

Building a Trauma-Informed Community Across All Levels of Care-20251212_153247UTC-Meeting Recording

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Simon-Ulysse, Phanide 0:11

Clubhouse Coalition. Today we'll explore essential strategies for implementing trauma-informed care across all various levels of engagement. We are pleased to have 3 distinguished speaker and I will allow them to introduce themselves. I'll give the floor to you, Julie, who will introduce herself first.



Julie Sprenkle she/her 0:29

Great. Thank you so much, Fineet. We apologize for the late start. We're having a few technology hiccups, but we're going to get through it. My name is Julie Sprinkle. I am the Dual Recovery Project Coordinator for the Massachusetts Clubhouse Coalition. I want to thank MBHP for hosting today's.

Training again on building a trauma-informed community across all levels of care. I am here with two of my esteemed teammates from our dual recovery project, James Terrio, who is a certified peer specialist and works for DMH Central Mass, and Zach Vasino.

Who is the LADAC Director for Community Counseling of Bristol County and is one of our project consultants. So happy to have you along with us today and you'll hear more from them later on. OK, so I think next slide.

Excellent. Thank you. And just want to give a a shout out to Caitlin Sudal, who's doing our technology for us. She's also one of our consultants. OK, so I'm going to kick things off by sharing a little bit of my story. So I am a licensed clinical psychologist in Massachusetts. I was licensed.

In 2007, after completing my training in Southern California in San Diego, I am from Massachusetts, so was happy to come back here with my husband, who I met in Southern California, bring drag him out here into the cold weather and the snow. And start practicing in 2007 after some mentorship with some psychologists out here. And we lived in the Berkshires. I practiced mostly child and family psychology until 2012.

At that point I had a toddler at home, a 15 month old, if you can call him a toddler at that point, and I did have a family history. We're going to talk about different types of trauma. I had a family history of intergenerational trauma.

Racial based. I had some vicarious trauma that I was experiencing and I also had what's called developmental trauma from my childhood. So kind of a potpourri of challenges I had experienced at that throughout my, I would say teen teenhood.

I had experienced some hypomanic symptoms, so mild manic symptoms and also some mild to moderate depression. All of that was being treated and managed through my journey to become a psychologist and then certainly afterwards.

And I thought I had it all under control. Don't. Don't we love to think that? And then what happened was I had some postpartum that kicked things into high gear. And I had in 2012 my first major psychotic break, which included.

Everything that a psychotic break can, including delusions, hallucinations, voices. And today, in 2025, I still hear voices regularly. So of course, at that point I couldn't practice anymore. So what do you do when your life's?

Inspiration is no longer at your fingertips and you don't have that outlet and and I will say that the mania and the bipolar symptoms played off of the trauma that I was experiencing that I experienced as a child.

And then I was re-traumatized during my break, my psychotic break. So I did end up with PTSD as well. And I know I'm throwing a bunch of labels at you, but I just want to kind of give you a introduction into some of the trauma education we're going to do today.

And also a little bit of of a personal flair. My recovery journey began through peer support meetings that were offered through the Kiva Center in Worcester. I hope that you all know about the Kiva Center, and if you don't, definitely look it up. There are some great resources.

And one of the peer support meetings I went to was held at Crossroads Clubhouse in Hopedale. Um So I went to the clubhouse after hours, not knowing what this location was. It was this big old mansion in Hopedale.

And they I said, what is this place? It's so cool. And they said it's a clubhouse. Have you heard of a clubhouse? And I said no, there are 36 clubhouses in Massachusetts. It's an international program. This clubhouse model is international.

And over 30 of our clubhouses here in Massachusetts are accredited by Clubhouse International. Every city and town in Massachusetts has a clubhouse that is part of of the programming of that town, so.

For example, Hopedale. I was living in Franklin at the time where I do live now, which is right next to Foxboro, and I was in the catchment area of Crossroads. So I learned that instead of staying home with a toddler and psychosis.

I could go and participate in what's called the work order day. It's a non-clinical model. It's a therapeutic environment. It's a vocational rehabilitation, but a clubhouse offers all types of opportunities around certainly employment, but also socialization, education.

And skill development, housing, and most importantly, improved Wellness.

So I began going to Crossroads every day and I was able to put my son in daycare, just like as if I were going to work, and was really fortunate to become a part of the longest running Dual Recovery Anonymous meeting in the Northeast.

So Dual Recovery Anonymous is a twelve-step fellowship for people in recovery from any addiction and any mental health challenge. And I was struggling with food and food addiction. Certainly being on a lot of mental health medication was not helping. And they said come along to our meetings. And I said this is not just for drug and alcohol. And they said no, it's not. It's for everyone. It's about Wellness and healing. And and I started going and took to it like a fish to water. So that was 11 years ago. I was fortunate enough.

Enough to get hired by the Massachusetts Clubhouse Coalition in my current role as the Dual Recovery Project Coordinator, and we help to support over 60 Dual Recovery Anonymous meetings across the state through state funding and also funding partners such as MBA.

HP The MCC's goal is to create environments and practices that acknowledge the impact of trauma and promote healing and resilience. OK, so let's move on to the next slide.

All right, so here's a little bit about MBHP's mission to prioritize trauma-informed behavioral health care. I think these bullets at the bottom are really just beautiful, so I'm going to read through them real quickly. It says ensuring a safe environment is fundamental to encouraging members to seek care, building trust through transparent practices.

Create a collaborative space that empowers personal involvement in one's care decisions and recognizing the diverse experiences of trauma influenced by cultural, historical and gender focus. All right, next slide.

Learning objectives for today. OK, first I just want to say please feel free to take notes if you like. We will send you the slides and also there are some great articles at the

end that you will have access to. Please keep your cameras off out of respect for the ASL interpreters.

We will do Q&A through the chat feature and we'll stop to take a look at at Midway if we have time and then also at the end depending on how much time we have. And certainly you'll have my contact information and you can reach out to us with any questions you might have afterwards as well.

Here are our learning objectives. Reflect a solid awareness of trauma. Obtain A comprehensive understanding of the impacts of trauma. Identify the six principles of trauma-informed care. That's SAMHSA's 6 principles.

And establish the need for trauma-informed care on every level of engagement. Next slide.

All right, here's a little icebreaker just to get people feeling comfortable with the chat. Why is trauma-informed care important to you? How have you applied trauma-informed care to your organization or treatment coordination? And please post your answers in the chat. We would love to hear from you.

From you. OK, next slide.

All right. With that, I'm I'm just so happy to introduce Zach Fasino from Community Counseling of Bristol County. Take it away, Zach.

