E-BOOK

Creating a *Trauma-Informed* System of Care

Addressing Individuals, Professionals, and Organizations

Nellie Galindo, MSW, MSPH and
Melissa Lewis-Stoner, MSW, LCSW-C

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This publication is dedicated to all survivors of trauma and the individuals who care for them.

Trauma-informed care shifts the conversation from "What's wrong with you?" to "What happened to you?"

A Primer for Trauma-Informed Care

Trauma-informed care (TIC) has become a widely recognized paradigm for creating safe spaces for individuals who have experienced trauma and reducing the likelihood that accessing services would cause re-traumatization. The impact of TIC on individuals and organizations is powerful, and this approach has shown to be effective in reducing trauma-related symptoms.

TIC as a treatment framework involves recognizing, understanding, and responding to the effects of all types of trauma. Rather than seeing trauma reactions as pathological, it reframes these reactions as adaptive. They are the individual's best attempt to cope with the experience of trauma.[1]

TIC is different from other models of care as it can be used in any type of service setting or organization. By using this approach, you can gain awareness of ways to anticipate and avoid institutional practices that are likely to re-traumatize persons served. It also focuses on the individual's strengths and encourages the individual's participation in the development, delivery, and evaluation of TIC services.[1]

TO PROVIDE A BASE FOR THIS WORK, WE WILL EXPLORE

- What trauma is and how it affects different populations.
- Best practices for addressing trauma with the individuals you serve, your staff, and throughout your organization.
- The products and resources Relias offers to help you become a trauma-informed organization.

What Is Trauma?

There are many ways to describe and categorize trauma. Ultimately, it is the emotional and physical response to experiencing an event (or witnessing an event) that is dangerous, frightening, or life-threatening.[2]

Trauma can affect different individuals or groups in different ways—two people may be exposed to the same event or series of events, but interpret these events in vastly different ways. Regardless of the severity or type of trauma, the immediate or long-term effects of the trauma can be met with resilience, or the ability to overcome the circumstances and meet new challenges with fortitude.[1]

Trauma affects different individuals or groups in different ways[1]:

Individual trauma

A single event that occurs to one person

Examples: Experiencing an assault; being severely injured in a car accident

Community trauma

Trauma that affects a community or culture

Examples: a neighborhood experiencing gang-related violence; surviving a school shooting

Group trauma

A traumatic experience shared by a specific group

Examples: First responders at a building fire; military service members experiencing war

Mass trauma

Traumas or disasters that affect large numbers of individuals, either directly or indirectly

Examples: January 2010 earthquake in Haiti; terrorist attacks of September 11, 2001

Different Types of Trauma

Traumatic stress

Stress that induces the flight/fight/freeze response. Unlike typical stress, traumatic stress includes intense physical and emotional responses that can have a lasting impact.

Complex trauma

The pervasive impact of exposure to multiple, simultaneous, or prolonged traumatic events. The feelings and behaviors associated with complex trauma can produce a domino effect and facilitate subsequent or repeated trauma.

Re-traumatization

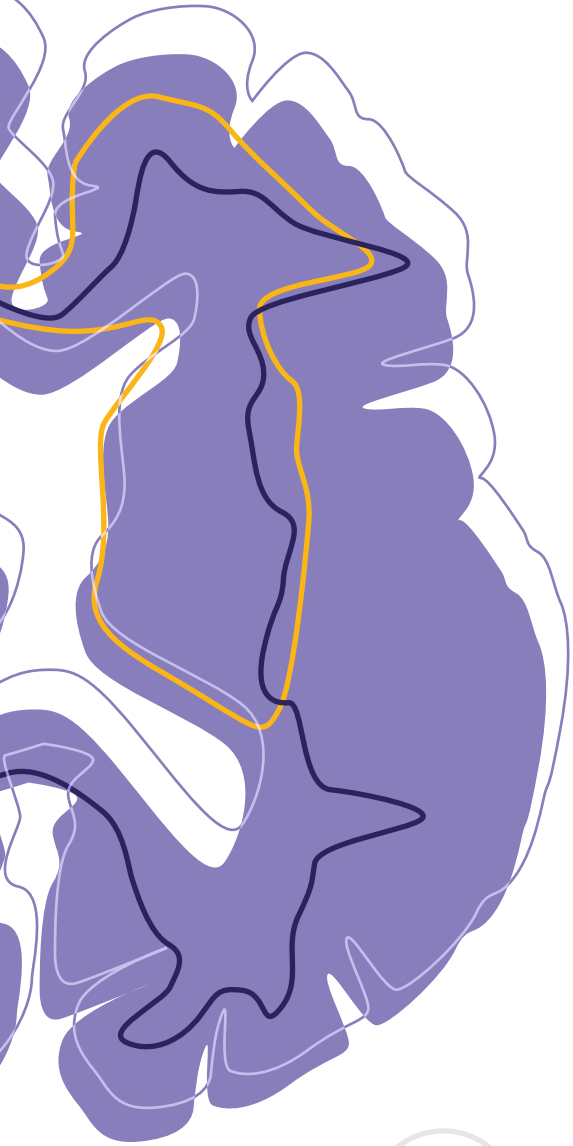
The recurrence of traumatic stress symptoms upon exposure to multiple traumatic events. Also includes reexperiencing traumatic stress symptoms when a new situation is similar to prior trauma.

Secondary or vicarious trauma

Experiencing trauma-related psychological and physical symptoms in response to helping or empathizing with others who have experienced traumatic events. This is very common among helping professionals working with trauma survivors.

Historical trauma

Also known as generational trauma, this refers to traumatic events that are experienced by a specific cultural, racial, or ethnic group. Examples include the enslavement and oppression of African American/Black Americans in the U.S., the forced migration and colonization of Native Americans, and the genocide of Jewish populations during the Holocaust. Historical trauma can have psychological and physical health impacts on a population and can result in individuals being hesitant to enter into systems of care that have historically oppressed these populations.[3]



How Trauma Affects the Mind

Trauma can provoke a wide array of emotional and cognitive reactions. Depending on an individual's personal characteristics, in the context of their environmental and cultural background, these reactions can include confusion, exhaustion, sadness, anxiety, dissociation, and physical arousal. Trauma can also profoundly shape an individual's worldview perception of personal safety and interpersonal relationships.

The **Cognitive Triad of Traumatic Stress**[1] highlights how trauma can alter three main cognitive patterns: views about the self, views about the world, and views about the future.

Views about the self

"I am incompetent"
"I should've reacted differently"
"It is too much for me to handle"
"I feel damaged"

Views about the World

"The world is a dangerous place"
"People cannot be trusted"
"Life is unpredictable"

Views about the Future

"Things will never be the same"
"What is the point? I will never get over this"
"It is hopeless"

Other common emotional and cognitive reactions to trauma include the following:

Foreshortened future Trauma can affect one's beliefs about the future via loss of hope, limited expectations about life, fear that life will end abruptly or early, or anticipation that normal life events won't occur (e.g. access to education, ability to have a significant and committed relationship, good opportunities for work).

Emotional dysregulation Some trauma survivors have difficulty regulating emotions such as anger, anxiety, sadness, and shame. This can occur more often in individuals who experienced childhood trauma. Self-medication using alcohol or other substances is often one way to attempt to regain emotional control; other methods can include high-risk or self-injurious behavior, disordered eating, compulsive gambling, or overwork.

Numbing This occurs when emotions become detached from thoughts, behaviors, and memories. Feeling or expressing too little emotion can sometimes mask how severe the trauma actually is.

Triggers and flashbacks A trigger is an external stimulus that reminds a trauma survivor of a specific traumatic experience. A flashback involves reexperiencing a previous traumatic experience as if it were happening in the moment. Flashbacks can be initiated by a trigger, but not always.

Other short-term and long-term physical reactions to trauma can include:

Nausea

Gastrointestinal distress

Elevated heartbeat, respiration, and blood pressure

Extreme fatigue or exhaustion

Somatization (i.e., increased focus on body aches and pains)

Hyperarousal

Sleep disturbances (i.e., nightmares)

Appetite and digestive changes

Lowered immune system response

Elevated cortisol levels

How Trauma Affects the Body

Traumatic events can deeply affect an individual's physiology, so far as to actually change the chemical makeup of the brain and increase the risk for developing certain physical ailments.

