000 families, randomly assigning them to either a Federal Home Visiting Program (also known as [Maternal, Infant and Early Childhood Home Visiting](#), or MIECHV) or another community service (Michaelopoulos et al., 2015). Initial findings, taken from surveying the first 1,600 mothers enrolled in the evaluation, found that 10 percent had experienced intimate partner violence in the past year and approximately 40 percent exhibited symptoms of depression or anxiety (Michaelopoulos et al., 2015; Office of Planning, Research, and Evaluation, 2016).

Both the rate and the likelihood of trauma exposure among children are also significantly affected by a variety of community factors. In both rural and urban areas, children living in low-income communities are far more likely to experience violence and trauma (U.S. Department of Justice, 2012). This can be compounded by the fact that impoverished communities often do not have access to the necessary resources to help caregivers address the effects of such trauma on children's development (U.S. Department of Justice, 2012). As over three-quarters of families in MIECHV live at or below 100 percent of the Federal Poverty Guidelines, these community factors and how they can affect childhood development is significant for home visiting (Health Resources & Services Administration, 2015).

The Importance of Trauma-Informed Approaches in Home Visiting Programs

A trauma-informed approach is one way that home visiting organizations are teaching their staff to recognize the effects of trauma and to work with families in a thoughtful way. Trauma-Informed Care is a perspective through which an organization realizes the impact of trauma on its families, recognizes the signs of trauma, and uses that understanding to improve client engagement, outcomes, and organizational services (Menschner & Maul, 2016; SAMHSA, 2014). According to Kennedy (2015), "In its simplest form, trauma-informed care is a way of thinking about and responding to families' struggles" (p. 1).

Home visiting can play an important role in alleviating the intergenerational transmission of trauma by helping parents and caregivers build positive and healthy attachments with their children. A safe environment and nurturing relationships are two important protective factors in a child’s life that can foster resilience and help to outweigh the long-term effects of trauma (AAP, 2014; CDC, 2014).

A trauma-informed approach can also help prevent burnout and turnover among home visiting program staff, which ultimately impacts retention, success, and well-being among the families served.

Becoming a Trauma-Informed Home Visiting Program

Building a trauma-informed home visiting program requires leadership, buy-in, self-knowledge, and intentionality. Programs must gather the right partners, ask important questions, and develop strong systems-level goals that focus on home visiting and early childhood community needs. In other words, it doesn’t happen overnight! As noted by JBS International Inc. and the Georgetown University National Technical Assistance for Children’s Mental Health (2016), “Becoming a trauma-informed organization can be a lengthy, gradual process and one that requires ongoing effort” (p. 5).

Consider the recommendations below and then ask yourself: *Is our program as trauma-informed as it needs to be? If not, what steps do we need to take to get started on or move further down this important path?*

- Engage in deep, thoughtful reflection, discussion, and exploration of what it means to be *trauma-informed*.
- Assess your organization’s readiness for change by taking a wide-ranging look at all aspects of the organization (e.g., developmental screening and surveillance, maternal and child mental health), and then make a plan of action.
- Train staff on recognizing the symptoms of trauma and how to talk to families about it.
- Incorporate screening for trauma, and ensure that those administering screening have been prepared to deliver it in a supportive way.

Note: The National Center on Early Childhood Health and Wellness offers a number of excellent resources on this; in particular, see [Breaking Through: Video and User’s Guide to Understand and Address Toxic Stress](#).

- Integrate evidence-based practices for providing trauma-informed care, such as those available through the [National Technical Assistance Center for Children’s Mental Health](#).
- Identify resources within the community; make strong connections and form partnerships with community agencies that offer treatment and supports for families who have experienced or are experiencing trauma.
- Support the well-being of your staff as they work with high-risk families.

- Promote awareness of the impact of childhood trauma by sharing issue briefs, infographics, and other publications within the community and through social media.

Note: CDC’s informative and [attention-grabbing graphics](#) are one good way to promote awareness of the long-term effects of trauma.

Snapshots of Success from the Field: Trauma-informed Approaches in Home Visiting

In this *Home Visiting Issues and Insights* information brief, three voices from the field share processes and resources that can support system-level change and sustained community impact:

- Leslie McAllister, Home Visiting Coordinator for the Wisconsin Department of Children and Families, describes the components of the National Child Traumatic Stress Network’s trauma-informed child and family service system framework and how this framework is implemented in the Wisconsin home visiting system.
- Lorrie Grevstad, Federal Project Officer, Region X, Division of Home Visiting and Early Childhood Systems, describes how the NEAR@Home Toolkit brings together evidence from **N**euroscience, **E**pigenetics, **A**dverse Childhood Experiences, and **R**esilience and then applies this science to home visiting.
- Jan Williams, Clinical Supervisor, Healthy Families Durham at the Center for Child and Family Health, talks about the impact of secondary trauma on home visitors, strategies for preventing secondary trauma, and how to identify and support staff who experience it.