ZV

Zachary Visinho 10:26

Thank you, Julie. So again, my name is Zachary Vecino. I work for multiple ACCS programs in the Southeast area in contract with the Department of Mental Health. I work as a licensed alcohol and drug counselor and I appreciate everybody being here today.

So when we talk about defining trauma, there's no singular way to define trauma. So what we're going to do is give you a general sense of a definition of trauma, and then we're going to go into detail about specific types of traumas. So when we're defining trauma, the word trauma literally means wound.

Shock or injury. Psychological trauma is a person's experience of emotional distress resulting from an event that overwhelms the capacity to emotionally digest it, and that is taken from Psychology Today.

Another definition from SAMHSA. Research shows that traumatic experiences are associated with both behavioral health and chronic physical health conditions, especially those traumatic events that occur during childhood.

It is important to understand the nature and impact of trauma and to explore

healing. Next slide please.

So.

Some people might have heard of big T and little T traumas. We are going to define them today as singular versus cumulative events. I like that wording better when we talk about big trauma versus little trauma and we use those definitions, right?

Sometimes it can separate the types of traumas.

Right. And we never want to do that because what's most important to understand is that trauma is trauma is trauma, right? To say that one type of trauma might be worse or more detrimental to a person than another type of trauma is doing that person an injustice. And so to define them as singular versus cumulative events.

As opposed to big and little, we're just using different language. That's all it comes down to. But when we talk about a singular traumatic event, or a big T trauma as often referred to, these are events that are widely acknowledged as traumatic.

Such as natural disasters, severe accidents, physical or sexual assaults, and other catastrophic occurrences that pose a serious threat to one's physical or emotional health. They are often sudden and intense.

Leading to immediate and severe psychological distress.

When we talk about cumulative traumatic events or little T traumas, in contrast, cumulative events are chronic, repetitive experiences that, while not life-threatening, can accumulate and cause significant emotional and psychological damage.

Examples include ongoing parental criticism, chronic feelings of inadequacy, workplace bullying, or persistent financial stress. These experiences may seem minor individually, but their cumulative effect over time can be deeply damaging.

So.

When we talk about a singular traumatic event, right, those are the ones that when we think of trauma, most often we think of singular traumatic events. So if a person that we're working with or a person that we know experienced a sexual assault as a child.

That is a singular traumatic event. That is something that is easily defined can be. Kind of categorized more specifically into a certain thing. When we talk about a cumulative traumatic event, right, we're talking about more persistent continuous trauma that happens over a period of time that builds up, right? And to say that one of those might be more damaging than the other is not necessarily.

True, because when we talk about cumulative traumatic events.

Chronic criticism, for example. And if you grow up in a household where you're

experiencing continuous chronic criticism, what does that look like over a period of time that leads to feelings of inadequacy or self-doubt? And then what does that turn into? That turns into anxiety, depression, other mental.

Health issues, right? So there's a behavioral impact to that that is pretty significant. So when individuals experience little T traumas or cumulative traumas, they're going to develop maladaptive coping skills, avoidance behaviors.

Very commonly leading to substance use, which is something I deal with on a regular basis. Other forms of self-destructive behaviors, overeating. Julie just mentioned a perfect example of how that can affect somebody over a period of time and what that looks like the subtle nature of these traumas.

Oftentimes make them harder to identify and harder to address, but cumulative traumas are the most common reasons that people end up in clinical settings or in individual therapy as opposed to the singular traumatic events. So when we look at it from a clinical lens, if.

Anybody here has ever been in an environment where you've done individual therapy or you've been in a clinical setting, or you've worked in that field before and you've worked in that setting, right? What's one of the first things that we do when we're meeting a person or we're dealing with a person or a client or a person served? We do a biopsychosocial.

Assessment, right. And So what are the questions that we ask that person? We ask them about their genetic predis genetic predispositions. We ask them about, you know, what was their lifestyle like? What was their housing like? What was their access to, you know?

Social factors and family dynamics. We ask them what are your social supports like and what are the quality of those social supports like more importantly and and how are you engaging in them and how are you engaging in your community, right?

There's a a very intentional reason.

That we pose these questions to people and we're getting to know them and we're trying to figure out, you know, what their life looks like and how we can best serve them. And the reason for that is because when somebody identifies a singular traumatic event, right, we can address that in in a way that might be similar.

To the cumulative traumatic events when we're talking about how they build up over a period of time and so.

The the real, the real message here, right, when we're talking about types of traumas, is that.

We need to be informed and we need to be educated, right? And we need to know what we're dealing with in order to be successful in our roles here. And so information and knowledge is power and.

I like to always start off a conversation when I'm getting to know somebody in a subtle way about what their life has looked like over a period of time and why they've gotten to the place where they've gotten to, right? And so when we talk about these types of traumas or traumatic events.

Building up and leading, we get into our next slide. If you can switch over Caitlin for me.

And we talk about the progression of trauma, right? And post-traumatic stress disorder is something we've we've often heard, but you can't have PTSD without the without the trauma, right? So the trauma comes first, whether it's a singular or it's a cumulative trauma and the development of that over time.

Leads to something called PTSD, which is a pretty common term that a lot of us have heard. And how common is PTSD? So most of us in this room, there's hundreds of people in this room, right? Most of us will experience at least one traumatic experience or trauma in our lifetime that.

Could lead to PTSD. However, most people who go through a traumatic event will not develop PTSD. And so when we're talking about the difference in that is Julie and I could be in a car together, right? We could be driving down the highway and we could get T-boned by a car the way Julie is going.

To process that mentally, physically and emotionally might look different than the way I'm going to process that mentally, physically and emotionally, based off of our perception of the the event, based off of our social supports, how we're processing it. There's so many layers to how it can affect a person and so most.

Often it might not developed into PTSD, but when?

A person is, is, is going through that experience and reliving that trauma, right?

That's when PTSD comes about and that's when we start to adjust the PTSD. So when we get to statistics, I'm a numbers guy. I really like looking at the breakdowns of it.

So about 6 out of every 100 people, which is 6%.

Of the population in the United States will have PTSD at some point in their lives. So again, if we're looking at this room and there's 300 people.

1820 people or so, right, will have experienced some type of PTSD at any point in their life, even if their symptoms do go away. About 5 out of every 10 adults or 5% experience PTSD in any given year.

Women are more likely to develop PTSD than men. About eight out of every woman, or 8%, and four out of every 100 men, or 4%, will develop PTSD at some point in their life. So 8 out of 100 women, four out of 100 men at some point in their life will have PTSD.