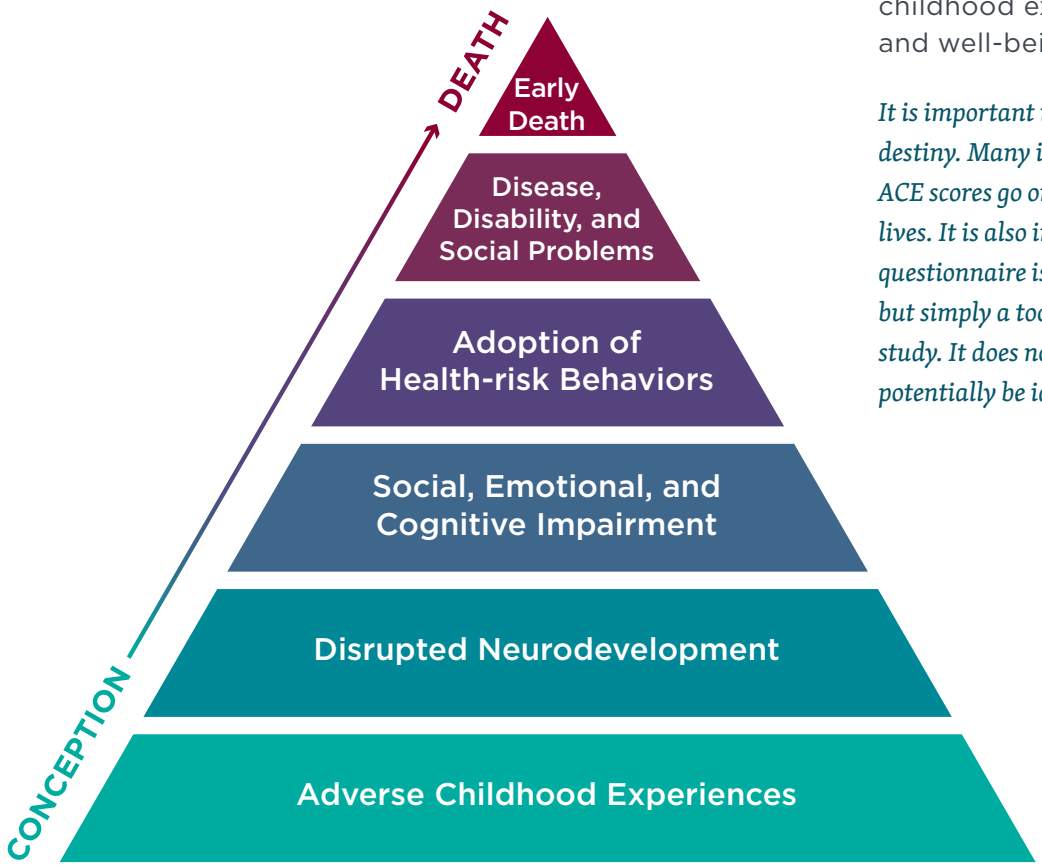
Experiencing trauma at any point of development can profoundly alter the brain's structure and makeup. Healthy human brain development is based on environmental input, being shaped by the experiences of the individual's life. Additionally, the brain consists of complex neural networks that interact with each other constantly. When one section of the brain is impacted, it is likely to affect other areas of the brain as well. If one's life experiences include chronic trauma, the brain's neural networks can restructure and affect areas of the brain that impact the emotional and physical regulation of the body.

Trauma also affects the body's autonomic nervous system. This system initiates a series of brain and body responses when a person is threatened, which trigger survival instincts (such as the flight or fight response). Typically, after the threat has passed, the autonomic nervous system shifts the body's survival reaction to a calmer, more restorative mode. For those who have experienced traumatic stress, this response system can become dysregulated, leading to an overreaction (such as becoming hypervigilant) or underreaction (feeling depression and dissociation).[4]

Adverse Childhood Experiences (ACEs) Study

The first large-scale study to showcase the physical impacts of trauma was the Adverse Childhood Experiences (ACEs) Study. This study highlighted a direct correlation between specific types of trauma experienced during childhood and lasting physical health consequences, including an increased risk of traumatic brain injury, HIV and other infectious diseases, cancer, diabetes, and substance use disorder.

This study also exposed the vast prevalence of trauma in the general population. Over 17,000 individuals participated in the study, which revealed that over two-thirds of respondents reported at least one ACE, and more than 20% reported three or more ACEs. Individuals who experienced four or more ACEs had a fourfold to 12-fold increase in health risk for depression, alcoholism, drug abuse, and suicide attempts, and a two- to fourfold increase in smoking and poor self-rated health.[5-6]



The ACE Pyramid

Mechanism by which adverse childhood experiences influence health and well-being throughout the lifespan.

It is important to recognize that ACE scores are not destiny. Many individuals with moderate to high ACE scores go on to lead satisfying and productive lives. It is also important to note that the ACE questionnaire is not a screening tool for clinicians, but simply a tool used for the purpose of the study. It does not assess all areas of life that could potentially be identified as a traumatic event.

"It's important to remember that what happened is not nearly as important as what the trauma means to the individual."[1]

Best Practices in Addressing Trauma in Individuals

Each person you serve at your organization will approach and display their trauma history in a different manner. In a trauma-informed approach, it is critical that providers meet individuals where they are in their healing journey, and that clinicians take the time to understand how the individual has adjusted to, perceived, and responded to their traumatic experiences. This shifts the conversation away from "provider knows best" to "together, we can find solutions."[1]

THIS SECTION WILL DISCUSS

- An overview of traumatic stress disorders.
- How trauma affects different populations.
- How cultural competency can help providers better serve trauma survivors.
- Clinical best practices for treating trauma, building resiliency, and including nonclinical staff in providing TIC.

Overview of Traumatic Stress Disorders

While many individuals will experience short-term reactions to traumatic stress (such as confusion, exhaustion, or physical arousal), these reactions commonly dissipate over time without long-lasting effects. For some, however, the symptoms of experiencing traumatic stress can linger and negatively affect the individual's ability to work, go to school, experience meaningful relationships, or engage in other activities of daily living.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5)[7] names two specific diagnoses for trauma-related disorders: Post-Traumatic Stress Disorder and Acute Stress Disorder.

Post-Traumatic Stress Disorder (PTSD)

PTSD is diagnosed when an individual experiences direct or indirect exposure to actual or threatened death, serious injury, or sexual violence, as well as the presence of one or more of the following symptoms:

- Recurrent, involuntary, and intrusive memories of the traumatic event
- Dissociative reactions where the individual acts or feels like the event is happening again
- Recurring distressing dreams related to the traumatic event
- Prolonged or intense psychological distress when exposed to stimuli that symbolize or resemble aspects of the traumatic event
- Physiological reactions to internal or external cues that resemble aspects of the traumatic event

Individuals may consistently avoid places, people, things, emotions, or other cues that resemble or can be associated with the traumatic event. They may also experience negative thoughts or moods associated with the traumatic event (e.g. feeling detached from others, feeling negative beliefs about oneself). PTSD can also result in marked alterations in an individual's behaviors, such as irritable or angry outbursts, hypervigilance, problems with concentration, or reckless or self-destructive behavior. The symptoms of PTSD must last for one month or more in order to be diagnosed.

Acute Stress Disorder

Acute Stress Disorder is similar to PTSD, with the main difference being the length of time symptoms are present. For a diagnosis of acute stress disorder, the individual may be experiencing intrusive thoughts, negative thoughts and feelings, arousal and reactive symptoms, and avoidance behaviors between three days and one month after exposure to a traumatic event. The presence of these symptoms is still severe enough to cause major disruption and distress in the individual's daily life.