Snapshot 1: Integrating Trauma-Informed Principles Within Home Visiting Systems

Leslie McAllister, the MIECHV state lead, shares the Wisconsin Family Foundations Home Visiting (FFHV) program’s approach for promoting trauma-informed practices in home visiting. FFHV has used the [National Child Traumatic Stress Network \(NCTSN\) framework](#) to develop a more trauma-informed statewide network of home visiting programs. According to NCTSN (n.d.), “A service system with a trauma-informed perspective is one in which programs, agencies, and service providers:

- Routinely screen for trauma exposure and related symptoms
- Use culturally appropriate evidence-based assessment and treatment for traumatic stress and associated mental health symptoms
- Make resources available to children, families, and providers on trauma exposure, its impact, and treatment
- Engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma
- Address parent and caregiver trauma and its impact on the family system

- Emphasize continuity of care and collaboration across child-service systems
- Maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff resilience.”

McAllister notes the importance of examining and strengthening the overall organization’s culture and philosophy regarding trauma practices, as well as the importance of working directly with children and families. Several studies and organizations (Davis & Maul, 2015; Kennedy, 2015; Menschner & Maul, 2016; NCTSN, n.d.) recommend Trauma-Informed Care (TIC) principles for adjusting both an organization’s culture and its direct-service processes. FFHV applies TIC principles by doing the following:

- Incorporating specific and layered training and supports for staff and supervisors on participant-centered screening and assessment practices
- Offering monthly groups that are facilitated by a trained infant mental health consultant and that build reflective capacity among staff and supervisors
- Creating communities of practice that provide a regular venue for peer-to-peer support
- Integrating information, resources, and activities for parents into home visits
- Providing opportunities for group socialization, which promotes protective factors that can strengthen families and support children’s optimal social and emotional development
- Providing additional professional development opportunities for staff (through the Maternal Depression Project, among other important resources) to more effectively support mothers with significant trauma histories who are at risk for maternal depression or anxiety

Wisconsin’s FFHV incorporates a variety of screens, including the ASQ-SE2 and the Childhood Experiences Survey—a tool developed by the state’s evaluation team to measure an array of potentially traumatic childhood events experienced by parents in home visiting services. Based on concerns noted by program staff, the state and its evaluation and training/technical assistance (TA) partners have identified several strategies—including tip sheets and other materials, on-site coaching, webinars, and a one-day training for supervisors—to help support more confident and competent administration of these tools. McAllister notes that in this way, the state and its partners have helped home visitors become more attuned to both children and parents during the home visit. By clarifying for staff how knowledge of a participant’s trauma history can enhance case planning and services, they have also helped to ensure that services are consistent with TIC principles.

Reflective practice groups and communities of practice help home visitors learn more about how their own experiences shape their interactions with families, while also providing opportunities to discuss and solve problems around issues related to burnout, compassion fatigue, secondary trauma, and strategies to more meaningfully engage with the high-needs families they serve.

As part of its trauma-informed approach, with a focus on building child and family resilience, Wisconsin has recently begun to more intentionally integrate the Strengthening Families framework into home visiting practice and professional development. For example, the introductory training, *Home Visitation Foundations*, has been updated to reflect goals for practice-grounded TIC principles and promotion of the protective factors that research has shown mitigate the negative impact of trauma. At the program level, while staff use their home visits to address trauma and child development, they have also partnered with local early care and education programs to engage parents in meaningful conversation and positive social interaction through parent-led Parent Cafes that use the [Strengthening Families framework](#).

McAllister adds that The Maternal Depression Project helps address the needs of mothers with significant trauma histories who are at risk for depression, as well as their babies. Participating home visiting program staff receives intensive training and TA—both *in vivo* and through the use of video replay—from experienced infant mental health practitioners on dyadic coaching to promote healthy parent-child relationships. This has been instrumental in increasing the confidence of home visiting program staff to work with mothers with the mental health issues that go hand-in-hand with exposure to trauma, while also providing meaningful and culturally respectful parenting support for very high-risk mothers.