This is in part due to the types of traumatic events that women's women are more likely to experience, such as sexual assaults compared to men. So when we talk about PTSD and PTSD symptoms, there are types of PTSD symptoms that are important to acknowledge. So for some people.

Well, it might be intrusive memories or intrusive thoughts.

Um.

That can look like unwanted, distrusting memories of the traumatic events, replaying over and over again, or reliving the event as if it were happening in the moment, like a flashback, right? Or upsetting dreams or nightmares. I I work with people that. Have identified they don't like to go to bed at night because when they sleep they have nightmares and it brings them back to that moment, right? That is an intrusive memory and intrusive thought that's directly correlated to a post traumatic stress disorder. It can also.

Come out in avoidance, right? So someone experiencing PTSD who's had traumatic experiences might avoid certain situations. So they might have had a bad experience in a car. I'll go back to that example, right? I work with somebody who will not drive on the highway.

They will not drive in their car on the highway. They will not be a passenger in a car on a highway because they had a very traumatic accident that happened on a highway when they were younger and they will do anything they can to avoid driving on a highway. And I've driven with this person on a.

Semi highway before and they had a full blown panic attack. We had to pull over. We pulled off the next, you know, possible side road and.

It was. It was just interesting to see that that moment in itself presented the same exact way as the traumatic experience would, even though it wasn't, you know, in the moment happening at that time because they were reliving that moment.

Right through their PTSD. Um.

Another example is that, you know, there's also negative thoughts about self, negative thoughts about other people in the world, ongoing negative emotions of fear or blame, or a lot of time it comes out as guilt and shame about the experience that happened and the trauma that they're experiencing.

Changes in physical and emotional reaction. So sometimes when we're talking about PTSD, we see an actual physical reaction or an emotional reaction. So somebody that gets easily startled or easily frightened when they're in a large room or a large group of people.

Um.

People that are very guarded, right? Or they're always on guard for something dangerous that can happen. One of the things I deal with most regularly is self-destructive behaviors, right? Substance use.

Alcohol use, right? Dealing with the emotion and trying to cope with it in a way that's maladaptive, but.

The person doesn't even realize that they're in the self-destructive cycle of behaviors, right? And so.

There are so many different ways to talk about trauma and there are so many different types of trauma and I just want to end with, you know.

Be mindful when we're talking about trauma that no one trauma, whether it's singular, whether it's cumulative, whether it's post-traumatic stress disorder, no one trauma is better or worse than another type of trauma. It's an individualized thing that we have to be aware of in the person.

Because no two people react to a situation the same. No two people process information the same. And just because we look at a situation and we might process it from our lens as it not being something that's traumatic or not being distressful, we can't assume that another person isn't experiencing this a different thing than we are, right?

So be mindful of that. And I'm going to pass it over to James. And while he talks, it's something we can all think about on the way we process information as opposed to the way someone else might process information. So next slide, please. And James, I'm going to hand it over to you.

J James 24:58

Awesome. Thank you, Zach. My name is James. I'm a certified peer specialist for Department of Mental Health Central Mass area and I work out of the Fitchburg site office and the next slide identifying symptoms of trauma.

One mental intrusive thoughts, flashbacks, nightmares, difficulty concentrating.

Two emotional intense fear, anxiety, persistent sadness, hopelessness, irritability or numbness. 3 Biological sleep disturbances, fatigue, physical pains, heightened,

startled response.

4 Narrational negative self-perception and excessive guilt or shame. 5 Relational avoidance of people, places or activities, social withdrawal and isolation, and six behavioral increased substance use.

Or other risky behaviors, difficulty trusting others.

So trauma dictated. You know, I look back and trauma really dictated my whole life. And looking back, that's how I see it today and you know, being a person and.

Long-term recovery for over 26 years now. I never knew what trauma was. I didn't understand trauma. And it wasn't until about four years ago when I met my current supervisor at the Department of Mental Health who introduced me to Julie.

And the dual recovery community that I finally began my own trauma recovery journey, so.

The only way I know how to present this slide is from lived experience, so I'm probably gonna hop around to the different symptoms through pieces of my experiences.

Um.

You know, I kind of when I look through the slide, I look at the last one and difficulty trust and others and you know I kept going back and I'm looking at that and the only thing I come up with and it's when.

You know, the thought that I have is when people are supposed to love me, hurt me. How can I trust anybody? And I didn't. I had a very hard time trusting and it didn't make good for any relationships in my life.

I avoided people, I avoided places, I avoided activities, definitely socially would draw and would isolate. And before I got sober and in recovery, you know how I dealt with that was drinking.

You know, I could fit in when I drank. You know, I could be part of things. I could go to events and activities, and as long as I was drinking, I'd be OK.

You know, it made it easier for me with that. And you know, when I got sober, not really understanding for years in recovery, not understanding that, you know, and I am going to use the word suffer. I was suffering from past traumas.

And I had no idea. And it wasn't until 10 years into my recovery that I actually had said something to somebody and was evaluated, you know, and you know, being around a good community in recovery, it did make it easier for me.

It's gotten a little better, but in situations like that for myself, even today, the only difference is, is I really know what's going on now. But you know, when I'm in the

middle of a crowd, all my senses are on high alert. I'm very hyper.

Vigilant and you know, and I never really knew what was going on and and just grateful that I do today because I can work through it. Sleep disturbances. You know, I had nightmares from the time I was a kid.

And you know, I somebody had mentioned, you know, there were nights I wouldn't want, even as an adult, as a kid, as a teenager, as an adult, I wouldn't want to go to bed because I I didn't want to experience those nightmares, you know, and.

I still have nights, but it's nowhere near like it used to be. I have many more good nights sleeping than than not, you know. But it wasn't until my mid 30s, a few years into recovery, that they started lessening and finally stopping.

And they were always violent, always violent.

You know, I have had in like the last, I'd say, year and a half. You know, I have a son who's very close to my heart, obviously. And you know, he is in a situation experiencing something I experienced in the past, which was prison.

And.

I won't get into some things he's gone through all myself, but you know, knowing my own son is in that situation, you know, I started having nightmares again about things that have happened in prison, about things I've seen and and again, just violent.

I was always very hopeless. I had dreams and goals and you know, but and negative self perception. I I, you know, I was never good enough. You know, I can't do that.

They're better than me. Not good looking enough. I'm not smart enough. I don't fit in. And somebody like me, you know, didn't deserve those good things.

And you know, intrusive thoughts. I never really kind of understood what those were until I realized I was having them and and I did pull something out.

That I wanted to share. Intrusive thoughts are unwanted, often disturbing ideas, images, or impulses that pop into your mind unexpectedly, causing distress and interrupting focus.