The type of traumatic event experienced can influence the prevalence of acute stress disorder. For example, between 13% and 21% of individuals who experience car accidents develop acute stress disorder, whereas 20% to 50% of individuals who survive assault, rape, or mass shootings develop acute stress disorder. About half of individuals who are diagnosed with acute stress disorder will go on to develop PTSD.[8]

Trauma in Different Populations

Certain subset of individuals can have a greater risk of experiencing traumatic stress and developing ASD or PTSD. The following are just a sample of different groups of individuals and how trauma specifically affects their lives:

Race, Ethnicity, and Trauma

Racial trauma involves a traumatic response to race- or ethnicity-related experiences of racism that can involve discrimination, prejudice, or violence against racial groups based on attitudes of superiority held by the dominant group. Examples of racial trauma can range from the interpersonal, such as overt racial slurs or threats, to the systemic—police harassment, workplace discrimination, community violence, and mass incarceration. Experiencing immigration difficulties and deportation can also be traumatic.[9] Black and Latino Americans have a higher rate of lifetime PTSD as compared to white Americans.[10]

Trauma in people of color can be compounded by seeking treatment, as they are more likely to experience barriers to treatment (such as language barriers) and systemic discrimination while seeking treatment. People of color are also consistently underrepresented in treatment studies, further limiting behavioral health practitioners' understanding of racial trauma and PTSD. Furthermore, certain experiences that are not included in the criteria of the PTSD diagnosis can still cause a traumatic reaction—meaning incidents of racial trauma may be under-assessed in these populations.[9]

Individuals With Disabilities

Individuals with disabilities—which can include physical, sensory, behavioral health, intellectual and developmental disabilities—are at a higher risk of experiencing trauma, largely due to their increased risk for experiencing abuse and neglect. People with disabilities are three times more likely than the general population to experience violent victimization, sexual assault, and to be sexually abused as children. They are also 1.5 times more likely to experience repeat instances of abuse and neglect as children.[11] They are also especially at risk as they can experience disability-specific abuse tactics, such as a caregiver withholding medication or denying access to assistive or mobility devices.[12]

It can be difficult for behavioral health clinicians and paraprofessionals to adequately identify trauma in individuals with disabilities. For some individuals with intellectual or cognitive disabilities, it can be difficult to discern due

to the ability of the survivor to effectively remember, communicate, or identify aspects of the traumatic event. Evidence of trauma may manifest in symptoms like developmental regression, communication loss, or behavioral outbursts—but many caregivers fail to recognize that these could be the result of a traumatic event.

Trauma and Substance Use

The 2018 National Survey on Drug Use and Health[13] found that approximately 20.3 million people in the U.S. age 12 or older had a substance use disorder (SUD) in the past year. Trauma and substance use often go hand in hand; many individuals who have a SUD have experienced traumatic stress, and serious substance use can also increase the likelihood that an individual will experience trauma (e.g. risk behaviors that lead to injury). Individuals who present with trauma and SUD often have poorer treatment outcomes and other difficult life issues, such as mental disorders, difficulty with homelessness, poverty, and an increased risk of HIV and other infectious diseases.[1]

It is important for clinicians to recognize that the presence of a SUD should not preclude an individual from receiving trauma treatment. Rather, these co-occurring disorders need to both be addressed in treatment planning. Helping clients gain control over trauma-related symptoms can greatly improve the rates of substance use recovery and lower the chances of relapse.

Children and Youth

As mentioned earlier, the Adverse Childhood Experiences (ACEs) study was the first major study to look at the prevalence of traumatic experiences in childhood and how they correlated with health and wellness later in life. Children and youth with exposure to traumatic events have an increased risk for

developing poor health behaviors, and these events can even impact brain and nervous system development. Childhood trauma is also associated with increased involvement with child welfare and juvenile justice systems.[14]

Bullying is of particular concern for school-aged children and youth. One in five students have reported being bullied, with 15% reporting bullying happening online (also known as "cyberbullying"). Bullying is often targeted toward a youth's physical appearance, race/ethnicity, gender, disability, or sexual orientation. Students who report frequent bullying are at an increased risk for suicide-related behavior.[15]

The LGBTQ Community

Individuals who identify as lesbian, gay, bisexual, transgender, queer, or another sexual minority identity are much more likely to experience trauma and victimization than their straight peers. These traumatic events often begin in childhood. LGBTQ children have rates up to two times higher for sexual and physical abuse and 1.5 times higher for emotional abuse.[16] The prevalence of trauma is very high among transgender individuals, where upwards of 91% of transgender people experience multiple traumatic events across their lifetime.[17] LGBTQ individuals are also twice as likely to experience hate crimes as compared to any other minority group in the U.S.[18]

Like other minority populations, LGBTQ individuals can face unique barriers to being able to access behavioral health and other community services. Discrimination and bias among providers, as well as legal discrimination and a lack of access to healthcare, make it difficult for LGBTQ communities to find trauma-informed and culturally competent providers to meet their needs.[19]

Veterans

Traumatic stress and the prevalence of PTSD in veterans is common; between 11% and 20% of veterans serving in Operations Iraqi Freedom and Enduring Freedom had a PTSD diagnosis in a given year, while about 30% of Vietnam Veterans have had PTSD in their lifetime. Factors that can contribute to trauma in veterans includes experiencing combat exposure, mass casualty events, and acts of terrorism. PTSD in the military can also result from military sexual trauma—55% of women have experienced sexual harassment when serving in the military, and 23% have reported sexual assault.[20]

Mental health stigmas continue to be prevalent among veterans. Military culture is also very distinct. It is imperative for clinicians and providers to understand what makes military life unique and how to navigate cultural aspects of military and veteran life.[21]

Clinical Best Practices

Health and human service professionals who provide direct services to their clients can help create a trauma-informed environment using certain clinical best practices. These best practices involve integrating key principles of TIC into their practice, using evidence-based assessments for trauma, and using trauma-specific treatment interventions.

Six Key Principles of a Trauma-Informed Approach

There are six key principles[22] that reflect a trauma-informed approach providers can take with persons served:

1

Safety

An individual must feel safe, calm, and secure in the environment, both physically and psychologically. The interpersonal interaction between persons served and providers throughout an organization helps promote a sense of safety for the individual.

2

Trustworthiness and Transparency

Trust is the foundation of the helping relationship. The provider's decisions are conducted with transparency and the mutual goal of building trust and maintaining trustworthiness.

3

Peer Support

"Peer" refers to other individuals with lived experience of trauma. Peer support and mutual self-help can create a sense of safety and hope for the person served. Utilizing peers' stories can promote recovery and healing.

4

Collaboration and Mutuality

Everyone on the treatment team works together for the common good of the person served. Treatment goals are person-centered, and the individual is supported in making their own decisions. Emphasis is placed on partnering with persons served and leveling the power differences that exist between providers and clients.

5

Empowerment, Voice, and Choice

The individual's strengths, gifts, and talents are recognized and built upon. Treatment is based on resilience and the belief that individuals who experience trauma can heal and recover. Persons served are supported in shared decision-making, choice, and goal setting.

6

Cultural, Historical, and Gender Issues

The provider recognizes the importance of culture in the individual's experience of trauma and how they interpret and heal from trauma. Providers offer gender-responsive services, leverage the healing value of traditional cultural connections, acknowledge and address historical trauma, and are responsive to the racial, ethnic, and cultural needs of the individual served.

Assessments for Traumatic Disorders

Being able to accurately diagnose trauma disorders is critical for successfully providing treatment. Some examples of evidence-based diagnostic assessments for behavioral health clinicians are listed here:

Clinician-Administered PTSD Scale for DSM-5 (CAPS-5) This is considered the gold standard in PTSD assessments. It is a 30-item structured interview that is used to make a past month or lifetime diagnosis of PTSD and assesses symptoms that have occurred within the past week.[23]

Structured Clinical Interview for DSM-5 (SCID-5 PTSD Module) This semi-structured interview is broken into separate modules for subgroups of diagnoses, with symptoms coded as present, subthreshold, or absent. A PTSD diagnosis is made following a diagnostic algorithm.[24]

Posttraumatic Stress Disorder Symptom Scale Interview for DSM-5 (PSSI-5) This is a 17-item semi-structured interview that assesses the presence and severity of PTSD symptoms. Symptoms are assessed within the last two weeks, and each item is assessed with a brief, single question; no further probing or follow-up questioning.[25]

University of Connecticut Racial/Ethnic Stress & Trauma Scale (UnRESTS) This semistructured interview provides a comprehensive assessment of race-based trauma relative to existing measures. This assessment is available in English and Spanish and can help facilitate a conversation between clinicians and persons served regarding their experience with racism and its connection to trauma.[26]

Treatment Best Practices

Grounding Techniques help individuals who experience traumatic flashbacks and other distressing symptoms of traumatic stress with managing overwhelming emotions. For clients who are discussing a traumatic experience for the first time or in a new way, grounding techniques can be helpful in managing hyperarousal and preventing re-traumatization. Examples of grounding techniques include focusing on one's surroundings, closing one's eyes and thinking of a safe place, or actively describing items around a room.[27]

Prolonged Exposure is a type of cognitive behavioral therapy that teaches the individual to gradually approach trauma-related feelings, memories, and situations that they have been avoiding since the traumatic experience. The therapist will first establish coping techniques with the individual (such as grounding techniques) to help manage any overwhelming feelings associated with discussing or re-experiencing the trauma. This treatment has been shown to be very effective in treating PTSD.[28,20]

Note: there are many other treatments that can be effective in addressing trauma and treating PTSD. These are just a few examples of promising practices and evidence-based treatments that can help persons served.