Snapshot 2: Addressing TIC at the Regional Level with a Toolkit

A good name for the story shared by Federal Project Officer, Lorrie Grevstad, is “It takes a region.” Grevstad shares that the four states in Region X, supported by their Project Officer, TA Specialist, and two experts with deep knowledge of and experience with NEAR (Neuroscience, Epigenetics, Adverse Childhood Experiences, and Resilience) science and ACES (Adverse Childhood Experiences) research and practice, took the seed of an idea about bringing together the four aspects of NEAR science and transforming them into a practical tool for home visiting programs and home visitors.

Grevstad remembers that it all began at a 2010 regional meeting, right at the start of the MIECHV Program, when ACE Interface LLC co-founder Laura Porter presented a plenary session on ACES that really hit home with many conference attendees. ACES continued to be a theme and a topic of conversation at regional meetings. Then, during a 2013 regional meeting, state recipients made a collective decision to transform their conversations into action. An ACES planning committee comprising subject-matter experts, state recipient staff, home visitors, and model developers was formed, and tasked with creating a toolkit that translated complex NEAR science into an easy-to-understand, easy-to-use resource.

The [NEAR toolkit](#) contains a plethora of resources for use in any home visiting community, including information on the science behind NEAR and how to become NEAR-informed. The toolkit also includes a theory of change, core elements of a home visit, a readiness checklist, and information on how to apply Continuous Quality Improvement to the NEAR approach.

Note: The authors ask that those who download and use the toolkit share their experiences, which will inform revisions and improvements to future editions.

Grevstad says that as the toolkit is being piloted by [Thrive Washington](#)—devoted to advancing high-quality early learning, with a commitment to innovation and equity, throughout Washington state—home visitors and their supervisors use its protocol of asking, listening, affirming, and remembering the life experience of each parent, including his or her ACES history, to promote resilience. Program managers, local implementing agency (LIA) leaders, and state administrators can also use the Near@Home resources to assess their organizational practices and increase their efforts to promote TIC at a system level through their communication and outreach efforts, partnerships, and efforts in connecting at-risk families with the resources they need.

Snapshot 3: Addressing Secondary Traumatic Stress

Because of the emotional toll of listening to and helping a highly traumatized population, home visitors are themselves at risk: Studies show that up to 26 percent of professionals working with traumatized populations and up to 50 percent of child welfare workers are at high risk of secondary traumatic stress (STS) (NCTSN, 2011). Also known as *compassion fatigue*, STS diminishes the quality of life of home visitors and can affect their emotional and even physical well-being. Symptoms of STS include insomnia, chronic exhaustion, guilt, hopelessness, an inability to listen, avoidance of families, anger, and cynicism (NCTSN, 2011). According to NCTSN (2011), the risk of STS for an individual is higher when that person is female, is a highly empathetic individual, has unresolved trauma in her or his own life, has a heavy load of traumatized families, or feels inadequately trained for the position. Ways to mitigate STS include informal self-assessment strategies, caseload balancing, use of a self-care buddy system with professional colleagues, and effective reflective supervision (NCTSN, 2011).

Jan Williams, clinical supervisor and past program director of Healthy Families Durham, a MIECHV-funded home visiting program, is aware of how the stresses of working with families experiencing trauma and listening to their traumatic stories can lead to STS for home visitors. Williams believes that reflective supervision helps home visitors develop coping skills and resiliency. Reflective supervision is characterized by three key elements (Heller & Gilkerson, 2009):

- Reflection (“stepping back” to consider the work from multiple perspectives, including how the work is emotionally affecting the home visitor)
- Collaboration (respectful mutual exchange that allows for creating solutions together)
- Regularity (a mutually determined and set schedule for supervision)

Williams notes that supervision should be offered in a “safe” environment, at regular times, in a reflective manner. Safety is created by offering regular supervision times with predictable routines for the session, in a confidential manner, and by building a relationship of trust between the home visitor and the supervisor.

Williams shares the following tips for LIAs and program managers to prevent STS and to support staff who experience it:

- Build awareness among all staff—from administrators and supervisors to home visitors themselves—about STS and its signs and symptoms. Include information about STS in the orientation packet for newly hired staff, and provide agency-wide trainings on STS at least once a year. Encourage supervisors to include information about STS in supervision sessions, to monitor home visitors for symptoms of STS, and to encourage self-care.
- Consider using a screening tool with staff, such as the [Professional Quality of Life tool](#), at least once a year. Follow up by having staff develop an annual, individualized, and confidential self-care plan.
- Assess the level of family risk, and use this information to balance caseloads so that no home visitor is overwhelmed by too many families experiencing intense trauma, even if that home visitor is particularly strong at working with these types of families. Research shows that the percentage of families experiencing trauma in a home visitor’s caseload has more impact on secondary trauma than the number of families assigned to that caseload.
- Supplement individual reflective supervision with peer group supervision. In Healthy Families Durham, home visitors take turns presenting a case, sharing where they feel successful, where they feel stuck, and how the case is impacting them emotionally. Care is taken to ensure that traumatic details are limited and that the process helps participants focus on how the case is affecting the home visitor. Note: The process can feel more supportive to the home visitor if the structure is clearly established ahead of time and if there is encouragement for comments to be strength-based and empathic.
- Create a culture of wellness in the agency by setting up a “wellness committee” that reinforces work-life balance and supports self-care activities. Foster clear boundaries; for example, do not expect home visitors to answer their phones or respond to e-mails after work hours, and do not engage in conversations about trauma in public places in the workplace, such as halls, bathrooms, or break rooms. Encourage home visiting programs to plan a “team day” off-site with team-building activities that are relaxing and fun.

