SAMHSA
Substance Abuse and Mental Health Services Administration

Practical Guide for Implementing a Trauma-Informed Approach



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Acknowledgments

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Abstract

SAMHSA's 2014 *Concept of Trauma* was a landmark publication that has influenced service provision beyond the areas of behavioral health and health care. In 2014, SAMHSA also released Treatment Improvement Protocol (TIP) 57, *Trauma-Informed Care in Behavioral Health Services*. Trauma continues to be a cross-SAMHSA priority, given its significant role in behavioral health prevention, treatment, and recovery. The primary goal of this practical guide is to expand the discussion presented in SAMHSA's earlier resources, specifically focusing on tools and strategies for implementing a trauma-informed approach (TIA).

This guide highlights the need for organizational assessment of readiness and capacity before implementing TIA and describes strategies for such assessments. The guide focuses on implementation strategies across the following 10 domains:

1. Training and Workforce Development
2. Governance and Leadership
3. Cross Sector Collaboration
4. Financing
5. Physical Environment
6. Engagement and Involvement
7. Screening, Assessment, and Treatment Services
8. Progress Monitoring and Quality Assurance
9. Policy
10. Evaluation

The guide is intended for anyone involved in organization-level change, including practitioners, state and local officials, policymakers, federal and non-federal funders, peers, and family members.



MESSAGE FROM THE ASSISTANT SECRETARY FOR MENTAL HEALTH AND SUBSTANCE USE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

As the Assistant Secretary for Mental Health and Substance Use in the United States Department of Health and Human Services and the leader of the Substance Abuse and Mental Health Services Administration (SAMHSA), I am pleased to present this new resource: *Practical Guide for Implementing a Trauma-Informed Approach.*

SAMHSA is committed to improving prevention, treatment, and recovery support services for individuals with mental illnesses and substance use disorders. SAMHSA's National Mental Health and Substance Use Policy Lab developed the Evidence-Based Resource Guide Series to provide communities, clinicians, policymakers, and others with the information and tools to incorporate evidence-based practices in their communities or clinical settings. As part of the series, this guide expands the discussion presented in SAMHSA's earlier resources on trauma-informed approach (TIA), specifically focusing on tools and strategies for implementing such an approach at the organizational level.

This guide and others in the series address SAMHSA's commitment to behavioral health equity, including providing equal access for all people to evidence-based prevention, treatment, and recovery services regardless of race, ethnicity, religion, income, geography, gender identity, sexual orientation, or disability. Each guide recognizes that substance use disorders and mental illnesses are often rooted in structural inequities and influenced by the social determinants of health. Behavioral health providers and community partners must give attention to health equity to improve individual and population health.

I encourage you to use this guide to implement interventions and programs that support individuals living with mental health conditions and/or substance use disorders.

Miriam E. Delphin-Rittmon, PhD
Assistant Secretary for Mental Health and Substance Use
U.S. Department of Health and Human Services

Behavioral health equity is the right to access high-quality and affordable healthcare services and supports for all populations, including Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.

As population demographics continue to shift, behavioral healthcare systems will need to expand their ability to fluidly meet the growing needs of a diverse population. By improving access to behavioral health care, promoting quality behavioral health programs and practice, and reducing persistent disparities in mental health and substance use services for underserved populations and communities, recipients can ensure that everyone has a fair and just opportunity to be as healthy as possible. In conjunction with promoting access to high-quality services, behavioral health disparities can be further mitigated by addressing social determinants of health, such as social exclusion, unemployment, adverse childhood experiences, and food and housing insecurity. In all areas, including the implementation of a trauma-informed approach, SAMHSA is committed to behavioral health equity.

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Key Terms

Key terms included in the guide are listed below. Key terms are **bolded** the first time they appear in the text.

Term	Definition
Adverse childhood experiences (ACEs)	Adverse childhood experiences (ACEs) are potentially traumatic events that occur within the first 18 years of life. ACEs can include experiences of violence, abuse, or neglect, as well as aspects of a child's environment that undermine their sense of safety and stability, such as parental separation or substance use problems within the household.
Baseline assessment	A baseline assessment provides a benchmark for measuring progress and improvement. It reviews an organization's current competencies, identifies trauma-informed approach related areas to address, and creates a reference for continual monitoring and evaluation.
Lived experience	Personal knowledge gained through direct, first-hand involvement. In the context of this report, lived experience refers to individuals who have experienced trauma.
Posttraumatic stress disorder	Posttraumatic stress disorder (PTSD) is a mental health condition triggered by a traumatic event—either experiencing it or witnessing it in person. Symptoms may include flashbacks, nightmares, and severe anxiety, as well as uncontrollable thoughts about the event.
Social determinants of health	Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
Trauma	Trauma results from an event, series of events, or a set of circumstances an individual experiences as physically or emotionally harmful or threatening, which may have lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Traumatic events may be experienced by an individual, a generation, or an entire community or culture.
Trauma-informed approach (TIA) or trauma-informed care	A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.



Chapter 1.

Introduction

Trauma can be a life-changing experience. Traumatic events can happen at any age to any person and may affect an individual's daily life and cause long-lasting harm to the individual's physical and mental health and well-being. Traumatic events may be experienced by an individual, a generation, or an entire community or culture. Trauma recovery and healing is possible through appropriate and adequate support at the individual, family, and community levels.

TIP: Trauma-Informed Approach Defined

A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.[1]

Systems and organizations that implement a **trauma-informed approach (TIA)**[a] create safer environments for their staff and the individuals they serve. They deliver services with the best chance of achieving optimal health outcomes.[2] Creating a safe environment, for both physical and emotional safety, requires intentionally and comprehensively incorporating trauma-informed principles and practices into an organization's structure, service delivery, and culture. It is important that agencies and organizations evaluate their current practices and procedures and take actionable steps to incorporate TIA strategies within their policies and practices. Agencies and organizations should not use procedures and practices that retraumatize and remind individuals and communities of past trauma (e.g., traumas such as use of restraints, seclusion, or invasive procedures in the medical system). These practices can unintentionally re-harm and recreate traumatic experiences for individuals who have a history of trauma.

[a] Implementing a TIA may occur at a systems or organizational level, or both. While we refer to "organizational" change in the guide, the same information and change processes apply at the systems level. Additionally, TIA is different from trauma-focused care, which centers the impact of specific trauma on an individual's life, and from trauma-specific services, which are clinical interventions designed to address trauma-related symptoms and PTSD directly in individuals and groups.

The need to incorporate a TIA is not limited to behavioral health services. It needs to be addressed across other systems as well, such as child welfare, law enforcement, criminal and juvenile justice, education, victim services, physical health care, services for housing insecurity, veterans affairs, and the military.[3] These systems can provide more effective services through operationalizing trauma-informed principles and practices that facilitate recovery.

This practical guide builds on SAMHSA's *2014 Concept of Trauma* and *TIP 57: Trauma-Informed Care in Behavioral Health Services* publications and is written in coordination with the federal Interagency Task Force for Trauma-Informed Care. Its primary goals are to:

- Provide implementation strategies across multiple domains—from governance to staff training to evaluation—based on the original *Concept of Trauma* publication
- Encourage leadership to adopt a TIA at the organizational level

This resource is intended for anyone involved in organization-level change, including practitioners, state and local officials, policymakers, and federal and non-federal funders.

1.1 Defining Trauma

Trauma results from an event, series of events, or a set of circumstances that an individual experiences as physically or emotionally harmful or threatening, which may have lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.[4] Trauma is associated with widespread health challenges across demographic groups and can have far-reaching implications across individuals, families, and communities.



TIP: "Three Es" of Trauma

Individual trauma results from an **event**, series of events, or a set of circumstances that an individual **experiences** as physically or emotionally harmful or life threatening and that may have lasting adverse **effects** on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

Worldwide estimates suggest that over 70 percent of people experience at least one traumatic event in their lifetime, with almost 31 percent being exposed to four or more such events.[5] In the United States, 90 percent of adults report exposure to at least one traumatic event, with women reporting higher rates of direct interpersonal violence, sexual assault, and physical assault than men.[6] Unaddressed trauma can lead to mental illness and substance use disorders, as well as chronic physical health conditions, including cardiovascular disease and cancer.[3,7-9]



TIP: Recognize the Long-Lasting Consequences of Trauma in the Developing Years

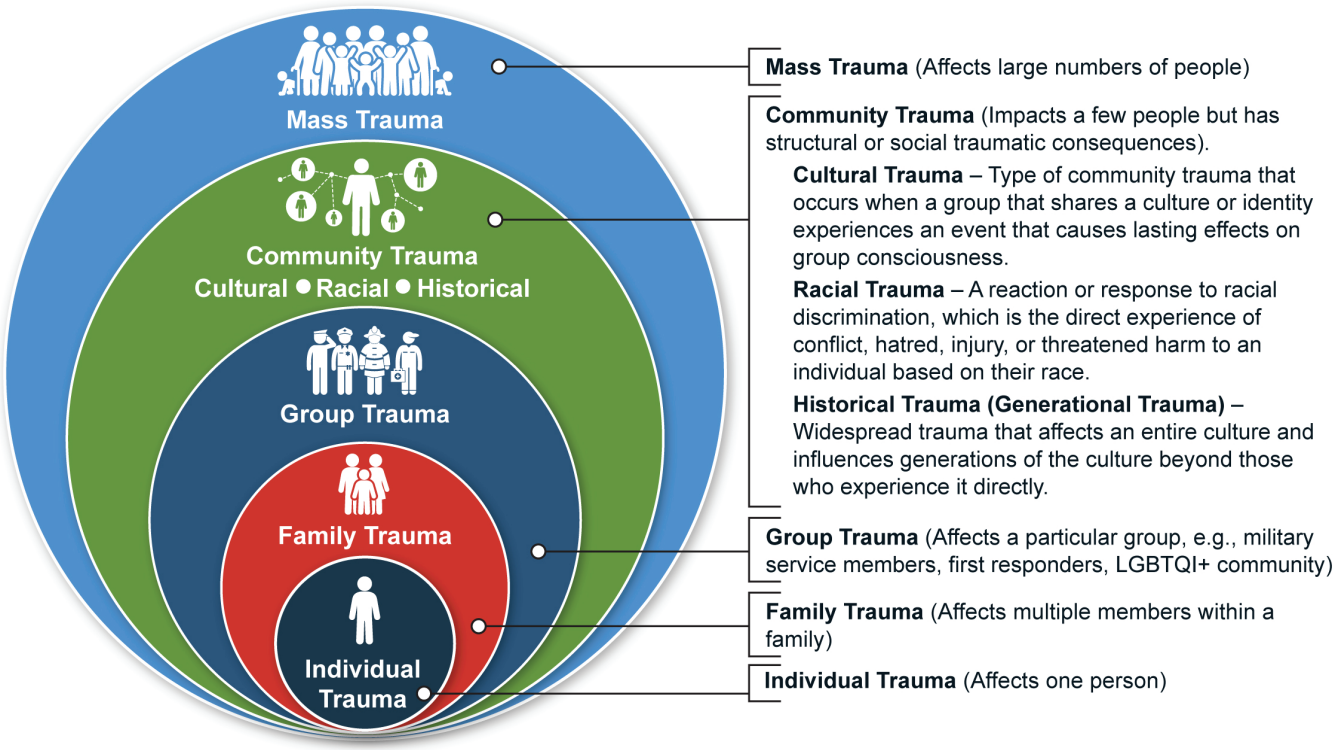
Adverse childhood experiences (ACEs) are potentially traumatic events that occur in childhood (0–17 years). ACEs can include experiences of violence, psychological or sexual abuse, and neglect, as well as aspects of a child's environment that undermine their sense of safety and stability, such as parental separation or substance use problems within the household.[10]

Traumatic events can be a single incident or a long-term chronic pattern and are often categorized as natural or human caused. Examples of traumatic events include, but are not limited to:[11]

- Physical, sexual, and emotional abuse
- Living with a family member with physical or mental health conditions or substance use disorders
- Domestic violence or sexual assault
- Chronic poverty, racism, discrimination, or oppression
- Violence in the community, war, or terrorism
- Living through a natural disaster or other period of distress

Traumatic events are experienced individually or collectively. The context within which the event takes place has implications for how individuals respond and the types of support or services they should receive.[12,13] Trauma occurs at various levels: micro (individual, family), mezzo (groups), and macro (organizations/community). It is essential to acknowledge that these levels are interconnected and contribute to trauma's collective impact.[14] At the community level, systemic causes of trauma sustain its likelihood and the perpetuation of its effects. Historical trauma, defined as collective complex trauma inflicted on a group of people who share a specific identity or affiliation, is an example of community-level trauma.[15]

Levels of Trauma Experience



1.2 Impact of Trauma

Individuals process traumatic events differently, and those who experience traumatic events may or may not experience any lasting, negative effects.[4] Previous life experiences, social supports, personal coping skills, early relational health, and community reactions can influence how an individual responds to a potentially traumatic event. Among some cultural groups, there are taboos associated with overt demonstrations of trauma's typical effects (described below).[16] As a result, people might not look traumatized, so other ways

of understanding their experience will be warranted. In addition, structural discrimination against groups, such as the LGBTQI+ community or BIPOC populations, and historical and intergenerational trauma, can exacerbate the effects of individual trauma. As a result of negative experiences with beliefs and actions stemming from White supremacy, structural racism, and social devaluation of people of color, subsequent exposure to traumatic situations can lead to complex trauma.