Cognitive Processing Therapy is a CBT-based therapy that provides psychoeducation on how to evaluate and change the upsetting thoughts that the person served has had since the traumatic experience. This therapy model usually take 12 individual sessions and is recommended as an evidenced-based treatment from the U.S. Department of Veterans Affairs and the International Society of Traumatic Stress Studies.[20]

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence-based treatment for children and adolescents who have experienced trauma. It is a structured, short-term treatment model that takes between eight and 25 sessions with the child and their caregiver. TF-CBT has been shown to effectively treat PTSD, as well as depression, anxiety, and behavioral issues associated with trauma. It has also been shown to help caregivers' personal distress regarding the child's traumatic experience and strengthen parenting skills.[29]

Eye Movement Desensitization and Reprocessing (EMDR) involves briefly focusing on the memory of a trauma while simultaneously experiencing back-and-forth eye movement or sound. This technique has the individual recall the upsetting memory until shifts occur in the way they experience and process information from the memory. EMDR is delivered by a specially trained therapist and has shown to be a promising approach for treating PTSD.[20,28]

Cultural Competency

Cultural competency and trauma-informed care go hand-in-hand; an organization cannot be fully trauma-informed without also being culturally-informed. It is the responsibility of the organization, as well as the clinicians, staff, and paraprofessionals within that organization, to acknowledge and respect the dynamic diversity of the people served.

Cultural competence involves constant learning and adaptation; it is a process rather than an end goal. This perpetual growth includes committing to continuously evaluating oneself and changing, fostering relationships with people and groups who advocate for others, and recognizing the need to correct power imbalances between providers and clients. It also means upholding the personal and relational viewpoints of cultural identity that are vital to the person served.[30]

Some specific ways that culture and trauma interact with each other include the following:[1]

- Some populations and cultures are more likely to experience a traumatic event or a specific type of trauma (e.g., historical trauma, racial trauma).
- Culture influences not only whether certain events are perceived as traumatic, but also how an individual interprets and assigns meaning to the trauma.
- Some traumatic events may have a greater impact on a specific population because those traumas represent something significant to their culture or disrupt a cultural practice or way of life.
- Traumatic stress symptoms can vary according to the cultural background of the individual (i.e., some individuals will present with primarily somatic complaints, which may not be recognized as PTSD symptoms).
- Culture will determine the acceptable response to a trauma, expression of distress, and can influence what qualifies as a legitimate health concern or which symptoms will warrant help.
- An individual's cultural background can provide a source of strength, specific resources, and unique coping strategies.

Note: The DSM-5 provides clinicians with the Cultural Formation Interview (CFI) that can be used to ascertain the impact an individual's culture may have on their clinical symptoms. The CFI's 16-point questionnaire has been field tested and found to be useful to both clinicians and persons served.

Trauma-Informed Care for Nonclinical Staff

In order for an organization to truly become trauma informed, it must involve every single person at that organization—this includes nonclinical staff such as receptionists, peer supports, and paraprofessionals. Every contact an individual has with someone at your organization will either contribute to a safe and trusting environment, or it will detract from a safe and trusting environment. For this reason, it is crucial that all staff members, regardless of their roles, are given the same trauma-informed training and communication as clinical staff. Recommendations for nonclinical staff include:[31]

- **Learn about how trauma affects persons served.** Staff who have a basic understanding of how trauma affects an individual's mind and body will be more likely to approach their work with a trauma-informed lens. Understanding concepts such as triggers can help nonclinical staff identify ways to prevent or reduce the likelihood of re-traumatizing a person served. Direct support professionals and peer supports can even learn how to facilitate grounding exercises with their clients when they recognize signs of distress.

- **Pay attention to language.** What kind of language does your organization use to describe the behavior of persons served? Rather than naming a client a "no show," acknowledge that there may be barriers to their being able to attend an appointment. Direct support staff may document an individual's behaviors as "noncompliant" or "resistant," when these are actually behaviors that reflect a trauma response. Pay attention to these terms and promote language that removes judgment from the individual's behavior.

- **Be strengths based.** Remember, TIC asks not "What is wrong with you?" but rather "What happened to you?" Withhold judgment about clients' behaviors and instead focus on how the behavior may be an adaptation of traumatic stress. Focus on the individual's strengths, talents, and gifts. These strengths are ultimately how clients can begin to move toward recovery from traumatic stress.

- **Focus on building relationships.** All work within health and human services is built on a foundation of trusting and therapeutic relationships. Consider what helps versus what hurts a trusting relationship—being dismissive, impersonal, or critical toward the persons served will break down trust. Active listening, respect, and patience will help a relationship thrive and make interactions with clients more successful.

- **Practice crisis de-escalation and prevention.** While many organizations will focus on training related to crisis response, they may gloss over or exclude training focused on preventing a crisis from occurring in the first place. Understanding precursors to behaviors that can be destructive or maladaptive, and preventing these precursors from happening or from getting worse, is a trauma-informed approach to care. Many of the traditional methods of crisis response can re-traumatize individuals (such as restraining or secluding an individual). Interventions such as these should be avoided and only used as a last resort to maintain the physical safety of the person served.

- **Remember to be person centered.** Ultimately, the person served is the expert of own their life. Person-centered practices keep the individual's goals, choices, and self-determination at the core of their treatment, and person-centered plans are often carried out by nonclinical or paraprofessional staff. Being person-centered will contribute to a client's ability to use voice and choice, a critical element of a trauma-informed approach.

Building Resiliency

Resilience is the ability to rise above or bounce back from adversity, using available resources to address the hardship or consequences of an adverse event. Resilience can describe an individual, but it can also be broadly applied to families, communities, and providers as well.[1] The recognition that individuals can overcome traumatic stress by building resiliency is a central tenet of trauma-informed care.

Rather than assuming that one is either born resilient or not, providers must recognize that everyone has the ability to become resilient. By building upon existing strengths and providing new tools for coping, resilience is a skill that can be fostered in individuals.

People who have experienced trauma are not condemned to a life of hopelessness and helplessness.

People can, and do, recover from trauma.

Three Main Ingredients for Building Resiliency

Social Support

Social networks, whether they are through employment, school, faith communities, or other networks, help buffer an individual's stress response. For example, LGBTQ youth with at least one supportive and accepting adult in their life were 40% less likely to report a suicide attempt in the previous year.[32]

Getting Back to Normalcy

Being able to resume day-to-day tasks can help create a sense of structure and purpose after an individual has experienced trauma. Even if these tasks require adjustment, getting back to life can help build resilience. For example, an individual who experienced traumatic injury and acquired a physical disability as a result can receive support to make accommodations at their place of employment, so they can continue a part of their life that existed prior to the trauma.[27]

Meaning-Making

If a trauma survivor can provide meaningful reasons for why the event may have occurred and how they are able to create some positive take-aways from the experience, this can help facilitate recovery. For example, an individual might process trauma and come away with the concept that going through the traumatic experience has made them a stronger person, or they might commit to work that helps others who have gone through a similar traumatic experience.[27]

Protective Factors

Protective factors[1] are characteristics or attributes that help individuals deal more effectively with traumatic stress and mitigate the risk of poor outcomes. Helping individuals establish individual protective factors with social supports within their community will help bolster resilience:

Community

Positive school experiences, community resources, affirming faith communities, safe neighborhoods

Social Support

Family and friends for support, supportive parent-child relationships

Individual

Cognitive abilities, self-efficacy, healthy coping strategies

Cultural Aspects of Resilience

Characteristics of an individual's cultural, racial, or ethnic background can often nurture resilience. The following list highlights some of these potential cultural protective factors:[1]

Strong kinship bonds

Respect for older adults within a family unit

Spiritual or religious practices

Expression of humor or creativity

A sense of heritage, history, or historical traditions

Community orientation, activities, or socialization

Beliefs and philosophies surrounding life, suffering, and perseverance

Trauma and COVID-19: How does a Pandemic Affect Trauma-Informed Care?

The coronavirus pandemic has impacted individuals across the world and will continue to create an impact long after it ends. Epidemics have been shown to create general stress across the populations they affect and can contribute to new cases of mental illness and substance abuse.[33] Many mental health professionals are predicting that COVID-19-related trauma, and its resulting mental health conditions, will be the next widespread public health issue to wrestle with.