Note: When STS is already present, increasing access to high-quality reflective supervision by adding additional time or additional sessions may be essential. Occasionally, even reflective supervision is not enough to meet the needs of a home visitor with persistent symptoms of STS, and additional mental health support outside of the agency may be needed.

Healthy Families Durham is part of the Center for Child and Family Health, and Williams says that being part of a larger organization that is also trauma-informed and supports trauma-informed practices has made it easier for Healthy Families Durham to monitor and prevent STS. Administrators at the agency understand STS and value self-care and work-life balance, even allowing an hour of work time each week to be spent on self-care activities planned by the wellness committee. Off-site team days are encouraged a couple of times a year, and budgets are designed to allow supervisors the time to provide regular, high-quality reflective supervision. STS information is included in the orientation packet, reminder trainings are held

throughout the year, and supervisors are encouraged to monitor staff for STS symptoms and to continue to ask questions about self-care.

Research shows that inadequate supervisory support is directly related to staff turnover (Hodas, 2005). It is to each organization's advantage to put time, energy, and money into the supervisory process.

Creating a Trauma-Informed System of Care

Neal Horen, director of the Early Childhood Division at Georgetown University Center for Child and Human Development, offers this summation of the above snapshots:

Home visiting programs at both the state and territory recipient and LIA levels have a unique opportunity to change the life trajectory of children and families. While there are so many demands put on organizations and on home visitors, trauma is so important and needs to remain central to the work. The consequences of not addressing trauma are that millions of family's mental health needs go unnoticed, and thus go untreated.

Everyone in the home visiting community, from the regional level to the state/territory and LIA level, has a role in developing a robust trauma-informed system of care. As Dr. Horen adds:

You can't be trauma-informed by yourself. Everyone needs to be trauma-informed in order to have an impact on children and families. This type of trauma-informed system of care comes from the top down as well as the ground up. High-level decision-makers and policy-makers are important, but so are local agencies and organizations doing direct work with high-need children and families.

Consider this story:

A young mother in a home visiting program in Chicago has spent several months in weekly, sometimes daily, contact with a doula, who is helping to prepare the mother for the birth of her first child. As this relationship has grown, the mother has disclosed many of the traumatic experiences she has been through in her 18 years. The doula realizes that this mother would benefit from working with a community service agency, such as a mental health consultant, and she helps bridge that connection. As the support group around this mother grows, the doula and consultant help the mother realize that she has a strong desire to provide a more promising future for her unborn child. Together, they connect the mother with the local home visiting program, in anticipation of the support she will need once her baby arrives.

The home visitor's first in-person contact with the mother goes smoothly, as the home visitor is aware of the mother's traumatic history, and the mother is relieved that she doesn't have to immediately bring up much of her past but can instead focus on her present and on being the best mother she can to her newborn. The home visitor comes to the first meeting well-informed on the impact of trauma and the warning signs to look for, and she is well-equipped with strategies to help the mother cope, develop nurturing and strong parenting skills, and have a hopeful outlook for herself and her child.

Together, individuals from several systems of care were able to work together to connect this mother with mental health services immediately, rather than wait until the need became more extensive and complex. From her prolonged work with high-risk families, the home visitor is also aware of the effects of stress and has a support system to take care of her own mental health, which in turn helps her take better care of the mental health of those she supports.

To develop a trauma-informed system of care, state/territory leaders must understand and be committed to the concept that home visiting doesn't stand alone but rather is part of a bigger early childhood system that includes the child welfare system, child and adult mental health services, and the juvenile and adult justice systems, among others. As the above story shows, creating a successful trauma-informed system of care requires (a) providing professional development and training for home visitors working with families who have experienced trauma, (b) collaborating across systems to support the family's many needs, and (c) fostering awareness of the stress associated with helping high-needs families, and ensuring that home visitors take good care of their own mental health.

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