Impact of Trauma on Individuals

Emotional	Behavioral	Physical	Developmental	Cognitive	Interpersonal	Spiritual
• Difficulty regulating emotions • Emotional numbness • Depression and anxiety • Post traumatic stress disorder	• Substance use • Self-destructive behaviors • Avoidance of situations, people, and places	• Physical symptoms resulting from emotional distress, including headaches, high blood presssure, and fatigue • Hyperarousal resulting in muscle tension and insomnia	• Impact varies by age group • Children and elderly at greatest risk • Changes occur in brain development	• Impaired short-term memory • Decreased focus or concentration • Feeling alienated or ashamed • Dissociation, depersonalization, and derealization • Flashbacks or re-experiences of the event	• Withdrawal from family, friends, community • Difficulty trusting others	• Depression and loneliness can lead to feelings of abandonment and loss of faith • Over time can experience increased appreciation of life or enhanced spiritual well-being

Adapted from:

1. Weisner, L. (2020). *Individual and community trauma: Individual experiences in collective environments.* https://icjia.illinois.gov/researchhub/articles/individual-and-community-trauma-individual-experiences-in-collective-environments
2. U.S. Department of Veterans Affairs (n.d.). *Spirituality and trauma: Professionals working together.* https://www.ptsd.va.gov/professional/treat/care/spirituality_trauma.asp

Individuals who experience trauma are at greater risk of developing mental health conditions such as anxiety disorders, depression, **posttraumatic stress disorder (PTSD)**, and serious mental illnesses like schizophrenia and other forms of psychosis.[12] Particularly among youth, childhood exposure to trauma is associated with increased odds of adult psychiatric and functional outcomes, after adjusting for a broad range of childhood risk factors.[17] Trauma can negatively impact social, economic, and cognitive functioning and emotional regulation, and prolonged exposure to traumatic events in early childhood may interrupt normal brain development.[18] Ignoring or suppressing experiences of trauma, rather than acknowledging and processing the adversity, has a greater negative impact on an individual's mental health.[19]

In response to trauma, some individuals may adopt maladaptive coping mechanisms such as unhealthy eating or self-harm. In particular, there is a strong link between trauma and alcohol/substance use, death by overdose, and suicide.[20,21] Among individuals diagnosed with PTSD, the prevalence of comorbid substance use ranges from 19 to 35 percent and comorbid alcohol abuse ranges from 36 to 52 percent.[22] Almost half (47 percent) of individuals with PTSD may also have a comorbid substance use disorder (SUD). Individuals with SUD are also more likely to experience traumatic events, creating a perpetuating cycle.[23]

Trauma is associated with mistrust of the healthcare system. For example, as a result of non-consensual medical interventions and repeated examinations of intersex traits for the benefit of doctors and trainees, many intersex individuals have significant medical trauma and mistrust, which leads to frequent delays and avoidance of care.[24]



Posttraumatic growth is the potential positive psychological change in individuals that may occur after experiencing trauma. It is facilitated by making sense of the traumatic event and its related effects in a way that results in new meaning, personal insight, and understanding of oneself, others, the world, or future expectations.[25] The concept of posttraumatic growth does not refute, minimize, or invalidate the negative impact and emotional, cognitive, or behavioral consequences frequently associated with trauma; individuals can, in fact, experience posttraumatic growth along with PTSD.[26] While not all individuals experience posttraumatic growth, some people do report personal growth following a traumatic experience.[27] The concept suggests that a traumatic experience may inadvertently lead to positive reactions, such as greater appreciation of life, relationships with others, new life possibilities, personal strengths, and spiritual change.[26]

At the community level, the impact of trauma is categorized as physical, social-cultural, or economic.[14] Examples of community trauma can be seen in different areas, including the:

- **Physical/built environment**, through deteriorated public spaces, degraded infrastructure, climate change, and limited availability of healthy food.
- **Social-cultural environment**, as evidenced by damaged social networks, low sense of collective effectiveness to bring about change, and experience of fear and shame.
- **Economic and educational environment**, characterized by intergenerational poverty, long-term unemployment, and limited employment opportunities.

RESOURCE

PTSD is a mental health condition triggered by a terrifying event—either experiencing it or witnessing it. Symptoms may include flashbacks, nightmares, and severe anxiety, as well as uncontrollable thoughts about the event.

This brochure from the National Institute of Mental Health provides information about PTSD, including who develops it, its symptoms, treatment options, and how to find help. The brochure is also available in Spanish.

It is essential to acknowledge that trauma is a social justice issue.[28] Minority and under-resourced communities disproportionately experience trauma. Trauma caused by systemic issues, such as racism, genderism, homophobia and transphobia, poverty, sexism, and ableism, can have severe, long-lasting, intergenerational impacts on individuals and communities. A commitment to TIA implementation requires recognition of the social conditions that produce trauma. Social justice—the elimination of systemic oppression and institutional barriers with the goal of ensuring equitable access to opportunities and resources for all—needs to be an essential component of a TIA for it to lead to positive outcomes.

Examples of Trauma



1.3 Prevalence of Trauma

Men and women are likely to experience different traumatic events, and women are two times more likely to develop PTSD than men.[29] Women report higher rates of sexual assault or child sexual abuse, while men are more likely to experience accidents, physical assault, combat, disasters, or be a witness to death/injury.[29] Lifetime prevalence of PTSD has been shown to be highest among Black populations.[30]

Minority youth are more likely to experience trauma, including historical trauma, immigration stressors, natural and man-made disasters, discrimination, and violence, and less likely to access medical and mental health care.[31] In particular, Black and Latino young men disproportionately experience violence, poverty, incarceration, lack of access to health care, marginalization, and low social status.[32] The historic and intergenerational trauma American Indians and Alaska Natives experience puts them at increased risk of modern-day traumatic experiences. Additionally, LGBTQI+ individuals are nearly four times more likely to experience violent assault than their cisgender, heterosexual counterparts.[33]



TIP: Recognize and Acknowledge the Connection Between SDOH and Trauma and Implement Holistic Strategies

Social determinants of health (SDOH) are the environmental conditions where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[34] SDOH fall into five categories: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context.

Each SDOH domain can impact, or be impacted by, the experience of individual or community trauma. Some experts suggest that experiencing trauma can itself be considered an SDOH example. SDOH impact the likelihood that individuals will experience trauma during their lives. Organizations and agencies need to focus on increasing protective factors that prevent or mitigate trauma and decreasing social and environmental factors that contribute to the experience of trauma.

1.4 Defining a Trauma-Informed Approach

KEY TAKEAWAY: Elements of TIA

SAMHSA's concept of a trauma-informed approach is grounded in a set of four assumptions, six key principles, and ten implementation domains.

Assumptions: 1. Realize the widespread impact of trauma and understand potential paths for recovery. **2.** Recognize the signs and reactions of trauma in clients,[b] families, staff, and others involved with the organization. **3.** Respond by fully integrating knowledge about trauma into policies, procedures, and practices. **4.** Resist re-traumatization

Principles: 1. Safety. **2.** Trustworthiness and transparency. **3.** Peer support. **4.** Collaboration and mutuality. **5.** Empowerment, voice, and choice. **6.** Cultural, historical, and gender issues.

Domains of Implementation:



Incorporating a TIA involves understanding the widespread impact of trauma, recognizing trauma symptoms in both staff and care recipients, avoiding re-traumatization, and supporting paths to recovery. For a program, organization, or system to be trauma-informed, it is not enough to provide trauma-specific interventions. An organization or agency must incorporate trauma-informed principles in its culture, policies, procedures, and practices.

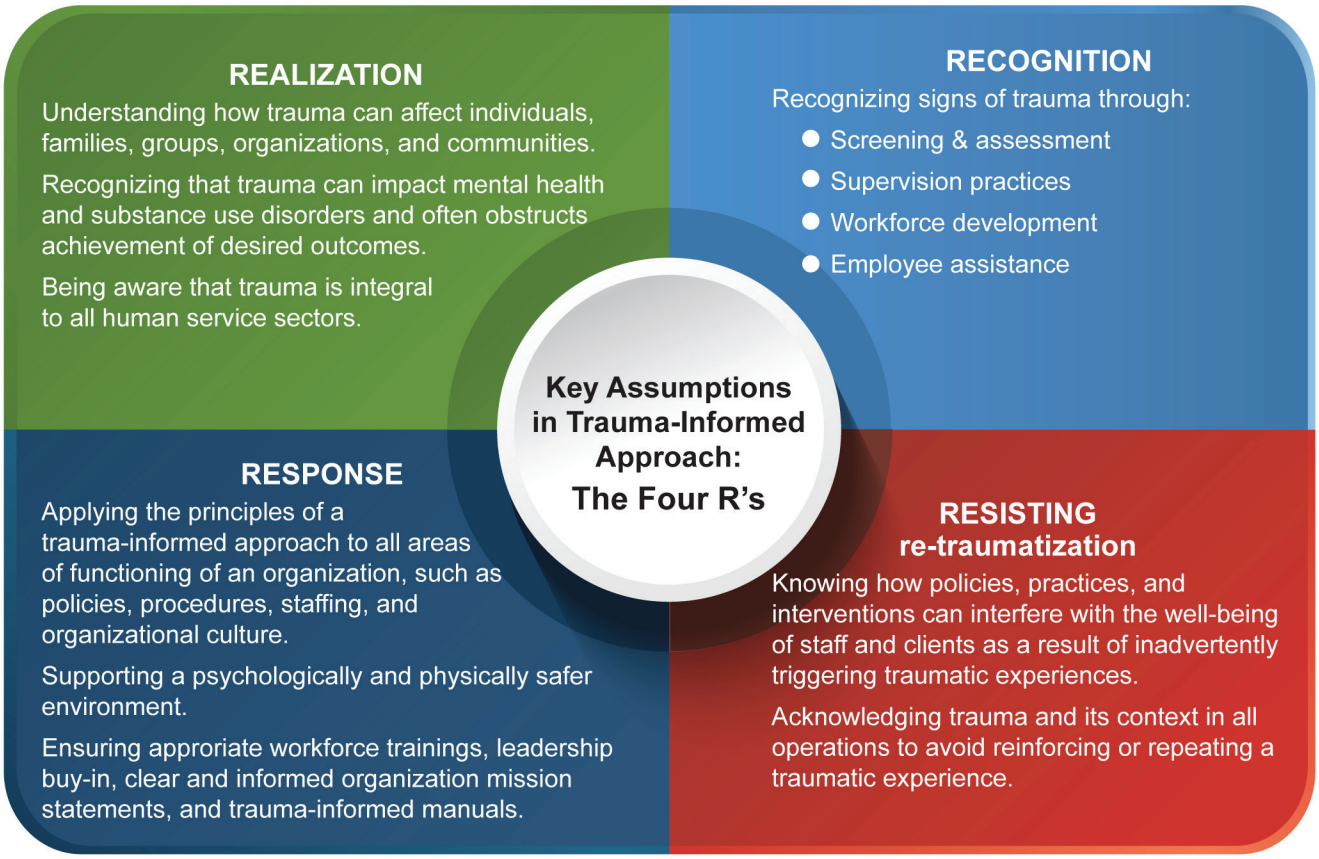
A TIA requires all personnel of an agency, including, but not limited to, administrators, providers, staff, and board members, to recognize that a care recipient's history of trauma can affect their:

- Experience, engagement, and receptiveness to the organization's services and supports
- Functioning in the community
- Interactions with staff and other clients
- Sensitivity to guidelines and interventions

[b] The guide uses the term clients, consumers, individuals, service recipients, and patients interchangeably, depending on the human services context.