Few are immune to the adverse effects of the coronavirus pandemic—even healthy individuals are at risk of COVID-19-related traumatic experiences. An April 2020 Kaiser Family Foundation poll found that nearly half of U.S. adults reported that their mental health had been negatively affected by stress over the pandemic. This stress has manifested from job or income loss, isolation due to social distancing, and fear for themselves or family members who may become ill.[33,34]

Groups at high risk of experiencing trauma due to COVID-19 include:

- **Healthcare workers,** especially those who are directly caring for COVID-19 patients, are experiencing unprecedented levels of burnout, moral injury, and traumatic stress. Coping with regular death, fear of infecting themselves or others, and shortages of necessary medical equipment are all impacting the mental well-being of nurses, doctors, and other hospital staff.[35]

- **ICU survivors** are at an increased risk of developing PTSD. Those who become critically ill with COVID-19 often end up in an intensive care unit and may need to be ventilated to support breathing, which can be a terrifying experience. Between 20% and 25% of ICU survivors experience PTSD symptoms up to a year after being discharged.[36]

- **Families of ICU survivors** are also at risk; a 2016 study found 15.7% of family members showed clinically significant PTSD symptoms after their loved one's ICU care was over.[37]

- **People of color** are experiencing significant disparities in how they are affected by COVID-19. Black and Latinx individuals are dying of COVID-19 at much higher rates than white individuals, often attributed to inequities in social determinants of health. People of color are also overrepresented in prisons, jails, and detention centers, where the risk of infection is higher.[38]

- **Individuals with disabilities** are disparately experiencing the ill effects of COVID-19. People with IDD are over five times more likely to contract COVID-19 and over four times more likely to die from it. This is because individuals with IDD are more likely to live in large congregate settings, such as state institutions or group homes, and are more likely to have comorbid chronic conditions (such as asthma or diabetes) that increase the risk of having complications with COVID-19.[39]

As with any other trauma-informed approach, the best way to combat the trauma associated with COVID-19 is to build resilience for individuals, clinicians, and organizations.

Follow the six key principles of a trauma-informed approach:[40]

Safety

Leaders must prioritize physical, emotional, and psychological safety in every level of an organization. Give space for affected individuals to express their concerns without fear of retribution. Avoid spreading blame and show compassion and grace to others.

Trust & transparency

Overcommunicate and share as much information as possible. Accept that some individuals may be slow to trust; remember, our brains react differently in times of crisis and higher-level functioning may be hindered. Practice intentional relationship building with everyone.

Peer support

For leaders at an organization, consider creating a "buddy system" to help staff connect and make sure no one feels outside of the protective culture. Celebrate wins and focus on what is possible during this time. Normalize symptoms of trauma that may appear and promote resilience among staff and persons served.

Collaboration & mutuality

Keep in contact with others regularly, even if it is through video conferencing or a telehealth platform. If working virtually, take the time to introduce your family members or pets online. Find ways to keep teamwork alive and share.

Empowerment, voice, & choice

Make sure everyone feels seen and heard. If you are a leader in your organization, offer flexible options for work schedules based on staff's needs. For individuals, give options for ways to seek services and supports virtually. Honor others' choices and preferences as much as possible.

Cultural, historical, & gender considerations

Continue to practice cultural humility and promote cultural competence among staff. Acknowledge your privilege and recognize that not all individuals are experiencing the same levels of risk or protective factors during the pandemic.

"The expectation that we can be immersed in suffering and loss daily and not be touched by it is as realistic as expecting to be able to walk through water and not get wet."

—Rachel Naomi Remen

Addressing Trauma in Professionals

Trauma can impact any individual, including those who enter helping professions. For many individuals working in health and human services, their own history of trauma may have been part of what drew them to help others. But as was discussed in Section 1 of this document, there are also individuals who may experience traumatic events as an occupational hazard of their work.

For these reasons and more, it is critical that clinicians and other professionals in health and human services are diligent about assessing their own levels of stress and trauma. It is also necessary that organizations have in place the resources to support professionals when they experience burnout, compassion fatigue, or vicarious trauma.

THIS SECTION WILL DISCUSS

- How trauma can affect clinicians and paraprofessionals in human services
- What trauma-informed supervision is and how it can help mitigate the impact of trauma
- Ways that professionals can build resilience to prevent and reduce vicarious trauma

The Effects of Trauma on Clinicians

As stated previously, many in the helping professions will experience secondary or vicarious trauma, which is experiencing trauma-related psychological and physical symptoms in response to helping or empathizing with others who have experienced traumatic events. There are other responses to working with trauma survivors that can be detrimental to clinicians[1]:

Burnout	The state of physical, mental, and emotional exhaustion resulting from prolonged stress in the workplace. Burnout also involves feelings of depersonalization (cynicism) and reduced personal accomplishment.[41] Burnout is most often associated with having a very high workload or an unsupportive work environment.
Secondary Traumatic Stress	The physical and emotional stress response to exposure to others' extreme or traumatic stressful events. The caregiver with secondary traumatic stress will often experience many common feelings and symptoms associated with victimization, such as difficulty sleeping or feeling afraid. Onset comes on more quickly than burnout.
Compassion Fatigue	The deep emotional, physical, and spiritual exhaustion accompanied by acute emotional pain. Compassion fatigue is the combination of burnout and secondary traumatic stress.[44] Compassion-fatigued practitioners can find it difficult to maintain a healthy balance of empathy and objectivity in their work.[42]
Moral Injury	Damage done to one's conscience or moral compass when the individual perpetrates, witnesses, or fails to prevent acts that transgress one's own moral beliefs, values, or ethical codes of conduct. Moral injury was first used to describe the emotional and psychological impact of service members returning from war, but is gaining traction in human service literature, as many professionals will experience situations in which they witness or perpetuate systemic injustices that negatively affect their clients. Moral injury can lead to depression, anxiety, or suicidality.[43]

Secondary Traumatic Stress + Burnout = Compassion Fatigue

How Does Traumatic Stress Affect Clinicians?

The range of symptoms that occur with secondary traumatic stress can be very similar to symptoms of acute or post-traumatic stress disorder. This can include:

- Difficulty in daily functioning
- Physical or psychological reactions to traumatic memories clients have shared
- Avoidance behaviors during client interactions
- Feeling numb or diminished affect
- Limited emotional expression
- Heightened arousal
- Insomnia
- Depressed mood
- Detaching from family, friends, and other social supports

How Does Clinician Stress Affect Persons Served?

Burnout has been associated with carrying negative feelings toward persons served. These negative staff attitudes, in turn, have been linked to poorer health outcomes among individuals with severe mental illness and has also been shown to correlate with poor client satisfaction.[41]

The experience of vicarious trauma or compassion fatigue is a common workplace danger for those working in behavioral health services. Clinicians who have unacknowledged trauma or secondary trauma symptoms can cause harm to their clients and are less likely to incorporate trauma-informed care practices.[1]

How Common is Burnout, Compassion Fatigue, and Secondary Traumatic Stress?

50%

of **mental health professionals** report moderate-to-high burnout.[41]

15.2%

of **master's level licensed social workers** meet diagnostic criteria for PTSD (twice the rate of the general population).[45]

20.8%

of **providers treating family or sexual violence survivors** experience symptoms of secondary traumatic stress.[46]

34%

of **child protective workers** experience PTSD symptoms due to indirect exposure to traumatic events.[47]

The Effects of Trauma on Paraprofessionals

Paraprofessionals in health and human services include direct support professionals (DSPs), peer support specialists, and many others. While they may not carry clinical licensure or provide therapy, they are a critical piece of the human services workforce and provide essential direct care to individuals with mental health needs, substance use disorders, and disabilities.

Paraprofessionals are often placed in difficult and potentially traumatic situations as part of their work. One study found that 25% of DSPs in community settings were exposed to aggression nearly every day. Many direct supports are also paid low wages and live in poverty, which is a general risk factor for experiencing trauma. Other scenarios can put paraprofessionals at a high risk of experiencing traumatic stress:[48]

- Working closely with populations that have a high risk of trauma history
- Witnessing abuse and neglect occurring to persons served
- Having to restrain or becoming injured by a client expressing violent behavior
- Witnessing self-injurious behavior that results in injury to persons served
- Witnessing property destruction

Paraprofessionals themselves are also more likely to carry a history of trauma. One study of Adverse Childhood Experiences among DSPs found the following:[49]

- 75% of DSPs experienced at least one ACE
- 30% of DSPs experienced four or more ACEs
- Female DSPs (who make up the majority of the DSP workforce) were more likely to have high ACE scores
- The most common ACE categories among DSPs were divorce, emotional abuse, experiencing mental illness, and substance abuse

What Is Trauma-Informed Supervision?