But they don't reflect your true desires of character, and there's some common types. Harm, thoughts of harming yourself or others, and often the opposite of what you would actually do. And I had thoughts of that.

Relationship doubts. You know, not trusting anybody. Every single relationship I was in, I I didn't trust and and it didn't make for a long my relationship lasting too long.

You know, worries about your partner or fears of cheating, feeling alone.

Um.

You know, and religious or moral worries about being sinful or impure, question who you are, what is right, what is wrong. And I was always confused with things like that and safety.

Catastrophic. What if scenarios about loved ones or yourself? And you know, I throw my son back in there again because, you know, being in recovery for a long time. That was something that really hit my heart and and really stirred some things up. You know, um.

I wasn't diagnosed until I was 43 with PTSD, general anxiety disorder, ADHD and major depressive disorder and I look back and I was always anxious and still from day-to-day can be and always full of fear and.

You know, and that intense fear that it mentions here.

I was always waiting for something bad to happen. Always something bad was going to happen, especially if I was in in a big crowd or around a lot of noise, and I wanted to throw something in here.

Um.

Intense fear. I had somebody say to me years ago when I was trying to get sober, that all anger comes from fear. And I was very angry. I was an angry kid. I was an angry teenager, young adult, angry man.

And you know, and full of shame and guilt for that and many other things. But what I have learned in my recovery.

Is that anger was my trauma response pretty much to everything, and it kept me safe.

It isn't who I am.

Wasn't who I Am. Anger isn't who I was then, and it isn't who I am now. It was a safety mechanism for me, and I'm going to share a little story before I move on. We move on to the next slide.

Within the last four years I I've been on this journey with trauma recovery. I I had this conversation with a friend and it was about the traffic and I'd get caught up in road rage and.

Always very anxious in traffic. Still today, but nowhere is near as bad. Traffic hasn't changed, but I have. And that conversation with this person sometime after that, I can't remember if it was days later, a week later, I'm driving down the highway and I'm heading to work.

And the traffic was being traffic. And for the first time I said to myself, as I'm assessing everything going on around me, that it has nothing to do with the traffic

and has everything to do.

We're feeling safe.

Had everything to do with feeling safe and had nothing to do to do with the traffic.

And all my life.

All I wanted to do was feel safe.

And.

I was able to say while I'm driving, it's, you know, while I'm, you know, my driving's getting a lot better. It's not personal anymore. It's not about the traffic anymore. It's about me feeling safe. And there are things I can do in the traffic to help in certain situations that may.

That make me feel anxious. I don't have to get angry and I don't have to get upset.

And we can now move on to the next slide.

So Sam says 6 principles of trauma informed care.

And look at #1 safety.

This word alone has been very become very important to me.

In the community that I'm in, in my life, and when I walk out the door.

That people feel safe.

You know, and so ensure physical and emotional safety for individuals receiving care.

And I have a few examples.

You know, like in healthcare, a nurse explains each step before touching a patient.

Education teachers post daily agendas to reduce uncertainty, and in counseling, a therapist checks in about comfort and pacing.

You know, I know my therapist does that and appreciates that. I've had other therapists that just want to dig in a spot that I'm not ready to dig in yet. And I shut right down and I there are times I hadn't gone back. You know, I believe people's journey. It's an individual thing.

And it's what you're comfortable with. And listening to people and hearing what they have to say and being concerned and caring could be a big help in their own recovery #2 trustworthy.

Trustworthiness. Build trust through transparency and consistency and practices.

And again, here are a few examples.

Healthcare providers explain why sensitive questions are asked. Education.

Clear grading criteria and predictable routines and counseling, confidentiality and limits are explained up front.

So I actually looked, you know, when it says healthcare and the providers, I have the

most amazing primary care doctor and I've been with her pretty much almost all. I actually have been with her all my recovery, so for 20 some odd years.

And you have this person that's a licensed medical doctor that says to me when I have certain health questions or whatever.

I love when she says to me, you know your body better than I do and she works with me and going on to the next one, peer support.

Incorporate support from individuals with lived experience of trauma, and I'll give some of those examples. Healthcare peer mentors guide patients in recovery education.

Students, student mentors help newcomers adjust and counseling and peer LED support groups and you know with peer support.

You know, I love the intentional peer support, the mutuality, because it isn't about me being the worker and you being the person I support. It's about us being peers together.

And when you really get, you know, I really found now I'm somebody that likes to talk a lot, but I know that when I meet with somebody, I really need to listen, especially when I first meet them. I need to really listen. I need to hear who they are. I need to.

Be interested, you know, and the one thing we do as peers in our peer support group is, and I love this because it's not about me, it's about the group. We have a comfort agreement and when we're starting a group.

Let's say our first day. We go around to each individual that gets an opportunity to put something on this list that could be a stressor to them during that group, and we do that together.

And before the group, every time we sit down, we read that and and we can add stuff. We can add more stuff if somebody's comfortable doing that. And again, it goes back back to that word safe. It's about having a safe, trauma-informed environment.

#4 Collaboration. Foster a collaborative environment that empowers individuals in their care.

You know, in healthcare patients help set their own care goals and I and I love that my doctor really works with me on on what I'm concerned with and what I think education students co-create class norms and you think in a classroom it's kind of similar how what we do in.

Our peer group counseling therapist follows clients, pace and priorities.

So.

The next one? Empowerment. Promote individual choice and control.

Over their treatment recovery and I love that.

You know, like in healthcare or even with my own counseling or peer support, you know, cause I I use peer support too and and have other recovery supports and when people sit and talk with me and are interested in my concerns.

And you know, want to know what I think works and walk with me in that it's empowering and I I am going to throw in there because it makes me think of this with the dual recovery project, the leadership development.

You know, I I've done other supports. I still use other supports. I would never criticize any other supports because I wouldn't be here without them. But with the leadership development, people are empowered. It gives them an opportunity to be part of their own recovery and someone else's recovery and.

The training really made me feel like I mattered and being part of that dual recovery anonymous community, I wouldn't be here without it. I wouldn't know a thing about trauma without that community.

Um and #6.

Cultural, historical, and gender issues recognize and address the impact of cultural, historical, and gender factors on trauma experiences.

And here are a few examples. Healthcare use interpreters and offer gender sensitive care.

Education inclusive curriculum representing diverse backgrounds.

Counseling, exploration of cultural roles and beliefs with respect.

One of the greatest things that I I've really come to open my mind to is what other people have to offer me. You know, different cultures, different race, different whatever. And and it's like different ideas, different thoughts, but be interested in what that person has to offer.