In addition, organizations need to implement TIA holistically by recognizing that trauma is not unidirectional and that the micro, mezzo, and macro levels of trauma are intricately connected. Finally, organizations need to acknowledge the trauma staff and providers themselves experience, either as part of their own personal lives or secondary to working with clients who share firsthand details about their trauma.

Assumptions of a Trauma-Informed Approach



Implementing a TIA involves an organizational change process that incorporates 10 implementation domains. This change process, along with the strategies involved, is discussed in Chapter 3. A TIA may start with a redesign of organizational practices to establish standards of care to enhance clients' strengths and resilience, protect the vulnerabilities of those with trauma history, and develop guidelines to support the delivery of trauma-specific services. Any redesign to incorporate a TIA should begin with a needs assessment and involve people with **lived experience**, their families, and communities, as part of the design, delivery, and ongoing evaluation of the services.[35,36]

A TIA adheres to six principles, not merely a set of practices, methods, or procedures. A system, organization, or program must embody each of these principles in how it operates, delivers services, and empowers its staff, people who receive care, and members of the community. A TIA can be generalized and adapted to multiple settings, people served, and practitioners. TIA adaptation in different settings or for a particular population will involve terminology and practices appropriate to that setting or set of individuals served.

Six Principles of a TIA

1	Safety	Safety in physcial settings and interpersonal interactions
2	Trustworthiness and Transparency	Operations are conducted and decisions are made with transparency, consistency, respect, and fairness so as to build and maintain trust
3	Peer Support	Support from those with lived experiences of trauma or, in case of children with history of trauma, their family members
4	Collaboration and Mutuality	Partnering, leveling of power differences between and among staff and clients
5	Empowerment	Individuals' strengths and experiences are recognized and built upon
6	Cultural, Historical, and Gender Issues	Organization moves beyond the cultural stereotypes and biases

Most importantly, an organization needs to consider that there are macro-level influences—including societal norms, generational history, government policies, and laws—that impact the individuals they serve and their TIA implementation. Understanding and acknowledging that there are overarching generational, cultural, and societal issues that have caused trauma in the past and continue to re-traumatize individuals is the first step toward TIA implementation. A TIA space needs to be collectively created. For a TIA to flourish, the organizational culture will need to value not only lived expertise but also trauma experiences of a person's ancestors that continue to affect the client today. TIA begins with cultural humility at all levels—individuals, organizations, and systems.



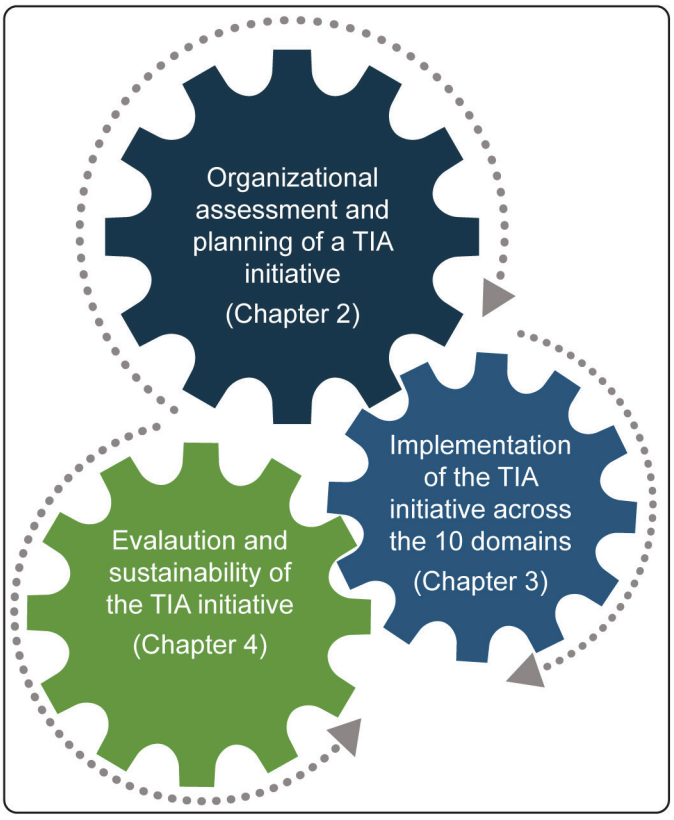
1.5 Framework for This Resource

Multiple frameworks describe the process of planning and implementing a TIA at the systems or organizational level. Most common among these frameworks are:

- Community Connections' Creating Cultures of Trauma-Informed Care (CCTIC)
- Trauma Informed Oregon's Roadmap to Trauma Informed Care
- Traumatic Stress Institute's Whole-System Change Model to Trauma-Informed Care

- American Institutes for Research's Framework for Building Trauma-Informed Organizations and Systems

Although the phases in each framework differ, common themes emerge. A graphic depiction of a comprehensive TIA implementation process that draws upon these themes is shown on the right.



The next chapters in this resource follow these three phases of TIA implementation:

- Chapter 2 discusses the process of organizational assessment of readiness, capacity, and planning for TIA implementation.
- Chapter 3 describes areas involved in the process of TIA implementation and provides strategies across its various domains.
- Chapter 4 discusses the process of evaluation and ensuring sustainability of the implemented TIA.
- Chapter 5 includes three case studies that illustrate a TIA in action across different types of systems and organizations.

Each chapter presents concise, actionable guidance and tools to support TIA integration with policy, practice, and culture at the organizational and systems levels. Strategies and recommendations are provided for each of the 10 implementation domains covered in the original concept paper and are marked with domain-specific icons. Each chapter includes tips, takeaway messages, and highlighted resources, and concludes with a list of additional resources for topics discussed in the chapter.



Chapter 2.

Organizational Assessment and Planning for a TIA

KEY TAKEAWAY: Organizational Assessments

Organizational assessments and monitoring should be built into the change process while implementing a TIA. There are typically two kinds of TIA assessments::

- Those carried out early in the process that allow an organization to identify its needs and evaluate its readiness and capacity for making systemic change.
- Those carried out during the systemic change process that allow the organization to evaluate its successes and barriers, modify its TIA implementation activities as needed, and prioritize areas for change.

An organization's readiness and capacity assessments are the first step in implementing a trauma-informed approach (TIA) for systems- or organization-level change. They establish baseline competencies and evaluate organizational readiness for change. A thorough, measurable assessment:

- Helps a system or organization determine areas for improvement and areas of strength across all levels of the system or organization
- Allows an organization to assess capacity and target training activities and strategic planning
- Helps the leadership and staff understand the need for a TIA
- Provides data to validate TIA need and assess readiness for TIA implementation

This chapter focuses on the first step of conducting a **baseline assessment**. However, assessment is also a continuous activity and may not always be a linear process.

TIP: Baseline Assessment Is an Essential Component of TIA Implementation

A baseline assessment provides a benchmark for measuring progress and improvement. It reviews an organization's current competencies, identifies areas to address related to a TIA, and creates a reference for continual monitoring and evaluation.

During the training and implementation phases, for example, assessment involves the ongoing process of progress monitoring and continuous quality improvement (CQI). During the evaluation and sustainability phase, assessment involves documenting changes to policy, practice, and organizational culture, and evaluating the impacts of a TIA at the staff, client, and organization levels. Chapter 4 focuses on assessment processes during these other phases.

2.1 Steps in Conducting a Baseline Assessment

Conducting a baseline assessment involves the following steps:

1. Form an organizational capacity assessment team
2. Encourage organizational readiness
3. Engage partner organizations and individuals with lived experience
4. Select an assessment tool
5. Decide on data collection and analysis methods
6. Implement the assessment and decide on next steps

2.1.1 Form an organizational capacity assessment team.

- Convene an assessment team.
  - Ensure that the team comprises individuals at all levels and departments within the organization, namely, administrators, practitioners and other direct care staff, and human resources staff. Make an explicit effort to include individuals of diverse backgrounds and experiences, as well as any other members of disempowered and under-resourced groups in the community.
  - Invite people with lived experience, who may be current or former clients, to be involved in the assessment team or as an advisory group. Equitably compensate individuals with lived experience for their time and expertise.
- Establish a clear timeline and expectations for deliverables from the assessment team.

2.1.2 Encourage organizational readiness.

- Measure staff and leadership motivation to adopt and implement a TIA with fidelity.
  - Conduct focus groups and interviews to assess willingness for change and commitment to implement a TIA.
  - Establish a common understanding of trauma and a TIA.
  - Address any concerns identified during organizational motivation assessment.
- Engage executive leadership and ensure leadership buy-in
  - Identify champions to foster internal buy-in. Champions can also help establish cross sector collaborations and reduce any staff resistance.
- Evaluate how a TIA is different from current operations. Identify any current operations that align with a TIA and assess how to build upon those.
- Assess the anticipated and desired impact of change from current operations to a TIA.

2.1.3 Engage partner organizations and individuals with lived experience.

- Identify existing cross sector and cross system collaborations and new, potential collaborations.
  - Determine the extent to which collaborating organizations are trauma-informed and incorporate awareness of trauma in all aspects of their operations and service delivery.

- Use a strengths-based approach and focus on already implemented trauma-informed programs or practices that have the potential to be expanded.

2.1.4 Select an assessment tool.

- Ensure the assessment tool covers all 10 domains of TIA implementation.
- Based on available resources, both human and financial, consider whether to implement a self-administered assessment tool or hire an external consultant to implement the assessment and interpret the results.
- Remember that many assessment tools can be used to assess readiness and capacity for a TIA across different service systems, although some are specific to a particular sector (e.g., child welfare). The reference list at the end of this chapter provides a range of assessment scales and tools.[c]

2.1.5 Decide on data collection and analysis methods.

- Establish clear data collection methods.
  - Design data collection protocols that identify who will collect assessment data and from whom.
  - Create safety around assessment and ensure that data privacy and anonymity are maintained.
  - Establish secure databases and processes for data management and analysis.
- Remember that organizational capacity assessment data can be analyzed in different ways to reveal insights into areas on which an organization may need to work. For example, consumers and staff may rate the same area (e.g., physical environment) very differently.
- Ensure data collection methods are culturally responsive.

RESOURCE

The Trauma Informed Care Project's Agency Self-Assessment guides an organization in implementing a self-assessment and provides insight on how to interpret results. Questions that reach a consensus with "strongly disagree" and "disagree" flag potential areas for change that should be strengthened. Questions that receive "do not know" as the most common response may point to a lack of clarity, lack of practice, different perspectives across various levels of the organization, or misunderstanding of current practices.

2.1.6 Implement the assessment and decide on next steps.

- If using a self-administered assessment tool, identify the resources needed to implement it.
  - Determine availability and sufficiency of all resource types—financial, physical, and human capital.
- Develop an action plan that considers all 10 implementation domains and includes concrete actions and changes within each domain.
  - At minimum, include organizational priorities based on assessment data, individual responsibilities (e.g., leadership, staff, partners), a timeline and budget for implementation, performance indicators, and monitoring and evaluation activities.
  - Acknowledge existing positive practices and policies and reinforce continued implementation of these across all 10 domains.
- Announce the assessment initiative to the organization's staff and keep them informed and involved at all implementation stages to increase buy-in.