Supervisors, including those who provide clinical supervision, are in a unique position to help staff who are experiencing secondary traumatic stress. They are also able to promote a trauma-informed framework within their organization by utilizing the principles of trauma-informed supervision. Trauma-informed supervision incorporates the fundamental elements of trauma-informed care into the supervisor-supervisee dynamic and focuses on offering relationship-based supervision. It breaks down the traditional hierarchy of manager to employee and emphasizes open, honest feedback.

Trauma-informed supervision follows the core concepts of the TIC model:[50]

Safety Supervisors focus on the psychological, emotional, social, moral, and physical safety of their staff. They create an environment where staff feel safe to provide open, honest feedback on their experiences at work and with serving clients experiencing trauma.

Trust and transparency Supervisors err on the side of "overcommunication" and show the process behind their decisions and directions. They are consistent in their management practices (i.e. keeping regular meeting times with staff) and also practice open, honest communication.

Peer Support Supervisors recognize that staff can benefit from supporting one another. They create opportunities for staff experiencing similar difficulties with secondary traumatic stress to connect and provide support to each other.

Collaboration and mutuality Supervisors work with staff in an engaged way; not telling them what to do, but determining goals and objectives together. Trauma-informed supervisors emphasize that they are on the same team with their supervisees and are working toward the same goals.

Empowerment, voice, and choice Trauma-informed supervisors empower their staff to take ownership of their position and their abilities. They set clear expectations, provide tools and resources to help them learn, and regularly provide praise more than criticism. The voice of staff is embraced and choices are offered in all aspects of work whenever possible.

Cultural, historical, and gender issues Supervisors recognize the intersection of culture, background, and gender in their supervisees. Rather than ignoring or minimizing how a staff's culture influences their work with trauma survivors, supervisors acknowledge its impact. Supervisors also recognize how past trauma (such as racial trauma, minority stress, or gender-based violence) can affect the way staff interact with their clients.

Building and Promoting Resiliency for Staff

Just as building resiliency is one way to mitigate the poor outcomes of experiencing trauma for individuals, it does the same for staff experiencing burnout, compassion fatigue, vicarious trauma, and moral injury. Practicing a trauma-informed care philosophy and promoting this paradigm in your organization has benefits not only for clients, but for staff as well. For example, one study found that a trauma-informed organizational culture was associated with increased psychological wellness for direct support professionals.[49]

Strategies To Promote Resilience for Staff[1]

1

Peer support Both personal and professional peer support helps prevent feelings of isolation and helps professionals share the emotional distress of working with trauma survivors.

2

Supervision and consultation Professional consultation helps clinicians understand secondary traumatization, recognize their own personal risk of experiencing traumatic stress, and identify protective factors to help them prevent or mitigate its impact.

3

Training Ongoing training on trauma can help improve providers' understanding of how it not only impacts their clients, but also themselves. It can also help provide a sense of mastery and self-efficacy in their work.

4

Personal counseling Seeking help from a personal therapist can help counselors and other professionals become more self-aware of how their work may be impacting their resilience. Individual therapy can help professionals process the psychological and emotional distress that can often accompany working with trauma survivors.

5

Maintaining balance Maintaining a healthy work-life balance, which includes developing positive coping skills and practicing healthy lifestyle choices, can help individuals better manage stress.

6

Engaging in meaningful or spiritual activities Connecting to a spiritual community or engaging in regular spiritual activities (e.g., prayer, meditation) can create perspective on trauma and enhance resilience.

Compassion Satisfaction

Ultimately, staff practices that promote resiliency should lead away from compassion fatigue and toward compassion satisfaction. Compassion satisfaction is about the pleasure derived from being able to do one's work well. For example, a paraprofessional may feel like it is a pleasure to help others through their work. Or a clinician may feel positively about their colleagues or their own ability to contribute to the work setting or the greater good of society.[1]

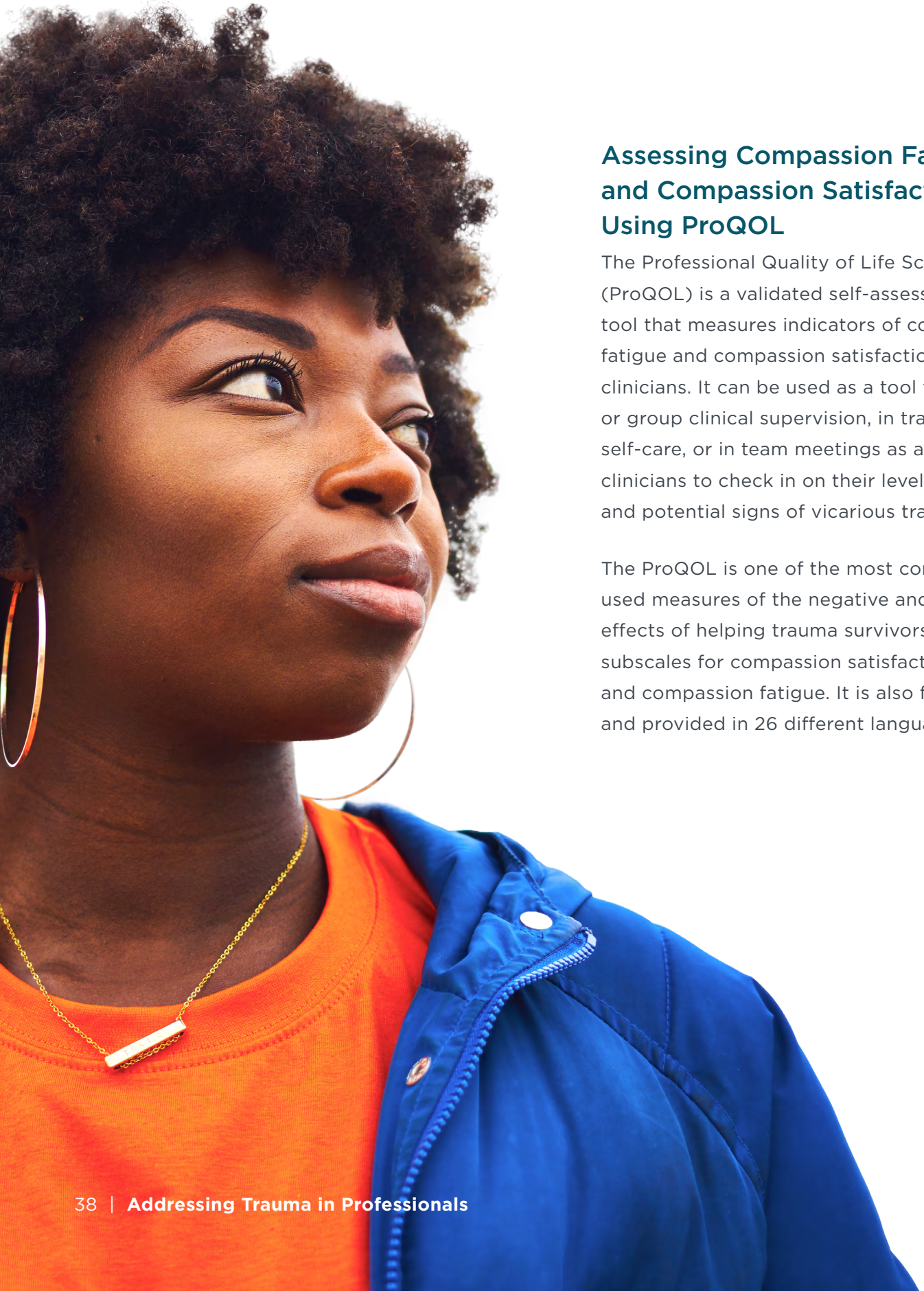
Self-Care

The importance of practicing self-care cannot be overstated. Professional self-care is an ethical imperative; it reduces the effects of burnout and lessens the possibility that compassion fatigue or traumatic stress will have a negative impact on persons served. Clinicians and paraprofessionals in human services should be responsible for developing their own self-care plans and committing to them, with the encouragement and guidance of their supervisors.

Self-care as a practice must go beyond common stereotypes of what this looks like in the media.