You know what I have learned is when I'm sitting there with somebody and I have their own story.

From wherever their cultural background is or or or gender issues, whatever it may be. And they're able to sit there and give you that information and share that with you. You know, that's just showing a deep respect and you know, the person I get to learn new things.

You know, and and I will say when it says healthcare, use interpreters and offer gender sensitive care. You know, if I'm working with somebody.

That speaks 2 languages. I always want to make sure they they're understanding what I'm saying and I always want to address that if I can find another way or somebody else they can work with that they could feel more comfortable with with their language.

Today, it really isn't about me, but it is. And I think that's a part of peer support is the working together kind of thing. You know, it isn't about one or the other. It's about doing it together. And in the last four years, this late in my recovery, I've found that. With people like Julie and Zach and the people that part of the dual recovery community.

And that's it for me. Thank you.

JS

Julie Sprenkle she/her 45:14

Thank you so much James for your moving presentation. I always love hearing you speak and there's some beautiful stuff in the chat if you have a second to look at it responses to your your share and also thank you to Zach who has been working in the field.

As both a peer and a clinician for quite some time, we're we're so grateful to have you both along for the ride with us today. And this leads us to a little bit of time for Q&A in the chat. An example of a question might be. Please share your questions and thoughts around incorporating the 6 principles.

We will be talking about incorporation in our next piece, so hang tight. But if anyone has any pressing questions, feel free to ask them now. I also want to talk a little bit about types of trauma. Zach went over.

PTSD for us, kind of a general understanding of the rates of PTSD and post-traumatic stress. And then James went through some of the symptoms of trauma. I just want to talk about like there's a lot of subcategories and we won't have time to really go over them all at length, but I thought maybe I could talk.

Talk a little bit about them as we see if people have questions as well. OK, so I had talked a little bit about race race-based trauma, so I want to give an example of that. So my mom's side of the family is Jewish and many of them are from Poland and I was very close to.

My great-grandmother growing up, you know, we had family members in Poland who did not survive the Holocaust. And also my great uncle was part was a prisoner of war during the Holocaust as well. And it was very traumatic event for my family and I remember.

As a small child going to visit them all in Brookline, all my great aunts, they all lived in the same apartment complex with their husbands on different levels of the complex. And it was this beautiful experience, cultural experience for me of getting to go and kind of it almost felt.

Like going back in time, you know, to all this old furniture and clothing and music and traditions. But there were some pieces of it that were always very confusing to me as a kid. How could these women who were so excited to see me and so loving also?

Become very harsh and angry and anxious. And I remember my mother kind of trying to reassure me, but also that my mother had that quality in her as well and I never understood the intensity and.

You know, I as a small child started having night terrors. We talked about sleep at sleep disturbances as a sign of trauma and and that was one of mine early on that it was the world seems so unpredictable to me and that people who loved me so much could also be kind of cruel and unpredictable.

Unpredictable at times and and it wasn't until later in life that I started to understand that this was race-based trauma based on oppression and their experiences with the Holocaust and fear.

Around around it. So these categories kind of overlap with each other because there was also the intergenerational trauma piece. So it had gotten passed down from my great great relatives to my grandmother who who also had a lot of intent.

intensity and anxiety and anger at times. And then she parented my mother through that lens and my mother had kind of this um complicated quality to her as well. So it was intergenerational and both with race-based and intergenerational, they they have.

of research that it actually can impact the DNA. So it can get passed down through your DNA, not just through behavioral interactions or interpersonal interactions. Um So there's that those those two examples.

I want to talk a little bit also, since we have some time, about vicarious trauma. So when I was in Graduate School, one of my very best friends was Middle Eastern and she was from Turkey and she decided to do her dissertation on vicarious trauma. So I got to learn all about vicarious trauma because I was one of her support people on her dissertation journey. And one thing she would do is interview clinicians. Specifically, her research was qualitative.

So she did deep interviews of clinicians experiencing vicarious trauma as a response

to hearing other people's, you know, scary and overwhelming life events, life experiences. And you know, we talk about burnout a lot, but I don't think we talk about vicarious trauma.

Enough. I know for me as a clinician many years ago who was treating children and families, I remember one family in particular coming into my office where there was a lot of abuse and that I actually witnessed some of it in my office and that was retrauma.

Traumatizing for me. And I also experienced some vicarious trauma through working with the children involved. So you know that that language wasn't something that was getting tossed around in my clinical supervision and peer supervision very much. It was more.

Words of around, you know, compassionate words around that must be really hard. It must be overwhelming. But the word like vicarious trauma or that language wasn't necessarily getting used. So put a pin in that. Think about that as you're talking language wise with your peers and fellow clinicians and also certainly.

You know, this is something you don't have to be a clinician to experience vicarious trauma. You can be a peer, you can be an administrator, you can be a person in the medical field or nursing. If you hear about someone else's life, life experiences that are scary and overwhelming, that can.

actually impact you as well. And then want to talk a little bit about postpartum PTSD. I remember when I was pregnant with my son meeting with a mom who had just had her child and I said to her, what was the birthing process

Like and gosh, the tone changed. It changed from being excited to have children to scary and overwhelmed and you know, just kind of trying to communicate to me caution and to be prepared.

And I thought, well, this is a layer to childbirthing that I had never heard as vulnerably before. And so I think that, you know, kind of being open to that experience both as clinicians.

But also just as as people who care about others, you know it could be helpful. And then finally moral injuries. So this is this is very common in the veteran world through acts of war where people are doing things as veterans.

Or is military. That would not necessarily be what they would morally do in their day-to-day life. So those are just some examples of different types of trauma, like Zach said.

There are, you know, the the rates that he showed for PTSD from Veterans Affairs are

on there, but the rates that we're going to show in the articles that I'll pull up at the end. So we're looking at like 90% of adults.

Are experiencing trauma at some point in their life. So just because somebody doesn't have PTSD, they could have just recently experienced some traumatic event. They could be dealing with acute stress or just kind of like normal processing from a traumatic event. So trauma-informed isn't just about PTSD.

TSD It's just about creating a trauma sensitive community. OK, so with that we do have a couple minutes left. Any suggestions for harm reduction and addressing trauma in the deaf and differently abled populations?

I think that's a beautiful question. I think that, you know, like Zach said, everybody's experience is different, so making space for.

Their personal interpretations, you know, I think that and this is like super general, but I think that like opening yourself up to really doing the listening like James said would be key. James, Zach, do you want to add anything to that?

You guys are both on mute.

ZV **Zachary Visinho** 55:11

I don't. I don't have anything specifically to add to that. No, I think you said it well.

J **James** 55:17

That should be. I'm all set. Thank you.