[c] Many of the assessment scales and tools are free for use. Some require permission of the author or require a payment. Assessment scales and tools are provided as examples. The federal government does not endorse any tool or any of its components.

TIP: Consider These Questions When Creating an Action Plan

1. What do you want to change (goals)?
2. Why did you choose these goals?
3. What steps will you need to take to meet these goals?
4. Who will be responsible?
5. When do you want to accomplish these goals?
6. How will you know that you have accomplished your goals?[37]

2.2 Additional Resources

- Trauma Informed Care Project's Trauma System Readiness Tool (TSRT) provides child welfare agencies with a self-assessment for trauma-informed care, including guidance on how to complete the self-assessment.
- American Institutes for Research's and Chapin Hall's Building a Multi-System Trauma-Informed Collaborative includes a system readiness tool and agency reflection tool.
- Trauma Informed Oregon's Standards of Practice for Trauma Informed Care includes a self-assessment with rating scales along the following domains: agency commitment and endorsement; environment and safety; workforce development; services and service delivery; and systems change and progress monitoring.
- Trauma Informed Oregon's Trauma Informed Care Screening Tool outlines the developmental phases of measuring an organization's readiness to implement a trauma-informed approach.





- Southwest Michigan's Children's Trauma Assessment Center's Trauma Informed System Change Instrument (TISC) and TISC Scoring Guide and Psychometrics provide an organizational change self-evaluation.
- The National Council for Mental Wellbeing offers a self-assessment tool titled Organizational Self-Assessment: Adoption of Trauma-Informed Care Practice.
- Community Connections has developed Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol.
- The Traumatic Stress Institute's organizational self-assessment tool is designed specifically for youth-serving organizations.
- The National Center on Family Homelessness at the American Institutes for Research has developed the Trauma-Informed Organizational Toolkit for Homeless Services.
- American Institutes for Research's (AIR) Trauma-Informed Care for Displaced Populations: A Guide for Community-Based Service Providers includes TIA implementation strategies along with an organizational self-assessment for agencies serving displaced children and families.
- The Wisconsin Children's Trust Fund's Trauma-Informed Organizational Self-Assessment for Child Abuse Prevention Agencies serves as a guide for child abuse and neglect prevention agencies to implement an assessment as part of the pathway to becoming trauma-informed.
- The University of South Florida's Self-Assessment for Trauma-Informed Care Practices is a tool used to evaluate organizational practices in youth residential settings.
- AIR's Trauma-Informed Organizational Capacity Scale is a validated measure of trauma-informed capacity in health and human services organizations. AIR offers consultation services for organizations looking to implement the tool.
- The ARTIC Scale (Attitudes Related to Trauma-Informed Care) is a psychometrically valid measure of staff attitudes related to trauma-informed care developed by Tulane University and the Traumatic Stress Institute.
- Coordinated Care Services' and the Institute of Trauma and Trauma Informed Care at the University of Buffalo's Trauma Responsive Understanding Self-Assessment Tool (TRUST) and Trauma Responsive Understanding Self-Assessment Tool for Schools (TRUST-S) are strengths-based organizational self-assessment tools that use SAMHSA's 10 implementation domains as a framework.
- The National Child Traumatic Stress Network's Trauma Informed Organizational Assessment is a tool to help organizations serving children and families who have experienced trauma assess their current TIA practices.
- The University of Buffalo's Center for Social Research's Trauma-Informed Organizational Change Manual contains a self-assessment tool.



Chapter 3.

Implementing a Trauma-Informed Approach

After an organization completes the assessment of its readiness and capacity to implement a strengths-based, trauma-informed approach (TIA), the organization is ready to move into the implementation phase. This phase requires simultaneous and iterative actions in the domains listed in Chapter 1. This chapter provides implementation strategies for each of these domains.

3.1 Governance and Leadership

Strong governance and leadership with an investment in prioritizing trauma-informed principles and practices are necessary for successful implementation and long-term sustainability of a TIA. A long-lasting initiative must be supported at the highest levels of the organization. Governance and leadership positions must also include individuals with lived experience of trauma.[3]

However, all individuals within the organization play a critical role in prioritizing a TIA.[38,39] To demonstrate a genuine investment in TIA, organizations can:[3,40]

- Show transparency with organizational operations and decisions, with a goal of building and maintaining trust at all levels, including regular, open communication with staff, partners, clients, and families regarding the organization's TIA commitment.
- Ensure individuals with trauma histories are in governance and leadership positions and involved in planning (i.e., "leveling of power").
- Identify a "champion" in a position of authority with a dedicated role of instilling trauma-informed principles and practices into the organization. This person also can help support staff in promoting and practicing a TIA.
- Ensure leaders model a TIA within their organization and encourage individuals at all levels to check one another when actions do not align with a TIA.

RESOURCE

The Center for Health Care Strategies, Inc. has created a resource that provides tips on implementing trauma-informed care within an organization. It describes the importance of open communication and engaging clients in planning, as well as hiring and supporting a trauma-informed workforce.

TIP: Review Roles and Structures with a TIA Lens

Review organizational structures with an eye toward ensuring consumers have meaningful representation in governance, a TIA champion has authority to advance a TIA within the organization, and there is clarity on all staff roles (clinical and non-clinical) in supporting TIA within the organization.

3.2 Training and Workforce Development

Implementing a TIA across organizations and systems involves intentional strategies for recruiting, hiring, training, and retaining both clinical and non-clinical staff. To facilitate this, organizations can:

- Hire a trauma-informed workforce.
  - Use behavioral interviewing techniques to screen for TIA skills, such as empathy, understanding, and trust.
- Train staff in a TIA.
  - Begin TIA training early in the onboarding process.
  - Implement ongoing training that focuses on:[37]
    - » General trauma theory, focusing on trauma's impact on children, youth, and families in the various domains listed in Chapter 1.
    - » An overview of trauma-informed principles and domains, including practical, culturally and linguistically relevant, and equitable implementation strategies at the organizational and practitioner levels.
    - » The effects of working with individuals who have trauma histories, including strategies to deal with secondary traumatic stress.
    - » Diversity, equity, and inclusion (DEI) to create belonging and avoid othering of Black, Indigenous, and people of color (BIPOC) communities as well as people with disabilities and people who identify as LGBTQI+.
  - Train non-clinical staff, such as organizational leadership, administrative personnel, reception staff, and security guards, along with clinical staff.
- Prevent secondary traumatic stress in staff.
  - Provide training that helps staff understand and recognize secondary traumatic stress.
  - Offer opportunities for staff to explore their own experiences with trauma, especially the ways in which trauma impacts their work.
  - Support the well-being and health of staff through multiple practices, such as avoiding extremely high caseloads and demanding hours.
  - Provide trauma-informed reflective practice and clinical supervision.

RESOURCE

The Texas Department of Family and Protective Services provides a free, foundational training on trauma-informed care to assist families, caregivers, social service providers, and members of the public in understanding trauma and its impact, child traumatic stress, effects of adverse childhood experiences (ACEs), and strategies for TIA implementation. This training is available to providers in all states.

TIP: Ask About TIA Implementation Experience During Hiring Process

While interviewing candidates, assess the following areas using the example questions provided:[41]

- **Experience working with clients exposed to trauma**
  - *Our agency is working to become more trauma-informed. How do you define trauma? How might past experiences affect a person's current situation? Describe how this might inform the services you provide.*
- **Experience working with adults/youth exposed to trauma**
  - *Describe your experience working with adults/youth with histories of multiple placement failures, high levels of aggression, trauma, or violence. What lessons did you apply from this experience?*
- **Understanding of a safe, trauma-informed environment**
  - *What does a trauma-informed work environment look like to you?*
- **Relationship-building skills**
  - *What techniques have you found to be effective in developing trusting relationships and rapport with clients?*
- **Responding to difficult/stressful situations**
  - *Tell us about a time when you found yourself in a stressful situation at work. How did you respond?*
- **Incorporating self-care**
  - *What have you done to display healthy self-care skills during the past year?*

After initial training, organizations can offer continued support and assistance in multiple ways:[42]

- **Recognize differences in staff needs:** Staff members may vary in their needs as they deal with intense situations or events with their clientele. Some may need a 15-minute break after seeing a client to calm themselves before returning to work, while others may need to speak with a mental health consultant or engage in a reflective supervision session. Ensure these provisions are in the organization's human resources policies.
- **Anticipate challenging situations:** Organizations can offer supportive check-ins for staff before anticipated intense or difficult conversations with clients or others.
- **Engage staff in decisions affecting them:** Organizations can involve staff in activities like setting ground rules about how meetings are carried out, discussing expectations around communication, and welcoming differences of opinions among the staff.
- **Offer opportunities for staff to come together:** Bringing staff together in safe, trusting, respectful spaces for formal or informal gatherings will both help bolster their working relationships and help create a strong emotional support system.

RESOURCE

A brief developed by the Center for Health Care Strategies, Inc.'s Trauma-Informed Care Implementation Resource Center provides practical strategies for encouraging staff wellness in trauma-informed organizations.

This document describes the impact of work-related stress on staff well-being. It provides self-care and organizational strategies, as well as case studies of organizations implementing them.

3.3 Cross Sector Collaboration

A TIA is most effective in reaching positive outcomes when implemented consistently and collaboratively across various human services sectors.[43] Organizations often focus on offering individual services; however, from a client perspective, multiple systems are engaged and intricately connected in people's lives. If individuals and their families receive trauma-informed services through one organization but not others they interact with, TIA's effectiveness is highly reduced. Integrated, collaborative, community-wide, cross sector TIA implementation is essential.

One way to establish a cross sector TIA is to create a trauma-informed referral network that includes all service providers within a community or system of care. This network can be achieved through efforts like convening a multi-agency TIA implementation task force that offers collaborative TIA training opportunities across the community or inviting clients to serve on advisory boards across agencies.

Another strategy is to establish a community-based learning collaborative. A community-based learning collaborative brings together multiple service-providing agencies within the community with the goal of facilitating implementation of interventions and innovations. This community-level, systemic approach to TIA implementation increases the likelihood of its sustained and long-term impact.

RESOURCE

The guide Building a Multi-System Trauma-Informed Collaborative from the American Institutes for Research provides a framework for coordinated TIA implementation across multiple agencies that serve children, such as health care, child welfare, juvenile justice, and early child development. The guide offers the underlying theoretical basis, as well as specific strategies for coordinated and collaborative TIA implementation.



3.4 Financing

Identifying a sustainable financing strategy is necessary to fund TIA, including resources for staff training; development of safe facilities; provision of screening, assessment, treatment, and recovery supports; and development of cross-agency collaborations. Traditional payment systems and billing codes often create barriers to implementing TIA, since there are few direct reimbursement mechanisms specifically for trauma-informed activities. Organizations can use several strategies to address these challenges and maximize financing opportunities:

- **Diversify funding streams by using a combination of sources to support TIA implementation:** Potential sources include public insurance programs, commercial insurance, client self-pay, state and federal grants, and private philanthropy.
- **Determine what potential TIA activities, procedures, staffing, or encounters are covered by funders or payers under current agreements:** This process should include cross-referencing with funding options available for TIA implementation through initiatives or other special programs; that is, certain evidenced-based practices or quality improvement initiatives that may align with trauma-informed activities are reimbursable.
- **Incorporate trauma-informed activities into existing reimbursable services:** Organizations can think strategically about how implementation changes made for a TIA fit into activities that are already provided and billed.
- **Consider accountable care models, which provide more incentives for investing in a TIA by rewarding value over volume:** Accountable care depends on coordinated care management and multidisciplinary collaboration, both of which align with TIA methodology.

TIP: Consider Community Grants as a Funding Stream

The Washington State Health Care Authority (HCA) used federal mental health and substance use block grant dollars to implement trauma-informed work. The HCA awarded over $1.4 million in grants to 31 communities across the state to implement a TIA.