It is a mindset as much as it is a specific activity or routine.[51] The National Council on Behavioral Health[52] recommends some of the following self-care actions staff can begin to incorporate into their work:

- **Take stock of your workload inside and outside of work.** Determine what factors are making your plate feel too full.
- **Start a self-care idea collection.** Brainstorm with a trusted individual to create a list of self-care activities to pull from when needed.
- **Find time for yourself every day.** Take small breaks—even 5 to 10 minutes at a time—to listen to music, close your office door, or walk outside.
- **Delegate tasks when you can.** Learn to ask for help at work as well as at home.
- **Keep healthy boundaries.** Learn how to say "no" more often and avoid becoming overcommitted.
- **Assess your trauma inputs.** Recognize how often you are reading about, seeing images of, or hearing difficult stories about traumatic experiences.
- **Learn more about secondary traumatic stress.** Learn what compassion fatigue and vicarious trauma look like and how to recognize and address them when they occur.
- **Attend workshops or professional training regularly.** This allows you to connect with peers, take time outside of your normal work environment, and gain skills that help you build mastery and expertise.



Assessing Compassion Fatigue and Compassion Satisfaction Using ProQOL

The Professional Quality of Life Scale (ProQOL) is a validated self-assessment tool that measures indicators of compassion fatigue and compassion satisfaction in clinicians. It can be used as a tool for individual or group clinical supervision, in training on self-care, or in team meetings as a way for clinicians to check in on their levels of stress and potential signs of vicarious traumatization.

The ProQOL is one of the most commonly used measures of the negative and positive effects of helping trauma survivors. It has subscales for compassion satisfaction, burnout, and compassion fatigue. It is also free to use and provided in 26 different languages.[53]

Professional Quality of Life Scale (ProQOL)[54]

Compassion Satisfaction and Compassion Fatigue, (ProQOL) Version 5 (2009)

When you [help] people you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

1 = NEVER, 2 = RARELY, 3 = SOMETIMES, 4 = OFTEN, 5 = VERY OFTEN

1. I am happy.
2. I am preoccupied with more than one person I [help].
3. I get satisfaction from being able to [help] people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I [help].
7. I find it difficult to separate my personal life from my life as a [helper].
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].
9. I think that I might have been affected by the traumatic stress of those I [help].
10. I feel trapped by my job as a [helper].
11. Because of my [helping], I have felt "on edge" about various things.
12. I like my work as a [helper].
13. I feel depressed because of the traumatic experienc-es of the people I [help].
14. I feel as though I am experiencing the trauma of someone I have [helped].
15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with [helping] techniques and protocols.
17. I am the person I always wanted to be.
18. My work makes me feel satisfied.
19. I feel worn out because of my work as a [helper].
20. I have happy thoughts and feelings about those I [help] and how I could help them.
21. I feel overwhelmed because my case [work] load seems endless.
22. I believe I can make a difference through my work.
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].
24. I am proud of what I can do to [help].
25. As a result of my [helping], I have intrusive, frightening thoughts.
26. I feel "bogged down" by the system.
27. I have thoughts that I am a "success" as a [helper].
28. I can't recall important parts of my work with trauma victims.
29. I am a very caring person.
30. I am happy that I chose to do this work.

"Integrating trauma-informed care is a journey, not a destination."

—Sharday Lewis, National Council for Behavioral Health

Becoming a Trauma-Informed Organization

Building a trauma-informed organization is an ongoing process; it has no end date and must continually build upon itself. World events and exposure to different types of trauma may become more prevalent and affect different populations, all while the knowledge base of best practices and evidence-based practices for trauma will continue to expand. Therefore, trauma-informed organizations continually keep a finger on the pulse of these advancements and regularly reassess their capabilities for providing trauma-informed care.

Before an organization can become trauma-informed, its leaders at all levels (e.g., board of directors, chief executive officers) must commit to this framework. It also requires change at all levels of the organization. One way to conceptualize this is with the four R's of a trauma-informed approach:[22]

Realizing the prevalence of trauma among persons served and the general population

Recognizing how trauma affects everyone involved—including clients, their families, staff, and the community

Responding to trauma by placing the knowledge of trauma-informed care into organizational policies, procedures, and practices

Resisting re-traumatization for persons served and staff

THIS SECTION WILL DISCUSS

- How trauma can impact the entire organization
- Best practices for implementing a trauma-informed model of care at your organization
- Ways to build a trauma-informed workforce through recruitment, hiring, and training

How Does Trauma Affect an Organization?

Previously, we described how trauma affects persons served and staff. But trauma in the individual and clinician level can also wreak havoc on the health of an organization.

Client Outcomes

For many years, the misconception among human service providers was that trauma was an abnormal experience. However, the first National Comorbidity Study established that 61% of men and 51% of women in the United States had experienced at least 1 traumatic event in their lifetime[55] (Kessler et al., 1999). Over time, the connection between trauma, psychological distress, quality of life, mental health, and substance use became clearer. The trauma-informed model of care recognizes these connections and reinforces the concept that individuals may be impacted by trauma despite whether they acknowledge it themselves. Unresolved trauma, and providers who do not recognize the importance of a client's trauma history, can ultimately lead to poorer outcomes or a longer recovery.[1]

Trauma-informed care also provides clients more opportunities to engage in services that reflect a compassionate perspective of their presenting problems. While some individuals may not want to connect with their trauma histories, staff who provide trauma-informed services offer an opportunity to build upon strengths and adaptations in managing traumatic histories, increase resilience, and understand the relationship between trauma and substance use, physical health, and mental health. Simply put, trauma-informed care creates a better customer service experience for persons served.[1]

Staff Outcomes

Burnout, compassion fatigue, and secondary traumatic stress among staff is correlated with many negative organizational measures:[41]

- Reduced commitment to the organization
- Negative attitudes toward the organization and persons served
- Absenteeism
- High turnover
- Job dissatisfaction
- Damaged team morale

High levels of burnout have also been shown to predict high levels of sick leave and increases the risk of absence related to mental health disorders, circulatory disorders, and respiratory illness. For employees in mental health services, staff absences and high turnover have also been correlated with reduced fidelity to evidence-based practices, placing clients at risk of poor treatment.[41]

The high turnover of staff due to burnout and secondary traumatic stress often places a financial burden upon organizations. Turnover rates for behavioral health workers linger around 37%, while the turnover rate for direct support professionals nationally is 51%. Some organization experience even higher turnover rates than these.[56,57] This turnover all translates into additional organizational costs for hiring, onboarding, and training of staff—a huge financial burden for organizations that typically run on thin margins.

Elements of Implementing a Trauma-Informed Model of Care

Once an organization and its leaders have bought in to the concept of trauma-informed care, how does an organization go about implementing it? Remember, this is not a one-time implementation, nor is it the responsibility of a small group of leaders or a committee to solely complete. There are tools, models, and resources that can help an organization take the first steps into building a trauma-informed environment.

5 Key Elements of Trauma-Informed Care

The 5 Key Elements to Trauma-Informed Care is a framework that can help your organization begin to work toward implementing trauma-informed policies and procedures, as well as work toward a cultural shift toward being trauma-informed.

Examples of organizational assessment tools for trauma-informed care:

National Council for Behavioral Health
Organizational Self-Assessment©

Traumatic Stress Institute
Attitudes Related to Trauma-Informed Care (ARTIC) Scale

University of South Florida College of Behavioral and Community Sciences
Creating Trauma-Informed Care Environments: An Organizational Self-Assessment

University of South Florida College of Behavioral and Community Sciences
Creating Trauma-Informed Care Environments: Organizational Self-Assessment for Trauma-Informed Care Practices in Youth Residential Settings

University of Kentucky Center on Trauma and Children
The Secondary Traumatic Stress Informed Organization Assessment Tool (STSI-OA)

1. Organizational Assessment

The first step in building a trauma-informed organization is to conduct an organizational self-assessment. Whether the organization is shifting into a trauma-informed approach for the first time or currently practicing trauma-informed care, conducting such an evaluation allows the organization to identify a baseline of competencies and then regularly reassess to determine strengths and areas of improvement.

2. Paradigm Shift

Shifting to a trauma-informed organization requires that the entire organization views itself through this philosophy. Services must shift to a strengths-based perspective by which leaders, supervisors, and clinicians understand maladaptive or unhealthy behavior through the lens of survival. It is critical that organizational leaders model this philosophy and apply it to everyone—persons served, clinicians and paraprofessionals, administrative staff, and the community at large.

3. Safety

Safety is the first of the six key principles of trauma-informed care, and as such, it should be part of an organization's approach to implementing a trauma-informed care philosophy. Creating safety should not be limited to just creating safe therapeutic environments. It should also include the physical, emotional, and psychological safety of persons served and the staff at the organization. Organizations should reinforce the importance of staff autonomy, choice, and a sense of control as well—if staff do not feel empowered in their role, it will be incredibly difficult for them to empower the individuals they work with.