ZV **Zachary Visinho** 55:17

There is a.

There is another question too while we have one more minute. How do you balance your boundaries when it comes to having a client who has experienced a similar trauma as yours? And so I think for me personally, having some lived experience and being a person in long-term recovery.

This comes up quite often for me dealing with people who have been in similar situations and I think you know what I always.

Advocate for my staff and try to live by myself is that I need to have my own sense of self-awareness. And so I always tell people even counselors need counselors, right?

Doctors need doctors, clinicians need clinicians. And so for me personally, when I'm. Dealing with that type of situation, I have to make sure that I am in the best possible mental space at that time to be able to deal with it. So how am I processing that

outside of those conversations I'm having with them? Am I seeking supervision? Am I seeking my own individual therapy to work through how to navigate those boundaries?

And still be effective, right? Because it can very easily lead to me, you know, my own stuff kind of bleeding into that or me trying to avoid some of it, right? Like some of the things we talked about and the the coping skills we talked about before, and I need to make sure I can avoid all of those things.

And how do I do that? I need to make sure that I'm in the best possible space to be able to deal with that person if it is overlapping with some of the stuff that I've dealt with. And so in those situations, I always go seek out supervision. I always go seek out individual therapy and and process those. And when I do that, I'm in a much better.

Base to be able to handle those and I'll pass it back over to Julie if she has anything to add on that.

JS Julie Sprenkle she/her 57:15

No, that was beautiful, Zach.

 **Simon-Ulysse, Phanide** 57:16

J.

We do have until 12, Julie, just so you know, I know you said we have a minutes, just making sure.

JS Julie Sprenkle she/her 57:18

Go ahead.

Yeah, this is just the mid, the midpoint Q&A. OK, so one last thing here is about vicarious trauma and burnout. I just wanna again, somebody talked about self-care in the chat.

I just want to reiterate that the importance of self-care, but I also want to say that opening up the conversation with colleagues, with peers, with fellow administrators around vicarious trauma, I think can be tremendously helpful raising awareness. So it's not.

Not just on the person themselves who's experiencing vicarious trauma, but it's the community at large that's appreciative of the intensity of that experience and how it can be impactful. All right, we do need to move on, but we will have more time for

Q&A at the end. So you can do next slide, Caitlin.

Awesome. OK. Thank you so much. All right. So why is it important to be trauma-informed? So healthcare providers as well as administrators must be taught about trauma and how it affects the lives of those they come in contact with. So again, the why, so that 90% rate and for children, it's a

72% rate. So if you think about, you know, the people that were coming in contact with data in day-to-day life, you know, I think that just kind of being mindful and remembering that whether somebody's experiencing acute stress, whether they're just processing a life of

Event. You know, Zach and James both talked about how we we both, we we all process a little bit differently and what might lead to PTSD in one person might not in another. That doesn't mean that the person who just experienced trauma, let's say I'm someone who's experienced A traumatic life event.

But you know, let's just say we had a crystal ball and it's not going to lead to PTSD. That doesn't mean that it's still, it's not overwhelming. You know, we can still experience feeling overwhelmed, feeling sad, feeling angry, feeling confused. So just, you know, the importance of it I think is really around.

In part the frequency of it, that it's just so common in our world. Unfortunately, it's part of being human. OK, next is trauma. Whether physical or psychosocial has profound effects on health and influences how people engage with their healthcare services.

Is so James' slide on the effects of trauma. So one piece of that was that trauma effects trust. So it may take someone who has recently experienced trauma or has PTSD more time to feel comfortable.

Strong listening skills are key to building trust, patience and reliability. And that's true in all environments, whether it's clinical, peer, work environment, medical environment, administrative, you know, just.

J **James** 1:00:21
Mm.

JS **Julie Sprenkle she/her** 1:00:35
Patience, reliability, strong listening and and time. Next, healthcare providers and anchor systems are beginning to learn the depth of the impacts of trauma and how to approach each other with a raised awareness.

So I want to talk a little bit about trauma-informed care. So the term trauma-informed care was coined in 2001 by a series of articles by trauma experts Maxine Harris.

Maxine Harris and Roger Follett, where they talked about using a collaborative approach to care and not causing re-traumatization through delivery methods. This was huge. I mean, it was groundbreaking and it's it was fascinating to me how many articles they put out.

Out in 2001 around trauma-informed care. You can imagine that this was so important to them and that they had been working on this for for quite some time. So if you have a chance, I would dig up some of those articles and the ones that we're going to post at the end of this and you can find on on our slides will lead you to that.

That research as well, and you can always do a Google search. And I was able to pull up the actual articles themselves online, so they are available. So this these articles were the inspiration for SAMHSA's National Center for Trauma.

Want.

Care which was formed in 2005. So this movement has been going on for well over 20 years and I I would like to think that it's now part of our world that this that this training for probably most if not all of you is not the first.

You've been to on trauma-informed care and and I think that's a really good thing. OK. And then finally, trauma-informed doesn't just mean knowing what trauma is and that it causes great harm, but also seeks to be responsive to it.

In a caring and compassionate manner, by raising our awareness, we make space for healing, growth, and organizational choices that reflect the needs of our community. So responsiveness is about implementation, OK? And we're going to talk more about trauma responsiveness versus trauma-informed.

Work hand in hand, and we're hoping you will come away from today's presentation with creative ideas for your work environment, whatever type of environment that is. All right, let's go on to the next slide.

OK, awesome. All right. Developing trauma-informed practices. This is kind of putting the rubber to the road how to be trauma responsive. So first, foster an environment of trust and transparency like James was talking about earlier. So by building supportive.

Collaborative and choice-centered relationships that honor each person's life experiences. You're going to foster this type of environment and create a

collaborative space. It's not about one person telling another person you know what they need to do, who they need.

to be and how they should feel. It's about being open, receptive, and what does it really mean to be a support person? I always like to think of myself as the scaffolding. You know, they're the most important part of the whole the whole thing, and I'm there to kind of help support as they build in

In a really solid way, what they need to build for their own Wellness. OK, next we have established physical, emotional, safe, physical and emotional safety within the workplace workspace.

So creating opportunities for heart-to-heart discussions, you know, whatever your workspace may be, giving honest feedback and taking privacy needs into account.

And and I think that like, you know, any, any message or communication, if we could just, you know, not to walk on eggshells, but rather than be kind of almost judgmental at times, if we could be curious, I think that would be really helpful.

And then this relational strength-based approach is at the heart of trauma-informed care.

OK, finally, communicate frequently, clearly, and honestly. Use a person-centered communication style which focuses on the individual, emphasizes empathy, active listening, and validation to build trust.