RESOURCE

Although there is no billing code specifically for a TIA, organizations can use billing codes strategically for reimbursement of direct trauma care services. The National Council for Mental Wellbeing has a list of common billing codes that can be used to support trauma-informed services.

3.5 Physical Environment

Within a trauma-informed organization, the environment must foster both physical and psychological safety for both clients and staff.[3,38,39] Individuals with lived experience of trauma should have a key role in identifying areas of strength and opportunities for improvement to make the physical and psychological experience more trauma-informed. When reflecting upon the physical environment, organizations should ensure that the neighborhood where services are offered is safe for collaborating providers and families.

A physically safe environment in a trauma-informed organization may have some of the following characteristics:[3,40,44]

- Well-lit exterior areas that do not allow for congregating outside entrances/exits, security guards available as needed, and monitoring of who is entering and exiting the building
- Low noise levels
- Signs that are warm, welcoming, and positive
- Seating arrangements that allow adequate space between individuals and clear sight lines of those entering a room
- Private areas to de-escalate stressful situations, promote calm, and attend to self-care
- Non-binary and gender-fluid spaces and activities

A psychologically safe environment would:[3,39,40,44]

- Include training for clinical and non-clinical staff in how to communicate effectively with clients and greet them in a welcoming and respectful manner.
- Ensure staff maintain healthy interpersonal boundaries and appropriately manage conflict.
- Provide staff and clients schedules and structures that are predictable and give adequate notice when there are changes.
- Respect the physical boundaries of staff and clients and provide options like leaving office doors open.
- Offer gender-responsive services, embrace traditional cultural connections, be culturally relevant, and address historical trauma.

RESOURCE

The Center for Health Care Strategies has created a fact sheet that provides tips on creating a safe physical and psychological environment.

3.6 Engagement and Involvement

Engagement of individuals with lived experiences, those in recovery, and those receiving services, and their families, is fundamental to TIA implementation within any service organization. This engagement needs to be intentional, meaningful, empowering, and ongoing as well as implemented across all organizational levels. Organizations can use multiple strategies to ensure this engagement:[45]

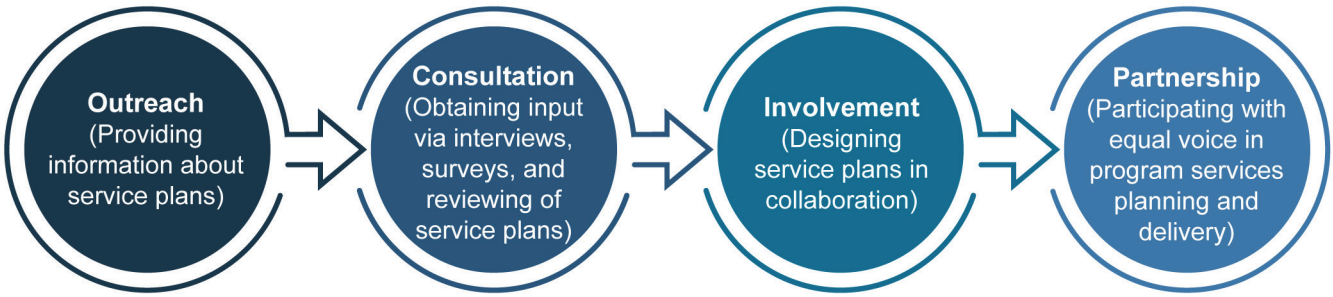
- Show empathy and ensure those receiving services and their families feel safe in the organization's physical space.
- Inquire about the individual's needs and those of their family, actively listen to their answers, and act upon those needs.
- Intentionally engage those in recovery, individuals receiving services, and their families in making decisions, encouraging them to speak up, and empowering them to make choices.
- Collaborate with and listen to individuals and families while developing service delivery plans and giving them options.
- Invite and encourage peer support or develop a peer support program; peers can offer support in the form of understanding and encouragement toward growth and resilience.

KEY TAKEAWAY: Peer Support

Encouraging peer support is a promising engagement strategy for TIA. Peer support principles include that it:[46]

- Is not mandatory
- Is non-judgmental
- Is empathetic
- Is respectful
- Requires honest and direct communication
- Involves mutual responsibility
- Is about sharing power
- Is reciprocal

As illustrated below, the extent of engaging individuals with lived experience and their families typically lies on a continuum, with increasing levels of involvement, authority, and responsibility.



Adapted from: Hogan, L., Gertel-Rosenberg, A., Thompson, G., & Chang, D. (2020). *Lived experience: The practice of engagement in policy.* https://www.movinghealthcareupstream.org/wp-content/uploads/2020/04/Nemours-Lived-Experience-Brief-Final.pdf

RESOURCE

The National Child Traumatic Stress Network has created a resource that focuses on the role of family engagement in creating a trauma-informed juvenile justice system. Families, being the core of childcare and support, are in a unique position to help the juvenile justice system strengthen and support the protective factors and resilience of the child involved in the system. Partnering with the family is an essential element in recognizing and responding to the trauma the child faces.

3.7 Screening, Assessment, and Treatment Services

A TIA involves implementing screening and assessment to support consumers and identifying their needs to tailor services accordingly. Screening and assessment that adhere to TIA principles involve:

- Developing a trusting and collaborative relationship with individuals who have experienced trauma and are seeking services.
- Preventing under-recognition of trauma that can lead to neglect or re-traumatization.
- Providing an opportunity for information gathering.

Trauma screening should be universal and involve brief inquiry to assess history of trauma, reactions to trauma, and specific behavioral health needs. Screening typically is limited to yes or no questions that allow a provider to identify if and what trauma has occurred and determine appropriate follow-up assessment, referral, or urgent response. Screening should be clear, straightforward, culturally appropriate, and culturally sensitive. It is essential to remember that trauma often is incorrectly viewed as a weakness and individuals who have experienced trauma may deny it.

TIP: Provide Screening and Assessment Training to Bolster Service Provider Competence

An organization must ensure service provider competence in administering screening and assessment questions and dealing with the full range of emotional responses that may accompany such inquiry.

It is recommended that training on how to conduct screening and assessment be part of TIA training and follow-up technical assistance.

Trauma assessment involves an in-depth exploration of the nature, severity, and timing of traumatic events and their associated effects and trauma-related symptoms. Assessment provides an opportunity for a more holistic and extensive examination and should be rooted in trust and safety. An extensively trained individual or clinician must conduct the clinical review, since it can involve psychological assessments, medical records, and interviews and contribute to a formal diagnosis and/or pathway to care. Moreover, trauma assessment should not be a single, one-time event, but a process that builds continuity and trust and establishes a grounded relationship with the individual.

Treatment services must be trauma-specific, culturally appropriate, grounded in evidence, accessible, effective, and adhere to TIA principles. When a comprehensive assessment suggests that formal treatment of trauma may be warranted as part of an individual's care plan, a clinician may wish to use one or more therapeutic approaches specifically designed to address the trauma symptoms. Multiple evidence-supported interventions to address trauma among adults are available. Some examples of such interventions include: Cognitive Processing Therapy; Eye Movement Desensitization and Reprocessing; Narrative Exposure Therapy; Prolonged Exposure Therapy for PTSD for Adults; Cognitive Behavioral Therapy for Acute Stress Disorder; and Seeking Safety.



RESOURCES

SAMHSA's TIP 57 on Trauma-Informed Care in Behavioral Health Services has a section on Creating an Effective Screening and Assessment Environment that outlines considerations for how to approach a screening and assessment process.

Additionally, the National Council on Mental Wellbeing's Trauma-Informed Care Screening and Assessment Toolkit provides:

- Links to resources for organizations planning to incorporate peers into their workforce
- Considerations and questions for culturally sensitive trauma-informed care assessment
- Critical elements within a TIA screening and assessment process
- A flowchart detailing a trauma-informed, resilience-oriented progressive screening and assessment process
- A trauma-informed, resilience-oriented Principles Assessment Tool for organizations to assess existing policies, practices, procedures, and outcomes in the framework of TIA principles
- A list of trauma screening and assessment tools

3.8 Progress Monitoring and Quality Assurance

Implementing a trauma-informed approach is an ongoing change process that involves a shift in knowledge, perspectives, attitudes, and skills throughout an organization. Achieving this type of systems change requires continuous quality improvement. The following strategies can help organizations put structures in place to track progress:

- Prior to starting implementation, identify action steps and corresponding performance indicators for each goal. Results from the organizational assessment (detailed in Chapter 2) can guide an organization in identifying these goals and potential measures.
- Create a specific workgroup tasked with monitoring progress and continuously reassessing goals.
- Consider a variety of indicators to track progress and monitor impact, such as staff and client satisfaction, staff engagement, and health outcome metrics. Remember that some parameters of progress, such as increased sense of client wellness or building of stronger rapport with the client, are important but may not be easy to measure and monitor.
- When selecting metrics, leverage existing quality improvement efforts, many of which require organizations to collect specific metrics.
  - Organizations working to become a patient-centered medical home or center of excellence, or working to meet Medicare quality measures, may already collect and monitor care quality metrics that align with TIA initiative outcomes.

RESOURCE

The National Council for Mental Wellbeing provides guidance to organizations on mapping TIA work with quality care initiatives. This approach not only expedites TIA planning and implementation, but also emphasizes the notion that a TIA is not a separate initiative. It is an overall approach or lens that an organization uses while delivering all services and offerings.

- Collect and incorporate ongoing feedback from multiple sources to monitor the "temperature" of the organization during implementation.
  - Regularly ask staff, clients, and family members to assess the level of transparency, safety, and trust they feel within the organization.
  - Consider dedicating time in staff meetings for reflective conversations to strengthen staff commitment to implementing a TIA initiative and brainstorm areas for improvement.
  - Solicit feedback. Create an environment where feedback is welcome. Provide multiple ways for clients, staff, providers, and community members to provide feedback (e.g., suggestion boxes in waiting rooms, surveys, listening sessions).



TIP: Consider Using a Quality Improvement Framework

Organizations should consider using a quality improvement framework to guide implementation. These frameworks include structures for continuous feedback and monitoring. Information about commonly used models, such as Model for Improvement, Lean, and Six Sigma, can be found at the Agency for Healthcare Research and Quality website.



RESOURCE

The National Child Traumatic Stress Network has developed a resource titled Screening and Assessment: Considerations for Implementation. It provides these guidelines to consider when selecting a trauma screening or assessment tool.

- **Cost:** Is the tool free or low-cost?
- **Length:** Is the tool length justified by the specificity it provides for the given context; how long does it take to complete?
- **Age-appropriate:** Is the tool appropriate for children and youth (if they are the clientele)?
- **Format:** Is the tool administered in a paper-pencil format or online; is the tool self-administered or does it require an interviewer?
- **Language:** Is there a need for translating the tool into a different language?
- **Accessibility and mobility:** Is the tool accessible for different respondents?[47]

3.9 Additional Resources

Trauma-Informed Approach or Care Implementation

- The Institute on Trauma and Trauma-Informed Care, Buffalo Center for Social Research, has a framework for implementing a TIA.
- Massachusetts Childhood Trauma Task Force's Framework for Trauma Informed and Responsive Organizations in Massachusetts provides guiding principles for establishing a trauma-informed and responsive approach within an organization.

- LeadingAge Maryland's Guidebook on implementing a TIA is designed to assist nursing homes in becoming trauma-informed organizations.
- The Center for Health Care Strategies brief provides recommendations for healthcare organizations interested in becoming trauma-informed.

Trauma-Informed Approach Training

- A list of resources from the Center for Health Care Strategies' Trauma-Informed Care Implementation Resource Center provides information on various topics related to hiring, training, and retaining a trauma-informed staff.
- The National Fund for Workforce Solutions' A Trauma-Informed Approach to Workforce is an introductory guide for employers and workforce development organizations on the topic of TIA.
- Trauma Informed Oregon offers individual modules on different trauma-related topics, such as what is trauma-informed care, why is it important, and differentiating among trauma-specific, trauma-informed, and trauma-sensitive.

