PERSON-CENTERED AND TRAUMA-INFORMED PRACTICE

Foundational Concepts & Elements of Transformation
Core Elements

• The individual is the expert on his/her life
• Focuses on natural supports
• Maximizes self-determination and choice
• Maximizes community connections
• Identifies an individual’s hopes, capacities, interests, preferences, needs, and abilities
Person-Centered Practice

• This is a philosophy, not a specific technique

• The beliefs of person-centered practice, when adopted, will come to infuse all aspects of an organization’s functioning

• The centrality of the person as the locus of control in a web of services and supports/resources defines the essence of person-centered practice

• Practice is a collaborative process. The professional brings their experience and expertise. The individual brings their personal expertise.
What Does A Person-Centered Organization Look Like

• Individual choice is evident
• Client’s voice is used in treatment plans – goals are in his/her own words
• Treatment decisions are made collaboratively
• Clinical and administrative processes that affect clients are transparent to all
• Families and natural supports are actively incorporated in treatment
What Does A Person-Centered Organization Look Like

• The structure of the organization is person driven not program driven

• A menu of services promotes choice and customization

• Nothing about us without us – transparency

• Efforts are made to retain and gain natural supports, connections, and integrations
Trauma-Informed Care

• Many of the features of person-centered practices are essential elements of an organization delivering care in a trauma-informed way.

• Safety, collaboration, trustworthiness/transparency, choice, and control and empowerment are shared elements between the two

• As part of the transformation process, organizations will integrate person-centered, trauma-informed, strength-based, recovery-oriented principles
<table>
<thead>
<tr>
<th>Trauma-Informed</th>
<th>Non Trauma-Informed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition of high prevalence of trauma</td>
<td>Lack of education on trauma prevalence &amp; “universal” precautions</td>
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<tr>
<td>Recognition of primary and co-occurring trauma diagnoses</td>
<td>Over-diagnosis of serious mental illness</td>
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<td>Assess for traumatic histories &amp; symptoms</td>
<td>Cursory or no trauma assessment</td>
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<tr>
<td>Recognition of culture and practices that are re-traumatizing</td>
<td>“Tradition of Toughness” valued as best care approach</td>
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Trauma-Informed vs. Non Trauma-Informed

**Trauma-Informed**
- Caregivers/supporters – collaboration – constant attention to culture
- Address training needs of staff to improve knowledge & sensitivity

**Non Trauma-Informed**
- Rule enforcers – compliance – emphasis on power and control
- “Patient-blaming” as fallback position without training
Trauma-Informed vs. Non Trauma-Informed

**Trauma-Informed**

- Staff understand function of behavior (rage, repetition-compulsion, self-injury)
- Objective, neutral language
- Transparent systems open to outside support

**Non Trauma-Informed**

- Behavior seen as intentionally provocatively
- Labeling language: manipulative, needy, “attention seeking”
- Closed system – outside support discouraged

(adapted from Fallot & Harris, 2002; Cook et al., 2002, Ford, 2003, Cusack et al., Jennings, 1998, Prescott, 2000)