And understanding. All right, next we have develop partnerships that ensure all voices are heard. So as a clinician, be sure that you're not again making decisions for your client, imposing your will or making assumptions, empowering.

Our clients through patience, intentionality is key as an administrator, collecting diverse input from everyone involved, putting in the time and making the effort to reflect that the whole community is represented in decision making and this is critical.

Great. Reduce rigid hierarchies and encourage collaborative relationships. So being conscientious about power differentials, I like to see any position of authority as a service position and any bottom line decisions that I that need to be made.

Or boundaries that need to be set on my end will always be imperfect, to be honest. And you know, I will be taking responsibility for those imperfections. So, you know, if I have to make a decision for the whole community, I know that there's going to be some fallout somewhere. And what can I do to manage that? Is there something?

I can do on the front end and and you know, rather than being defensive, how can I be open to feedback? It's my job as the clinician or administrator to be as inclusive

and process oriented. I like to think as possible.

All right. Conduct regular check-ins and provide opportunities for self-care. So encourage an environment of self-awareness and acceptance. Sometimes it can be helpful to be reflective. So I just noticed that I'm starting to feel a little anxious and I'm wondering.

how you're doing. This is a really tough topic. Do we need to take a break? Um One of the modalities that I used as a clinician way back when was exposure with response prevention. And I loved the trainer who trained me. She was from Texas and

She did a really great job at showing us how exposure with response to prevention should actually be the opposite of scary and overwhelming. It should feel empowering and uplifting. And you know, so there's these like subjective units of distress. So you you help.

The person who who you're supporting to communicate what level of feeling overwhelmed they're at? Are they at a level where it's productive and they're excited and yes, they're a little bit anxious and nervous, but it's a good thing and they're hopeful? Or are they feeling so overwhelmed that they're not going to be able to process the information?

And benefit from the treatment. And so when they would start to get to a certain level where it was like rising above productivity, what do you do with that downtime? And people would always say, well, you take a break, but what does that break really look like? And I used to always like to take breaks that people felt excited to take that they were in.

Joyful about talk about a topic that they can't wait the vacation that they're going on and they're so excited about. Or the new car they just got. Or, you know, with kids, we used to like, watch funny YouTube videos and like, howl hysterically and laugh. You know, whatever it is, Sky's the limits. No judgment. How can we give you a break from this intensity for a minute? And then that will translate to day-to-day life. So, you know, feeling overwhelmed.

Take a break. How do I take a break? What does it look like? What are the tools? What are all the different things that I can that I can try to kind of get myself back to a space where I can process information again. So again, with self-care, we talked about somebody asked a question about self-care. You know, what kind of breaks are we taking?

For ourself and we want to promote choice, control and collaboration. OK, create

create trauma informed policies for screening, assessment and treatment planning. So prioritize trauma-informed care, attend regular training such as this one. I like to go to at least one per year. This year I think I'm my rate's a lot higher than that and my team and I make it a topic. We make it a priority, this topic a priority. It's integrated into all of the work we do and and whenever we do trainings, even if it's on a different topic, we're always integrating the language around trauma-informed care into that. So how does that work for administrators? So make sure. On your someone on your staff or everyone on your staff is trained, you know, make it a a requirement. And it can also be helpful to send out surveys where staff can give feedback regarding the prioritization of trauma sensitivity in the workspace. So again, opening up that dialogue, creating opportunities for feedback. OK, assign a key administrator to oversee trauma-informed care. So this is a great tool to use in programs, agencies and organizations. So if.

Organizations. So if it's someone's job, it's not going to be overlooked. Or at least it's a heck of a lot likely. Examples of role responsibilities might include bio breaks, self-care breaks, encouraging that, giving opportunities. What do those look like? What does our community want?

Stress management. How do we handle such stress management in the workspace? You know, if someone needs to put on some sneakers and go for a walk, you know, however long walk is part of stretch management and a bio break. Are we normalizing that and actually making it a good thing as a community?

Or are we, you know, kind of rolling our eyes and feeling frustrated? And you know what? What kind of expectations do we want to set around that?

Making space to talk about upsetting or stressful experiences. So just having it become part of the language of the workspace and you know that can be one of the responsibilities of someone who is kind of the point.

Person for trauma-informed care in the workspace and then finally taking an inventory of staffing needs and brainstorming accommodations.

All right, I think we can move to the next slide.

OK, excellent. Thanks, Caitlin. OK, we're getting there. Trauma sensitivity on the organizational level. So again, this is for administrators. A trauma-informed organization is 1 where all practices and services are viewed through the lens of trauma, so.

In a trauma-informed organization, programs respond empathically to survivor needs, ensure their physical and emotional safety, develop realistic goals, and avoid

re-traumatization. Now let's just make this clear. I don't personally feel like it's a good thing to set an expectation.

Where people have to self-identify as either recently experiencing a trauma or struggling with PTSD or, you know, feeling activated by something that's going on in the workspace. I think that what we want to do is get into the preventative mode and do these things proactively so we're not putting it on the the person.

Who's experienced the trauma to have to self identify. That being said, if the person does want to identify, let's make it part of the community to support and uplift that person by understanding the roles that governance and leadership play in a trauma informed approach within an organization lead and.

Administrators work to establish clear policies that prioritize trauma-informed care across all levels. So in my role with the Mass Clubhouse Coalition as Dual Recovery Project Coordinator, I have administrative responsibilities and what I have noticed over the last 11 years.

Is the more we use the term trauma-informed and the more we make these initiatives a priority, the more compassion, empathy, patience, mutual respect and intentionality I see in myself and the staff whose programming I am privileged enough to.

Coordinate and oversee. So we are making space to deeply care about ourselves and each other on every level. Isn't that an environment that you want to work in? All right. And then next slide.

OK, so here are some trauma support resources that you can use. Again, we're going to make these slides available to everyone. I want to give a shout out to our friends at the Behavioral Health Helpline. They do a great job at of providing trauma resources to people.

The National Alliance on Mental Illness NAMI Mass has some great groups for trauma support that you can find on their website. I'm sure many of you have been to Riverside Trauma Center for trainings. I've gone to several of them myself and they were outstanding, so you can access.

These resources again on the slides. OK, next slide please.

OK. So here are those articles that I was telling you about. So these are recent articles and they touch on all the topics that we talked about here today in a really great way. And all they'll give you statistics and that some of them will also talk about SAMHSA's 6 principles.

Some of them talk about that original research in 2001 and give you some some

information about that. So I I would recommend these articles and they're hyperlinked on our PowerPoint and you can access them that way or you can just Google them.