Governance and Leadership

- Accelerate Learning Community at the University of Utah maintains a website, Five Ways to Practice Trauma-Informed Leadership (utah.edu), that provides tips on practicing trauma-informed leadership.
- Trauma-Informed Care Training & Education | Relias provides resources on developing a more trauma-informed organization, including trainings, white papers, fact sheets, and other resources.
- Addressing Burnout in the Behavioral Health Workforce Through Organizational Strategies is a resource developed through SAMHSA's National Mental Health and Substance Use Policy Laboratory. It addresses secondary trauma in the workforce and is part of SAMHSA's Evidence-Based Resource Guide Series.
- Psychology Today's Workplace Trauma and Trauma-Informed Leadership is a brief article on the importance of trauma-informed leadership for psychological safety and connection in the workplace.

Cross Sector Collaborations

- The Philadelphia ACE project's resource The Role of Philanthropy in Fostering Collaboration Through Cross Sector Networks presents a continuum of collaborative relationships and the factors associated with their success.
- The Restorative Integral Support (RIS) model is a systemic, flexible framework to bring together various systems in a collaborative relationship to build resilience and recovery from ACEs.
- The Family Policy Council's Community Capacity Development resource provides the essential elements of successful cross sector collaborations and steps to implement those elements.

Financing

- The National Council for Mental Wellbeing provides guidance to organizations on Financing Trauma-Informed Primary Care.
- The Center for Health Care Strategies, Inc.'s Key Ingredients for Successful Trauma-Informed Care Implementation resource details payment considerations for organizations.

Physical Environment

- PACEs Connections' blog Trauma Informed Physical Environments - Assessment Tools describes trauma-informed physical environments and how to assess an environment.
- Region 3 Behavioral Health Services, Kearney, Nebraska's resource Agency Environmental Components for Trauma Informed Care provides assessments for a positive trauma-informed care environment, a non-trauma-informed care environment, and residential settings.

- The National Council for Mental Wellbeing's Recommendations for Trauma-Informed Design brief describes the importance of using trauma-informed principles in the design of physical environments to promote physical, mental, and social health.

Engaging Persons With Lived Experience

- Guide for Sharing Lived Experience is a resource from PsychHub that describes topics such as what is lived experience and why is it beneficial to engage individuals with lived experience.
- The National Child Traumatic Stress Network's What's SHARING POWER Got to Do with Trauma-Informed Practice encourages providers to share power in the context of trauma-responsive practice.
- The National Child Traumatic Stress Network's webinar on Compensation for Family and Youth Involvement: Why It's Critical discusses the importance of providing compensation for family and youth involvement.
- Youth Move National's Creating a Youth Advisory Board focuses on topics such as key decisions for forming a youth advisory board and building relationships with youth.

Screening, Assessment, and Treatment Services

- The National Child Traumatic Stress Network has a repository of resources on screening and assessment developed by the network.
- The National Council for Mental Wellbeing's Trauma-Informed Care Screening and Assessment Toolkit for Community Mental Health and Substance Use Care Organizations and Mobile Crisis Units provides an overview of screening and assessment and their critical components and a list of tools and resources.
- The U.S. Department of Veterans Affairs' National Center for PTSD provides a Trauma Screening Questionnaire (TSQ) designed for use with individuals who have experienced all types of traumatic stress.
- The Network of Infant/Toddler Researchers' Research to Practice brief, Services for Families of Infants and Toddlers Experiencing Trauma, provides information on evidence-based interventions for infants and toddlers exposed to trauma.
- SAMHSA's TIP 57, Trauma-Informed Care in Behavioral Health Services, includes a chapter on Screening and Assessment.
- The Screening and Assessment of Child Trauma page on the Department of Health and Human Services' Child Welfare Information Gateway website includes a repository of trauma screening and assessment tools.

Progress Monitoring and Quality Assurance

- The Missouri Model helps organizations determine whether they are meeting basic criteria for integration of trauma principles and includes processes and indicators for organizations to identify where they are on the continuum and where they want to be.
- The Roadmap to Trauma Informed Care developed by Trauma Informed Oregon includes considerations for implementing and monitoring a trauma-informed approach. The accompanying Standards of Practice for Trauma Informed Care provides benchmarks for planning and monitoring progress and a means to highlight accomplishments.





Chapter 4.

Evaluation and Sustainability

For the sustainable implementation, learning, and replication of positive TIA outcomes, it is essential for organizations to evaluate their TIA initiatives. It is equally important they undertake overarching changes to policies and procedures to ensure continued implementation of their initiatives. This chapter provides strategies across these two domains of TIA implementation.

4.1 Policy

Written policies and procedures help sustain a TIA, especially when an organization incorporates it into its mission, operating policies, and bylaws. Putting in place formal policies and procedures that reflect trauma-informed principles ensures these approaches will continue, even with changes in leadership and staff. To ensure policies support a TIA:

- Review and modify agency policies and procedures to ensure a focus on trauma (providing guidelines to support the delivery of trauma-informed services and a commitment to reducing re-traumatization), safety, and confidentiality.
- Embed trauma-informed principles into the organization's mission statement, bylaws, and operating policies and procedures. Consider sharing the written policies and procedures among partner organizations. By sharing policies that have been successfully implemented, greater alignment between organizations is possible, while reducing the stress associated with its initial development.
- Within policies and procedures, clearly define the roles of individuals with lived experience of trauma in leadership/decision-making positions.
- Clearly communicate with collaborators regarding the organization's emphasis on using TIA.
- Ensure organizational policies attend to the emotional impacts that working with individuals experiencing trauma has on staff. This intervention can be through offered assistance, such as peer support and mutual self-help, mental health days, and an employee assistance program.

KEY TAKEAWAY: Six Principles of TIA

The six principles of a TIA—safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment; and cultural, historical, and gender issues—should be evident in organizational policies and procedures. These policies and procedures, developed with individuals with lived experience of trauma, should be reviewed and revised (as needed) at regular intervals.

- Recognize that everyone's experiences are unique and require an individualized approach. Formalize a process for clients, family members, and staff to feel empowered to choose how to address their trauma needs. This empowerment includes offering gender-responsive services, recognizing and addressing historical trauma, and implementing traditional cultural ways of healing.

RESOURCE

Campaign for Trauma-Informed Policy and Practice (CTIPP) is a non-partisan, nonprofit organization that promotes trauma-informed approaches and communities. The organization's focus and work are grounded in NEAR science, a body of scientific research that includes neuroscience, epigenetics, adverse childhood experiences (ACEs), and resilience. CTIPP's resource center offers a variety of videos, blogs, podcasts, and written resources on the topics of policy and policy changes in relation to TIA. It also includes call-for-action events that encourage readers to take an active role in policy change.

4.2 Evaluation

Evaluation is a key component of a successful TIA implementation and often takes place at multiple points in time. Before implementing a TIA, an organization should conduct a baseline evaluation to determine implementation priorities or readiness for a trauma-informed initiative.

During implementation, ongoing evaluation can help determine whether the program is having an impact and how it is affecting the quality of services. The evaluation includes collecting feedback from providers, leadership, and staff, as well as those receiving services. In the long term, an organization should evaluate whether change efforts are sustained and if further refinements are needed.



There are several validated tools available to evaluate an organization's progress in becoming trauma-informed. Consider examining the following target outcomes when developing an evaluation:

- To what extent is the organization or system trauma-informed?
- Does being trauma-informed improve the quality of the organization's services?
- Does the quality of the services improve clients' abilities to meet their service goals?
- To what extent has the larger community engaged in collaborative TIA implementation?

RESOURCES

Since 2014, the San Francisco Department of Public Health (SFDPH) has implemented a practice change model, centered in implementation science, to support organizations in nurturing and sustaining trauma-informed practices. Evaluation was a key component of the model and was designed to capture how well the training promotes learning and implementation of trauma-informed systems (TIS) core principles. Evaluation of the initiative included an attitude scale, effectiveness of training, and participants' experience with implementing change.

SFDPH developed the Tool for Trauma-Informed Work Life (TTIW), an evaluation instrument that asks staff about the extent to which they experience TIS principles in the workplace. The TTIW measures internal-facing components to determine how well the workplace reflects the six core principles of a trauma-informed system. In 2017, SFDPH published an evaluation report summarizing the findings from process and outcome data collected during the three years of implementation.

KEY TAKEAWAY: Evaluation Questions

Consider questions to help plan a TIA evaluation:

- What is the purpose of the evaluation?
- How will data be collected, managed, and analyzed?
- From whom will the information be collected?
- On what target outcomes will you focus and how will you report them?



RESOURCES

Examples of scales/assessments to evaluate TIA across organizations and systems.

Tool	Use	Links
TICOMETER/TIC Scale	Gauges the extent to which organizations provide trauma-informed care. • Use this tool to assess current capacity to provide trauma-informed care, identify areas for improvement, and monitor changes in practice over time.	Tools Factsheet Validation
The Attitudes Related to Trauma-Informed Care (ARTIC) Scale	Measures staff attitudes toward trauma-informed care. • Use to gauge readiness, evaluate the impact of staff training, and assess the sustainability of trauma-informed culture change efforts.	Tools FAQs Validation
Trauma-Informed Practice (TIP) Scales	Measures, from the clients' perspective, the degree to which programs are using trauma-informed practices. • Use to assess six domains of trauma-informed practice: 1) Environment of agency and mutual respect; 2) Access to information on trauma; 3) Opportunities for connection; 4) Emphasis on strengths; 5) Cultural responsiveness/inclusivity; 6) Support for parenting.	Guide Validation
Trauma Informed System Change Instrument	Measures the extent to which staff understand trauma-informed practice, use safety plans, and perceive their organization as having formal TIC policies.	Tool/ Scoring Guide Validation

4.3 Additional Resources

Policy

- Pacific Southwest Mental Health Technology Transfer Center Network has developed Creating Trauma-Informed Policies: A Practice Guide for School and Mental Health Leadership
- The Michigan State website provides an example of a trauma policy.

Evaluation

- The Trauma-Informed Care Implementation Resource Center has resources to help organizations assess trauma-informed care.
- The Traumatic Stress Institute's Measuring Trauma-Informed Care Series provides guidance to schools and organizations in planning and implementing effective evaluations of trauma-informed interventions.





Chapter 5.

Case Studies

This chapter includes three case studies that exemplify a trauma-informed approach (TIA) in practice, with each example from a different human services sector. Each example follows the 10 TIA implementation domains described in Chapter 1.

5.1 Cambridge Police Department, Cambridge, MA

Beginning in 2015, the Cambridge Police Department (CPD) planned and implemented a trauma-informed initiative in conjunction with the City of Cambridge. The goals of this initiative were to:

- Create department policies, culture, and capacity that focus on the wellbeing of staff and prevent re-traumatization.
- Increase staff knowledge and skills in responding to individuals who experience trauma.
- Improve interactions with the public by responding in a trauma-informed manner.



The CPD developed a Guide for a Trauma-Informed Law Enforcement Initiative to serve as a manual for other law enforcement agencies and community organizations. The guide shares information about the CPD initiative, logistics for implementation and evaluation, and lessons learned. The CPD implementation team learned a key lesson from this initiative that implementing a TIA is more than a one-time training or screening tool. It requires a shift in culture, focused staff support, and continued educational policies.

Governance and Leadership

- Leadership team at the CPD was supportive of the initiative and actively involved in communicating their support and participating in the training.

Training and Workforce Development

- The staff attended a three-day training focused on mindfulness and resilience, understanding trauma, and incorporating trauma-informed practice into work.

Cross Sector Collaboration

- The planning team for the initiative included the police department, city government, community agencies, and trauma experts.

Financing

- The initiative was funded through grants from Massachusetts Office for Victim Assistance.
- The CPD ensured that the budget for training included the expenses for the physical space needed for the training, speaker fees and travel, food, materials, and supplies.

Physical Environment

- A structural change to the physical environment included redesigning the interview room to be a more comfortable space to talk with individuals who have experienced trauma.

Engagement and Involvement

- The CPD collaborated with community organizations that work with individuals who experience trauma across all phases of implementation, leading to the inclusion of different perspectives and learning.

