What is Trauma Informed Care?

Purpose. This document provides general information about Trauma informed Care (TIC) especially for individuals new to this topic. Included are guiding considerations, principles and definitions offered by experts in the field.

Trauma Informed Care vs. Trauma Specific Services?

Trauma Specific Services (TSS) are programs, interventions, and therapeutic services aimed at treating the symptoms or conditions resulting from a traumatizing event(s).

Trauma Informed Care **(TIC)** is an approach, based on knowledge of the impact of trauma, aimed at ensuring environments and services are welcoming and engaging for service recipients and staff.

Background. TIC is based on growing knowledge about the negative impact of psychological trauma. Trauma is common in society and among service recipients. The service system can re---traumatize individuals affecting their willingness to participate and engage.

Harris and Fallot[1] introduced the idea of TIC in their influential publication, *Using Trauma Theory to Design Service Systems: New Directions for Mental Health Services.* Since that time, significant effort has been made to define and clarify a trauma informed approach and incorporate this framework in policies, practices, and workforce development. Although service providers and agency leaders are anxious to implement trauma informed practices, much of the conversation about TIC remains abstract. As more becomes known about the application of TIC, the service sector will benefit from practical and concrete examples for implementation.

Definition. Despite years of work in this field, there is not a common definition of TIC. The field should strive to create a definition that includes the following:

- An awareness of the prevalence of trauma;
- An understanding of the impact of trauma on physical, emotional, and mental health as well as on behaviors and engagement to services; and
- An understanding that current service systems can retraumatize individuals.

One example by Hopper, Bassuk & Olivet[2] combines definitions of TIC from several experts in the field and provides what they call a consensus definition (see box below).

"Trauma-informed care is a strengths based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment."

(Hopper, Bassuk, & Olivet, 2010)

A program, organization, or system that is trauma informed:

Realizes the widespread impact of trauma and understand potential paths for recover;

Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system;

Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively **resist** re-traumatization"

Substance Abuse Mental Health Administration (SAMHSA, 2012)

The Substance Abuse and Mental Health Administration[3] offers the four Rs as a helpful way to think about TIC (see box at left)

TIC will look different in every setting, based on unique individuals and organizations. Whether viewed as a culture shift, a framework, or a lens through which services can be viewed --- a commitment must be made to:

- Culturally responsive principles
- Service recipient involvement
- Workforce development

A trauma informed approach "would be experienced by all involved as a profound cultural shift in which consumers and their conditions and behaviors are viewed differently, staff respond differently, and the day---to---day delivery of services is conducted differently" (Jennings, 2004, p. 21)[4]

Principles of TIC. Many principles, values, and beliefs have been used to guide TIC practice. Those shown in the box *Principles of TIC* are well accepted in the field.

Principles of Trauma Informed Care

Trauma Awareness: Those who are trauma informed will understand the prevalence and impact of trauma among their service recipients and within the workforce. Policy and practice reflect this awareness and may be supported with activities such as screening and assessments.

Safety: Policy and practice reflect a commitment to provide physical and emotional safety for service recipients and staff.

Choice & Empowerment: To facilitate healing and avoid re-traumatization, choice and empowerment are part of trauma informed service delivery, for both service recipients and staff.

Strengths Based: With a focus on strength and resilience, service recipients and staff build skills that will help them move in a positive direction. (Hopper, Bassuk, & Olivet, 2010)

1. Harris, M., & Fallot, R. (Eds). (2001). Using Trauma Theory to Design Service Systems: New Directions for Mental Health Services.
2. Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings.
3. Substance Abuse and Mental Health Services Administration. (2012). SAMHSA's Working Definition of Trauma and Principles and Guidance for a Trauma-Informed Approach
4. Jennings, A. (2004). Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services.

Trauma Informed Oregon is funded through Oregon Health Authority, and is a partnership between Portland State University, Oregon Health Sciences University and Oregon Pediatric Society.

In writing these TIPs, Trauma Informed Oregon will strive for easy to read text, avoiding technical language and spelling out acronyms as needed. For TIPs that include information from other sources this may not always be possible.

Addictions and Mental Health Division (AMH)

Policy Title:	Trauma Informed Services				
Policy Number:	AMH-060-1607	Version:	1.0	Effective Date:	7/1/2015

Approved By: *(Authorized Signer Name)*

7/3/2014
Date Approved

Policy | Procedures | Forms, etc. | Definitions | References | Contact | History

Overview

Description: It is the policy of the Oregon Health Authority (OHA) Addictions and Mental Health Division (AMH) that state and community providers and those who oversee public mental health and addiction services are informed about the effects of psychological trauma, assess for the presence of symptoms and challenges related to that trauma, and develop and offer or refer to services that facilitate recovery in accordance with best or promising practices, Oregon Administrative Rules (OAR), Oregon Revised Statutes (ORS), County Financial Assistance Agreements (CFAA) and federal regulations. The policy includes national guidelines for establishing resources for the development of trauma informed services, and to provide educational resources to treatment providers and individuals receiving services regarding the impact of trauma, healing and resiliency strategies.

Purpose: The purpose of the Trauma Informed Services Policy is to:

- Promote resiliency, health and wellness for those who have experienced trauma and for their families;
- Create a minimum standard of care for those serving individuals with mental health and addiction challenges in addressing the impact of trauma;
- Establish a standard to provide treatment in a trauma informed manner;
- Increase access to effective and appropriate services for individuals who have experienced trauma; and
- Mitigate vicarious traumatization of treatment providers and others working with traumatized individuals.