Alright, next slide.

OK. All right. So just before we get to the final Q&A and I see that there are some great questions popping up in the chat, um please feel free to take down my contact information, our dual recovery project programming.

Is open to the public. We have a Dual Recovery Anonymous certification program. It's a four-month program where we teach you all about the 12 step fellowship of Dual Recovery Anonymous and and help people to have leadership and facilitation skills in the programming and we get people from all over clinicians.

Peers, certainly members in recovery supporters who want to support others. So take down my information. We we are, we are accepting applications for one more week for the the next cycle, the spring cycle, which will start at the end of January.

Just as a plug, the class is on Tuesdays on Zoom from 10:30 to 12:00 and it lasts for four months and you get a certificate at the end that you can hang on your wall if you want. And we also have bi-monthly educational meetings on tons of.

Different types of recovery topics that are pertinent to the month. For example, our November topic was on tobacco recovery for Tobacco Recovery Month. Our July event will be on health equity for Minority Recovery Month.

So every other month we have a topic and again it's open to the public and we have some other programming as well. Our website I posted at the beginning of this presentation, so you can find our website and all of the information on there as well.

OK, next slide.

OK, so it is time for the Q&A. Thank you all so much for all your beautiful shares in the chat. It's been great to see what people are writing and we would love to hear about your successes, challenges, thoughts, certainly questions. We have just a few. A few minutes left. I know Faneet is also going to be posting information for you to get CEUs in a minute or two if they haven't already, I think. Yep. OK, the evaluation is on there, so that's all set. All right, so let's see what people have in the chat.

Oh.

KS Kaitlyn Sudol (she/her) 1:19:11

Julie, do you want me to go ahead and take the slide down?

JS Julie Sprenkle she/her 1:19:16

Yeah, and I actually have some bonus content I wanted to talk about.

ZV Zachary Visinho 1:19:20

So Julie, we have one question here from Tom S So it was regarding your honest feedback point and his question was the difference between genuine honest feedback and harmful criticism.

JS Julie Sprenkle she/her 1:19:25

Right.

ZV Zachary Visinho 1:19:36

And so I think, you know, when we're reviewing that right to get to give a personal example of if we were talking about this presentation and I was giving feedback to Julie, I would say some harmful criticism would need me be saying.

Julie, those slides were too busy. You know, I didn't like this part of it. It was, it was kind of terrible if you ask me, right? That's pretty harmful. It's not helpful, right?

When we talk about feedback, it's like, hey, I noticed on this slide it looked a little busy. I think maybe next time we can split it up into two and it would be helpful for people to kind.

Kind of understands it a little better. So there's the acknowledgement of the situation in two totally separate ways. And so criticism focuses on the past. It focuses on what we don't want. It focuses on the negative where the feedback.

Right. It's helpful. It's solution focused. It focuses on what we can do to improve, how we can work together. And that's the the biggest difference and we're talking about how we're approaching that situation with an individual.

JS Julie Sprenkle she/her 1:20:42

That I love that. Thank you for catching that question, Zach. And I wanted to piggyback on what you just said. One way that I like to kind of address feedback is if I have in my head an area that I feel like could use some workshopping.

What I like to do is ask some open-ended questions around it. I like to know what the other person's thought was around it and just again be be be curious as opposed to judgmental so.

Great question. OK, I do wanna take the last minute or two to talk about healing centered engagement. You can find some stuff on the Tufts University website around this. That is really great.

Healing centered engagement is a holistic framework actively fostering well-being, strength and resilience by focusing on collective healing, cultural identity and future possibilities rather than just deficits or symptoms.

It aims to create positive futures by building on assets rather than just repairing damage. So it's strength based. It shifts the focus from what's wrong with you or what happened to you to what is right with you. And if I could just give a quick plug for dual recovery and.

So I think probably everyone here is familiar with Alcoholics Anonymous. I had some very dear friends when I was in Graduate School who kind of like took me into their fold and they were all part of AA and I got to learn about the value of 12 step recovery.

And one thing that I noticed is that, you know, character defects is part of the inventory of Alcoholics Anonymous, part of the steps. But when you work the steps, your sponsor is often going to become strength based with you and talk to you about what do you have going for you. However, it's not in the steps themselves. In Dual Recovery Anonymous, the founder, Tim Hamilton, in 1989, said we really could use some of that reflection in the steps. And he put language around assets in the 12 steps of Dual Recovery Anonymous, which was founded in 1990 and eighty-nine.

is an offshoot of Alcoholics Anonymous. Most of our members either attend AA or NA, are part of other 12-step fellowships. Um It's a multiple pathways approach. Um But yeah, I just wanted to talk about the importance and value of being strength-based. And again, you can

Google information about healing centered engagement and go to the Tufts University website and there's some great videos on there that I think you can access around it, but it goes hand in hand with trauma-informed care. It's all about Wellness, health and Wellness.

All right, I think we are just about at time and I'm gonna see if I'm gonna put that link to the Tufts website in the chat for you right now so you can access it.

KS Kaitlyn Sudol (she/her) 1:24:04

I got it, Julie.

JS Julie Sprenkle she/her 1:24:05

Oh, you got it. Oh, fabulous. OK, perfect. Awesome. All right. So I think with that, Faneed, we want to thank you for hosting and you know, want to thank my co-facilitator, Zach and James for for sharing themselves and all the outstanding work they're doing.

ZV Zachary Visinho 1:24:07

Caitlin, be your tour.

 **Simon-Ulysse, Phanide** 1:24:27

And thank you, Julie. We have a question before we wrap it up and say our goodbye. We have one more question. Can we take one more? I see someone's raising.

JS Julie Sprenkle she/her 1:24:36

Sure.

 **Simon-Ulysse, Phanide** 1:24:41

OK. All right. We'll just wrap it up since we are at time. Thank you all for joining our webinar on building trauma-informed care across our level of care. We sincerely appreciate the expertise and vulnerability shared by our presenter, Julie, Zach and James. Thank you, Julie.

Zach and Jane for bringing life into the presentation. I also do want to apologize for the inconvenience caused by the absence of our interpret ASL interpreter. So your understanding is greatly appreciated. And lastly, we kindly ask that you complete the evaluation of our program and speakers your feedback.

Is invaluable in helping us improve and continue to provide meaningful content.

Thank you again for your participant engagement. Let's continue to build compassionate and supportive environment across all level of care. Thank you.

Happy Friday and have a wonderful weekend.

ZV Zachary Visinho 1:25:38

Thank you, everybody.



James 1:25:40

Thanks everyone.

● stopped transcription