Screening, Assessment, and Treatment Services

- To provide support to officers who experience a traumatic event, the CPD offered stress management resources and formed Peer Support and Resilience Teams.

Progress Monitoring and Quality Assurance

- The training for the initiative included clear goals with measurable learning objectives. In addition, progress was monitored at the trainings through check-ins and check-outs to incorporate staff perspectives.

Policy

- A new policy that required detectives to implement a trauma-informed interview procedure when interviewing individuals who experience trauma was put in place.

Evaluation

- The CPD brought in an outside researcher to conduct an evaluation to determine the effectiveness and impact of the training. The evaluator collected data through pre/post-surveys for the trainings and interviews with detectives, patrol officers, and supervisors.

5.2 Fall-Hamilton Elementary School, Nashville, TN

Fall-Hamilton Elementary School began its transformation into a trauma-informed school in 2015. The school uses a whole-school approach, moving away from a focus on student compliance to ensuring a feeling of safety, nurturing, and support among the students. The aim is to focus on key relationships at all levels—between adults and students, among the staff, and among the students. The implementation was rolled out gradually and intentionally, as described in this video.



Governance and Leadership

- Leadership, especially the principal, recognized that teachers need to be supported in understanding and catering to their students' needs, namely, that TIA is not a checklist but a shift in mindset for all staff and across all areas of the school.

Training and Workforce Development

- The school started with monthly professional development sessions on TIA for the teachers in March 2016 and continues to offer intermittent sessions.
- New hires receive a letter explaining the philosophy and practice of TIA. They are also connected to related resources before their first day of employment at the school.
- The school has had on staff a full-time trauma-informed practitioner trained in Adverse Childhood Experiences (ACEs) since 2016 and a full-time social worker since 2020.

Cross Sector Collaboration

- The school partnered with a local nonprofit organization to establish a Family Resource Center (FRC) which serves as a hub for family support. The FRC brought together various community organizations, including churches, businesses, and universities, and provided monetary help and volunteer hours.
- The school provided training on ACEs for collaborating partners.

Financing

- The school received multiple grants to begin TIA implementation. For example, a Building Stronger Brains grant from the State of Tennessee funded the school's staffing of the trauma-informed practitioner.
- A Panda Express Leadership Grant funded the implementation of the *Leader In Me* program for three years.
- When the Metro Nashville Public Schools moved to a student-based budgeting system, the district gave school leadership autonomy to budget funds to match their needs and strategic plan.

Physical Environment

- Classrooms use warm lighting, calming colors, and essential oil diffusers. In 2020, the school moved to school-wide flexible seating as an option.
- Teachers use mindfulness as a key strategy. Every classroom has a "peace corner" where students can go to calm down and reflect. These corners are equipped with a comfortable seat and a timer; some also have stuffed animals, or a worksheet where students can document and monitor their feelings and reactions.

Evaluation

- Outcome data the school collected revealed that TIA implementation was associated with:
  - 96 percent reduction in office referrals
  - Zero suspensions between 2018 and 2022
  - 90-95 percent teacher retention rate
- Fall-Hamilton was in the top 5 percent in Tennessee for academic growth in 2021-2022.

Engagement and Involvement

- The school implements the *Leader In Me* program:
  - Offers students a class in leadership and teaches them seven habits practiced by leaders.
  - Empowers students by having them lead other students in different activities, from the classroom to sports.
  - Allows students to apply for school-wide activities/chores, for example, as data collectors, calculating attendance numbers, and managing breakfast for younger children.

Screening, Assessment, and Treatment Services

- By 2020, nearly 275 of the 320 students were receiving either individual or group support services from the school counselor, social worker, or community mental health provider.
- In 2020, the school implemented a school-wide mindfulness and movement program in partnership with BeWell in School, which included weekly classroom-based mindfulness classes. In addition, the school hired a full-time teacher certified in mindfulness and yoga to implement the program in designated de-escalation spaces.
- The school offers teachers support through the "Tap in/Tap out" program, which allows teachers to call on a peer when they need to take a break or need to step back from a tense situation. Teachers use a specific mobile app to locate help. Importantly, teachers know that asking for help is not only supported but promoted at their school.

Progress Monitoring and Quality Assurance

- The school holds bi-weekly social-emotional learning (SEL) team meetings to discuss case load and evaluate the effectiveness of support for students and staff.
- The school implements a Check-in Check-out (CICO) system for selected students:
  - Students are paired with an adult who is not their classroom teacher.
  - At the beginning of the day, this adult has a brief check-in that starts with greeting the student, asking a question about something the student is interested in, and then establishing a small attainable goal (social, academic, or executive).
  - Staff and students check out at the end of the day to evaluate the goal.
  - This mentor-mentee relationship allows monitoring of progress and demonstrates to the students that there is an adult that is excited to see them in the morning and again right before they leave.

Policy

- The leadership at the school changed multiple policies, including adding peace corners and including co-regulation, self-regulation, and de-escalation as first-line strategies for staff to implement school-wide.

5.3 Center to Advance Trauma Informed Health Care, San Francisco, CA

The vision of University of California–San Francisco's (UCSF's) Center to Advance Trauma Informed Health Care (CTHC) is a healthcare system designed and resourced to be a protective factor that interrupts the impact of childhood and adult trauma on preventable illness, preventable death, and disparities in health. Key programs CTHC runs include:

- Since 1993, the Women's HIV Program (WHP) has provided interdisciplinary medical and psychosocial primary care to cis and transgender women living with HIV and other complex health and social conditions. For the past 10 years, WHP has been developing a trauma-informed model of care for its patients and working to develop the field and movement of trauma-informed health care. In 2013, WHP and the Positive Women's Network–USA co-led a National Strategy Group on Trauma-Informed Primary Care that developed and published the core components of an effective response to recent and past trauma in adult healthcare settings.
- The UCLA/UCSF ACEs Aware Family Resilience Network (UCANN) is a University of California multi-campus initiative co-led by the Department of Pediatrics at the David Geffen School of Medicine at University of California–Los Angeles and UCSF CTHC to implement the State of California's ACEs Aware initiative. The initiative is a first-in-the-nation effort to screen and respond to adverse childhood experiences (ACEs) throughout California's 14+ million member Medicaid system.
- The Whole Family Wellness Study seeks to interrupt intergenerational trauma by studying how to effectively engage and support the caregivers and families of children receiving care in pediatric healthcare settings.
- The Health, Empowerment, and Recovery Services (HERS) program is developing and studying trauma-informed approaches to outpatient substance use treatment, with a focus on opiate addiction. The HERS+ program focuses on trauma-informed treatment of stimulant addiction among Black women .



Governance and Leadership

- The Director of CTHC, the center's interdisciplinary leadership team, WHP physician and social worker leads, and the WHP patient leadership council are all committed to TIA implementation across programs.

Training and Workforce Development

- In WHP, the clinic had an outside expert provide three half-day trauma trainings to clinical and non-clinical staff, including those at partner agencies. The trainer also provided five, hour-long, follow-up interactive trainings over 12 months addressing actual situations clinical staff faced during practice.
- UCAAN, via the ACEs Aware initiative, trains providers throughout California's Medicaid system.

Cross Sector Collaboration

- WHP has strong, long-term collaborations with community organizations, such as an intensive case management agency, a behavioral health clinic, an Afro-Centric expressive arts organization, and a domestic violence agency.
- The Whole Family Wellness program uses a hub-and-spoke model, in which a family care manager ensures collaboration and coordination between the program and outside agencies, such as community-based social service agencies, adult physical and behavioral health services, and housing, legal, and other social supports.
- UCAAN's community grant-making and pilot projects engage community-based organizations, primary care clinics, and Medicaid managed care plans throughout California.

Financing

- CTHC was established with a seed grant from a charitable trust and is sustained by funding it receives principally from state and federal grants.
- WHP is funded by federal Ryan White HIV services grants, reimbursement from Medicaid and other health insurance, limited supplemental support for various staff positions from UCSF, and limited private philanthropy.
- UCANN/ACEs Aware is funded by the California Department of Health Care Services.
- The Whole Family Wellness program is funded by Genentech.
- HERS and HERS+ programs are funded by clinical service grants from SAMHSA and a HRSA Special Projects of National Significance (SPNS) grant.

Physical Environment

- WHP staff and patients worked together to redesign the clinic to make it feel safe, calm, and inviting for everyone. Additionally, the clinic provides chair massage, food, acupuncture, and a therapy dog in the waiting room (before COVID, and again soon) to enhance the experience for patients and staff.

Engagement and Involvement

- WHP conducts formative focus groups with its patients to include patients' voices in every aspect of WHP's operations. WHP seeks ongoing patient feedback during monthly Patient Leadership and Advocacy Group (PLAG) meetings.
- UCAAN has a well-supported Community Council which provides input and oversight on a variety of operational policies, trainings, and products.

Treatment Services

- Care at WHP includes various trauma-specific interventions, including individual and group therapy, psychiatry, substance use counseling, an Intensive Outpatient Program (IOP) for stimulant use, and medication-assisted treatment for alcohol and opiate use, in addition to comprehensive primary care.
- CTHC's trauma-informed substance use programs are provided at WHP and at a variety of other locations caring for women living with HIV throughout San Francisco.

Progress Monitoring and Quality Assurance

- WHP innovated a trauma-informed method of chronic care management that guides its allocation of resources and delivery of care. It developed an algorithm for stratifying patients by their risk of death. The stratification assists in determining the patients' treatment plans and is readdressed every month by the entire interdisciplinary team.

Policy

- WHP also instituted a policy that all staff receive high quality, regular reflective supervision.

Evaluation

- Baseline evaluation data from WHP show that patients who had experienced childhood and/or adult trauma were significantly more likely to report post-traumatic stress disorder, depression, and anxiety symptoms; significantly more likely to report potentially harmful alcohol and drug use; had a significantly poorer quality of life; and were significantly less likely to report being on and adhering to HIV medications.[48] Published baseline data for the healthcare team provided a better understanding of the opportunities and needs for trauma-informed systems change.[49] Other studies by WHP have demonstrated positive impact of expressive therapy intervention and a clinic-based group intervention.[50, 51] WHP has also published data informing the emerging field of trauma-informed health care.[52-54]
- UCAAN is in its second year of existence and is being rigorously evaluated across all domains by the RAND Corporation on behalf of California's Department of Health Care Services.