Organizational safety can include actions like:

- Implementing trauma-informed supervision practices
- Creating confidential or anonymous avenues for staff and clients to provide feedback to the organization
- Open and honest communication from leaders to clients, staff, and community members
- Implementing practices and policies that promote safety and reduce the risk of workplace violence

4. Wellness and Self-Care

From the top down, organizations must recognize the critical importance of wellness and self-care. As discussed previously, lack of employee wellness and self-care can create multiple poor outcomes for persons served, clinicians and paraprofessionals, and the organization as a whole.

However, research has demonstrated that, while valuable, relying on individuals to conduct their own self-care strategies alone does not work. Organizational leaders must bolster the ability of staff and clinicians to practice self-care through policies and practices that encourage it.

Some examples of this can include:[42]

- Seeking regular employee feedback and implementing feedback thoughtfully
- Establishing an employee assistance program (EAP) and making it easily available for staff to utilize
- Establishing regular staff and supervision meetings as part of organizational policy
- Planning for staff retreats or other opportunities for engaging in self-care activities
- Establishing an employee recognition or appreciation program that all staff can participate in

5. Everyone is Included

Every individual at an organization, including those who do not do clinical work, should be involved in the process of implementing a trauma-informed framework. Even more importantly, the individuals served at an organization (especially those who are survivors of trauma) need to be involved in your organization's strategic implementation of trauma-informed care. Placing trauma survivors and their experiences with your organization at the center of your implementation plan is one of the best ways to accurately determine if the organization's efforts are creating a positive difference.

Universal Precautions

The concept of universal precautions was introduced to the field of trauma-informed care in 2005 by Dr. Gordon Hodas. This concept states that given the widespread prevalence of trauma in the general population, organizations need to presume that persons served are likely to have some history of traumatic stress. Rather than trying to incorrectly categorize individuals as "traumatized" or "not-traumatized," creating a trauma-informed system of care ensures that every individual served at an organization is given the same courtesy, compassion, and assumption that they are resilient.[58]

Organizational Screening for Trauma

One key element of a trauma-informed model of care is implementing universal routine screenings across all services, regardless of the client's path in accessing services. This is especially important given the high prevalence of traumatic experiences in the general population. Without universal screening policies, organizations miss the opportunity to tailor treatment services that would more likely meet the needs of the individual.

There are many other benefits to universal screening—in general, it is a prevention strategy and can help clinicians identify individuals at risk of developing more pervasive symptoms of traumatic stress. It can also lessen the risk that a client could be re-traumatized by organizational policies, practices, or procedures. Screening can also prevent misdiagnosis and inappropriate treatment planning.

Examples of Trauma Screening Tools

Brief Trauma Questionnaire (BTQ)

Childhood Attachment and Relational Trauma Screen (CARTS)

Short Post-Traumatic Stress Disorder Rating Interview (SPRINT)

Life Events Checklist for DSM-5 (LEC-5)

Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)

Screening for Suicidality

All clients—especially those who have screened positive for a trauma history—should also be screened for suicidality. All clinicians should be trained in how to properly screen for suicide, and positive suicidality screenings should follow appropriate next steps for that individual. Organizations should have safety policies, staff training, and suicide prevention resources in place before implementing universal suicide screening.

Examples of questions for suicidality screening:

- "In the past, have you ever had suicidal thoughts, the intention to commit suicide, or made a suicide attempt?"
- "Do you have any of those feelings now?"
- "Have you had any such feelings recently?"

Recommendations for Trauma Screening Practices

- Use a self-administered, written checklist rather than an interview when possible—individuals are more likely to report trauma with a self-administered tool.
- Clarify for the client what to expect in the screening process.
- Respect the client's personal space and allow for a private space for screening.
- Make sure there are no communication barriers during the screening by providing interpreters when needed.
- Give the client as much personal control as possible during the assessment (i.e., the right to refuse to answer any or all questions).
- Allow time for the client to become calm and oriented if they have intense emotional responses during a trauma assessment.

Building a Trauma-Informed Workforce: Recruiting, Hiring, and Training

Health and human services organizations benefit from work development practices that plan for, attract, and retain a diverse workforce who are knowledgeable about the impact of trauma. Creating a trauma-informed organization involves hiring and promotional practices that will attract and retain individuals who are educated and trained in trauma-informed practices at all levels of the organization.

Recruiting and Hiring Practices

There are several ways organizations can focus their recruitment and hiring techniques around trauma-informed care:

- Actively recruit and do outreach to prospective employees who are part of trauma-informed organizations, such as professional or conference sites, peer support groups, or advocacy groups.
- Hire counselors and peer support staff members with educational backgrounds and training in trauma-informed or trauma-specific services, or with lived experience of being a trauma survivor.
- Provide incentives during recruitment and hiring that take into consideration prospective employees' trauma-related training, education, and job responsibilities.
- Routinely survey the demographics of the populations served by the organization and recruit a workforce that is similar in its composition. This can be done through outreach to advocacy groups, recovery-oriented programs, community and faith-based organizations, or other groups with knowledge and expertise in lived experience with trauma, resilience, and recovery.

Training and Onboarding Practices

Training is one of the most important factors to creating a trauma-informed organization and workforce. As mentioned previously, all staff at an organization should be given training on the basics of trauma and the elements of trauma-informed care. Furthermore, clinicians and those staff who practice any direct services should receive more in-depth training in screening, assessment, and how trauma is related to substance use and mental health disorders.

Taking the time to provide staff with adequate training during initial onboarding and throughout the first 30 to 90 days of employment is also beneficial. Direct care staff should not be thrown into work with persons served prior to receiving adequate training on trauma-informed care, crisis prevention and de-escalation, and understanding how to recognize and report abuse, neglect, and exploitation. Staffing challenges may tempt providers to expedite onboarding, but a staff member who is not fully trained on trauma-informed topics is at a higher risk of re-traumatizing persons served.

"Organizational practices are only effective if supported by unswerving trauma awareness, training, and education among staff."

SAMHSA, 2014

Examples of Trauma-Informed Training Topics:

- The basics of trauma-informed care
- Crisis prevention, de-escalation, and intervention
- Abuse, neglect, and exploitation prevention
- Cultural competency
- Professional ethics
- Motivational interviewing
- Trauma-informed supervision
- Evidence-based practices for trauma treatment
- Employee wellness practices and self-care

Ongoing training and continuous education can have a huge impact on the well-being of direct care staff and clinicians. When work demands and pressures are not matched to the employee's knowledge, skills, or abilities, they will struggle significantly more than an individual who already has the necessary skills or experience to work with trauma survivors.[42]

Properly assessing the incoming knowledge, skills, and abilities of new staff and assigning tailored training plans to meet their deficits not only decreases the overall onboarding time, but also ensures that all staff are given the necessary training to round out their knowledge base.

Retaining a Skilled Trauma-Informed Workforce

With the high rates of turnover across human services, retaining a skilled workforce is of utmost importance to trauma-informed organizations. Besides the negative financial outcomes of high turnover, organizations who continually experience the turnover of their trauma-informed staff will see it impact their clients. A strong therapeutic relationship with a counselor or other clinician is one of the best predictors of an individual's ability to recover from trauma. Additionally, continuous turnover of staff creates stressful disruptions for persons served, affecting their feelings of safety and trust.

If an organization can successfully address deficits in the employee experience, they will be better positioned to retain their best staff. Some steps organizations can take to help retain their workforce include:

- Offering competitive wages, benefits, and performance incentives
- Providing ongoing professional development and training in trauma-informed practices
- Creating a working environment that focuses on physical, emotional, and psychological safety of staff
- Instituting manageable caseloads that mix clients with and without trauma-related concerns
- Establishing an organizational culture that normalizes secondary traumatic stress and provides outlets for staff to process these experiences

Ready to Implement the Trauma-Informed Care Framework?

Implementing a trauma-informed framework for individuals served, clinicians, and on an organizational level produces improved outcomes for everyone. While the task can seem daunting, you do not have to do it alone.

Relias has resources to help organizations implement a trauma-informed model of care. Through our comprehensive online training platform, we can offer:

- Accredited training in trauma-informed topics created by subject matter experts in the field of trauma
- World-class training in topics like cultural competency, crisis prevention, and employee wellness
- Assessments to inform incoming employees' knowledge base and create individualized learning plans
- Professional development courses for clinical and non-clinical staff
- Innovative tools to ensure competency and boost knowledge retention

GET STARTED

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