References

1. The Institute on Trauma and Trauma-Informed Care. (n.d.). *What is trauma-informed care?* University at Buffalo. https://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/what-is-trauma-informed-care.html
2. Center for Health Care Strategies. (2017). *Key ingredients for trauma-informed care.* https://www.chcs.org/media/Fact-Sheet-Key-Ingredients-for-TIC.pdf
3. Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach* (HHS Publication No. (SMA) 14-4884). https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf
4. Substance Abuse and Mental Health Services Administration. (2022). *Trauma and violence.* https://www.samhsa.gov/trauma-violence
5. Benjet, C., Bromet, E., Karam, E. G., Kessler, R. C., McLaughlin, K. A., Ruscio, A. M., Shahly, V., Stein, D. J., Petukhova, M., Hill, E., Alonso, J., Atwoli, L., Bunting, B., Bruffaerts, R., Caldas-de-Almeida, J. M., de Girolamo, G., Florescu, S., Gureje, O., Huang, Y., … & Koenen, K. C. (2016). The epidemiology of traumatic event exposure worldwide: Results from the world mental health survey consortium. *Psychological Medicine, 46*(2), 327-343. https://doi.org/10.1017/S0033291715001981
6. Kilpatrick, D. G., Resnick, H. S., Milanak, M. E., Miller, M. W., Keyes, K. M., & Friedman, M. J. (2013). National estimates of exposure to traumatic events and PTSD prevalence using DSM-IV and DSM-5 criteria. *Journal of Trauma Stress, 26*(5), 537-547. https://doi.org/10.1002/jts.21848
7. Dube, S. R., Felitti, V. J., Dong, M., Chapman, D. P., Giles, W. H., & Anda, R. F. (2003). Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: The adverse childhood experiences study. *Pediatrics, 111*(3), 564-572. https://doi.org/10.1542/peds.111.3.564
8. Anda, R. F., Brown, D. W., Dube, S. R., Bremner, J. D., Felitti, V. J., & Giles, W. H. (2008). Adverse childhood experiences and chronic obstructive pulmonary disease in adults. *American Journal of Preventive Medicine, 34*(5), 396-403. https://doi.org/10.1016/j.amepre.2008.02.002
9. Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245-258. https://doi.org/https://doi.org/10.1016/S0749-3797(98)00017-8
10. Centers for Disease Control and Prevention. (2022). *Fast facts: Preventing adverse childhood experiences.* https://www.cdc.gov/violenceprevention/aces/fastfact.html
11. Trauma-Informed Care Implementation Resource Center. (2021). *What is trauma?* Center for Health Care Strategies. https://www.traumainformedcare.chcs.org/what-is-trauma/
12. Substance Abuse and Mental Health Services Administration. (2014). *A Treatment Improvement Protocol (TIP 57): Trauma-informed care in behavioral health services* (HHS Publication No. (SMA) 13-4801). https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4816.pdf
13. Pinderhughes, H., Davis, R., & Williams, M. (2016). *Adverse community experiences and resilience: A framework for addressing and preventing community trauma.* Prevention Institute. https://www.preventioninstitute.org/publications/adverse-community-experiences-and-resilience-framework-addressing-and-preventing

14. Weisner, L. (2021). *Individual and community trauma: Individual experiences in collective environments.* Illinois Criminal Justice Information Authority. https://icjia.illinois.gov/researchhub/articles/individual-and-community-trauma-individual-experiences-in-collective-environments

15. Substance Abuse and Mental Health Services Administration. (2016). *The national tribal behavioral health agenda.* https://store.samhsa.gov/product/The-National-Tribal-Behavioral-Health-Agenda/PEP16-NTBH-AGENDA

16. von Ameln, F., & Becker-Ebel, J. (2020). Emotional trauma, shame and "taboo topics". In *Fundamentals of psychodrama* (pp. 243-255). Springer Singapore. https://doi.org/10.1007/978-981-15-4427-9_16

17. Copeland, W. E., Shanahan, L., Hinesley, J., Chan, R. F., Aberg, K. A., Fairbank, J. A., van den Oord, E. J. C. G., & Costello, E. J. (2018). Association of childhood trauma exposure with adult psychiatric disorders and functional outcomes. *JAMA Network Open, 1*(7), e184493-e184493. https://doi.org/10.1001/jamanetworkopen.2018.4493

18. Teicher, M. H., Samson, J. A., Anderson, C. M., & Ohashi, K. (2016). The effects of childhood maltreatment on brain structure, function and connectivity. *Nature Reviews Neuroscience, 17*(10), 652-666. https://doi.org/10.1038/nrn.2016.111

19. Moore, S. A., Zoellner, L. A., & Mollenholt, N. (2008). Are expressive suppression and cognitive reappraisal associated with stress-related symptoms? *Behaviour Research and Therapy, 46*(9), 993-1000. https://doi.org/10.1016/j.brat.2008.05.001

20. Curran, E., Perra, O., Rosato, M., Ferry, F., & Leavey, G. (2021). Complex childhood trauma, gender and depression: Patterns and correlates of help-seeking and maladaptive coping. *Journal of Affective Disorders, 292*, 603-613. https://doi.org/10.1016/j.jad.2021.06.011

21. Kimerling, R., Makin-Byrd, K., Louzon, S., Ignacio, R. V., & McCarthy, J. F. (2016). Military sexual trauma and suicide mortality. *American Journal of Preventive Medicine, 50*(6), 684-691. https://doi.org/10.1016/j.amepre.2015.10.019

22. Banerjee, S., & Spry, C. (2017). Concurrent treatment for substance use disorder and trauma-related comorbidities: A review of clinical effectiveness and guidelines. In *CADTH rapid response reports.* Canadian Agency for Drugs and Technologies in Health. https://www.ncbi.nlm.nih.gov/books/NBK525683

23. Bowen, S., De Boer, D., & Bergman, A. L. (2017). The role of mindfulness as approach-based coping in the PTSD-substance abuse cycle. *Addictive Behaviors, 64*, 212-216. https://doi.org/10.1016/j.addbeh.2016.08.043

24. Rosenwohl-Mack, A., Tamar-Mattis, S., Baratz, A. B., Dalke, K. B., Ittelson, A., Zieselman, K., & Flatt, J. D. (2020). A national study on the physical and mental health of intersex adults in the U.S. *PLOS ONE, 15*(10), e0240088. https://doi.org/10.1371/journal.pone.0240088

25. Magne, H., Jaafari, N., & Voyer, M. (2021). Post-traumatic growth: Some conceptual considerations. *L'Encephale, 47*(2), 143-150. https://doi.org/10.1016/j.encep.2020.05.021

26. Tedeschi, R. G., & Calhoun, L. G. (1996). The posttraumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9*(3), 455-471. https://doi.org/10.1007/BF02103658

27. Turner, d. S., & Cox, H. (2004). Facilitating post traumatic growth. *Health and Quality of Life Outcomes, 2*(1), 34. https://doi.org/10.1186/1477-7525-2-34

28. Sabnis, S. V., Sullivan, A. L., Yohannan, J., Karner, K., & Gutierrez, S. (2021). Trauma as a social justice issue: Foundational knowledge. *Communique, 50*(3), 31-33.

29. U.S. Department of Veterans Affairs. (n.d.). *How common is PTSD in adults?* https://www.ptsd.va.gov/understand/common/common_adults.asp

30. Roberts, A. L., Gilman, S. E., Breslau, J., Breslau, N., & Koenen, K. C. (2011). Race/ethnic differences in exposure to traumatic events, development of post-traumatic stress disorder, and treatment-seeking for post-traumatic stress disorder in the United States. *Psychological Medicine, 41*(1), 71-83. https://doi.org/10.1017/s0033291710000401

31. Pumariega, A. J., Jo, Y., Beck, B., & Rahmani, M. (2022). Trauma and US minority children and youth. *Current Psychiatry Reports, 24*(4), 285-295. https://doi.org/10.1007/s11920-022-01336-1

32. Prevention Institute. (2014). *Making connections for mental health and wellbeing among men and boys in the U.S.* https://www.preventioninstitute.org/sites/default/files/publications/Making%20Connections%20for%20Mental%20Health%20Wellbeing%20among%20Men%20and%20Boys.pdf

33. Valentine, S. E., Livingston, N. A., Salomaa, A. C., & Shipherd, J. C. (n.d.). *Trauma, discrimination and PTSD among LGBTQ+ people.* U.S. Department of Veterans Affairs. https://www.ptsd.va.gov/professional/treat/specific/trauma_discrimination_lgbtq.asp

34. U.S. Department of Health and Human Services. *Social determinants of health.* https://health.gov/healthypeople/priority-areas/social-determinants-health

35. Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology, 33*(4), 461-477. https://doi.org/10.1002/jcop.20063

36. Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal, 3*(1), 80-100. https://doi.org/10.2174/1874924001003010080

37. THRIVE Institute. (2010). *Guide to trauma-informed organizational development.* https://nhchc.org/wp-content/uploads/2019/08/thrive-guide-to-trauma-informed-organizational-development.pdf

38. Centers for Disease Control and Prevention. (n.d.). *Infographic: 6 guiding principles to a trauma-informed approach.* https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm

39. The National Child Traumatic Stress Network. (n.d.). *Trauma-informed partnership.* https://www.nctsn.org/trauma-informed-care/family-youth-provider-partnerships/introduction

40. Menschner, C., & Maul, A. (2016). *Key ingredients for successful trauma-informed care implementation.* https://www.chcs.org/media/Brief-Key-Ingredients-for-TIC-Implementation.pdf

41. National Council for Mental Wellbeing. (n.d.). *Trauma-informed care interview questions.* https://www.nationalcouncildocs.net/wp-content/uploads/2014/01/Interview-Questions-for-Trauma-Informed-Care.pdf

42. U.S. Department of Health and Human Services, Administration for Children and Families, Office of Head Start, & National Center on Parent Family and Community Engagement. (2020). *Understanding trauma and healing in adults: Brief 5. Creating a program-wide trauma-informed culture.* https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/utha-trauma-brief-05-strengthening-trauma-informed-staff.pdf

43. The Philadelphia ACE Project. (n.d.). *The role of philanthropy in fostering collaboration through cross-sector networks*. https://www.philadelphiaaces.org/sites/default/files/CrossSectorInfographic_Spreads.pdf

44. Center for Health Care Strategies. (2018). *Creating safe health care environments for patients and staff.* https://www.traumainformedcare.chcs.org/wp-content/uploads/2018/11/Fact-Sheet-Safe-Health-Care-Environments.pdf

45. Center for Children Families and Workforce Development. (n.d.). *Trauma-informed care and family engagement.* https://www.umt.edu/ccfwd/public-policy/ffpsa/asset%20resources/ti-fam-engagement-final.pdf

46. Blanch, A., Filson, B., Penney, D., & Cave, C. (2012). *Engaging women in trauma-informed peer support: A guidebook.* https://www.nasmhpd.org/sites/default/files/PeerEngagementGuide_Color_REVISED_10_2012.pdf

47. The National Child Traumatic Stress Network. (n.d.). *Screening and assessment considerations for implementation.* https://www.nctsn.org/sites/default/files/resources/fact-sheet/screening_and_assessment_considerations_for_implementation.pdf

48. Cuca, Y. P., Shumway, M., Machtinger, E. L., Davis, K., Khanna, N., Cocohoba, J., & Dawson-Rose, C. (2019). The association of trauma with the physical, behavioral, and social health of women living with HIV: Pathways to guide trauma-informed health care interventions. *Women's Health Issues, 29*(5), 376-384. https://doi.org/10.1016/j.whi.2019.06.001

49. Dawson-Rose, C., Cuca, Y. P., Shumway, M., Davis, K., & Machtinger, E. L. (2019). Providing primary care for HIV in the context of trauma: Experiences of the health care team. *Women's Health Issues, 29*(5), 385-391. https://doi.org/10.1016/j.whi.2019.05.008

50. Empson, S., Cuca, Y. P., Cocohoba, J., Dawson-Rose, C., Davis, K., & Machtinger, E. L. (2017). Seeking safety group therapy for co-occurring substance use disorder and PTSD among transgender women living with HIV: A pilot study. *Journal of Psychoactive Drugs, 49*(4), 344-351. https://doi.org/10.1080/02791072.2017.1320733

51. Machtinger, E. L., Lavin, S. M., Hilliard, S., Jones, R., Haberer, J. E., Capito, K., & Dawson-Rose, C. (2015). An expressive therapy group disclosure intervention for women living with HIV improves social support, self-efficacy, and the safety and quality of relationships: A qualitative analysis. *Journal of the Association of Nurses in AIDS Care, 26*(2), 187-198. https://doi.org/10.1016/j.jana.2014.05.001

52. Hessol, N. A., Schwarcz, S. K., Hsu, L. C., Shumway, M., & Machtinger, E. L. (2017). Gender differences in causes of death among persons with HIV/AIDS in San Francisco, California, 1996–2013. *International Journal of STD & AIDS, 29*(2), 135-146. https://doi.org/10.1177/0956462417720370

53. Machtinger, E. L., Haberer, J. E., Wilson, T. C., & Weiss, D. S. (2012). Recent trauma is associated with antiretroviral failure and HIV transmission risk behavior among HIV-positive women and female-identified transgenders. *AIDS and Behavior, 16*(8), 2160-2170. https://doi.org/10.1007/s10461-012-0158-5

54. Machtinger, E. L., Wilson, T. C., Haberer, J. E., & Weiss, D. S. (2012). Psychological trauma and PTSD in HIV-positive women: A meta-analysis. *AIDS and Behavior, 16*(8), 2091-2100. https://doi.org/10.1007/s10461-011-0127-4

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