Rationale: Trauma is a hidden epidemic. As the OHA leads health system transformation, and improves health outcomes, understanding the impact of trauma and providing trauma informed service delivery is critical to better health, better care and lower costs. The human and economic costs of adverse experiences drain individuals' resources for health and productivity across the lifespan and affect all the major human service systems in Oregon.

Addressing individual, family, and community trauma requires a comprehensive, multi-faceted

public health approach. This approach includes increasing awareness of the harmful short and long term effects of trauma experiences across the life span; development and implementation of effective preventive, treatment and recovery/resiliency support services that reflect the needs of diverse populations; creation of strong partnerships and networks to facilitate knowledge exchange and systems development; training and tools to help providers effectively identify trauma and intervene early; and establishing public policy that supports and guides these efforts.

Applicability: Individuals receiving services and their families, and staff and administrators in all programs licensed and/or funded by AMH. These include Community Mental Health Programs (CMHPs), subcontracted providers of CMHPs, and other entities receiving behavioral health funding either directly or indirectly through Medicaid or state general funds.

Compliance:
Providers shall follow OARs 309-018-0100, 309-022-0100 and 309-019-0100 and any applicable contracts with AMH with respect to providing trauma informed services. Service providers in need of technical assistance to implement the policy shall follow through with AMH recommended targeted technical assistance.

Policy

1. Effective July 1, 2015, AMH funded and/or licensed services and supports shall be engaged in a clearly outlined process to become trauma informed. Providers will examine existing practices, environment and treatment approaches to insure trauma specific services (see definitions) are readily available to all individuals. Agencies contracted with AMH will provide trauma services that are individualized, as defined. Services are recommended to be evidence based, promising, or best practices.
2. Community Mental Health Programs, and any providers contracted with CMHPs, must follow the AMH Biennial Implementation Plan Guidelines to describe, assess and plan for effective trauma informed services.
3. Services are provided in a collaborative, person-centered process. A person receiving services and their designated support person(s) will be partners in the treatment planning process.
4. AMH will facilitate the implementation of this policy by providing educational resources, toolkits and other technical assistance, as available, to agencies, customers, community partners or providers.
5. AMH will share guidelines for behavioral health providers to screen, assess and treat acute, chronic and complex trauma (see definitions).

Recommended Resources

1. Universal precautions (see definition) are recommended in the provision of services and supports.
2. AMH shall make available fact sheets to provide basic information for CCOs, families, child serving systems, and other interested and impacted stakeholders.

Procedures that Apply:

AMH Trauma Informed Services

Forms that Apply:

Definition(s):

Evidence-based Practices: Evidence-based practices are those practices for which there is consistent scientific evidence of positive outcomes. AMH approved evidence-based practices for trauma treatment include but are not limited to Trauma Focused Cognitive Behavioral Therapy, Seeking Safety, Child Parent Psychotherapy, Cognitive Behavioral Interventions for Trauma in Schools, Eye Movement Desensitization and Reprocessing (EMDR) and Dialectical Behavioral Therapy (DBT).

Individualized: Customized treatment strategies, services and other supports that suit the particular needs and strengths of an individual.

Promising Practice: A program, activity or strategy that has worked within one organization and shows promise during its early stages for becoming a best practice with long term sustainable impact. A promising practice must have some objective basis for claiming effectiveness and must have the potential for replication among other organizations.

Provider: An organizational entity, or qualified person, that is operated by or contractually affiliated with, a community mental health program, or contracted directly with the Division, for the direct delivery of addictions, problem gambling or mental health services and supports.

Re-traumatization: Individuals may be unintentionally traumatized or re-traumatized in agency or provider settings when psychological trauma is not recognized or addressed. Re-traumatization can be either overt, as in the use of seclusion and restraint, or less obvious, as in a lack of sensitivity by clinicians or others to the potentially triggering impact of their words or behavior, or when the physical environment may emphasize control over an individual's comfort and safety.

(Psychological) Trauma: Trauma is the unique individual experience of an event or enduring conditions in which a person's ability to integrate his/her emotional experience is overwhelmed. The person experiences, either objectively or subjectively, a threat to his or her psychological safety, bodily integrity, life or the safety of a caregiver or family member.

Inter-relational trauma refers to the range of mistreatment, interpersonal violence, abuse, assault, and neglect experiences encountered by children and adolescents, and some adults, including familial physical, sexual, emotional abuse and incest; community-, peer-, and school-based assault, molestation, and bullying; severe physical, medical, and emotional neglect; experiencing or witnessing domestic violence; as well as the impact of serious and pervasive disruptions in caregiving as a consequence of severe caregiver mental illness, substance abuse, criminal involvement, or abrupt separation or traumatic loss. Inter-relational trauma is characterized by a repeated pattern of damaging interactions.

Children and adults can also experience trauma from accidents, natural or human-caused disasters, death of a caregiver, and interventions associated with medical procedures.

Trauma experiences are emotionally painful or distressing, and frequently result in lasting mental and physical effects. Trauma responses are described as acute, chronic, or complex:

- **Acute** trauma response: Immediate response to a situation where a person experiences or witnesses an event that causes the victim/witness to experience extreme, disturbing or unexpected fear, stress or pain, and that involves or threatens serious injury, perceived serious injury or death to themselves or someone else. Acute trauma is generally short-lived. A single event can lead to long-term trauma responses. The presence of supportive people in the individual's life can make a difference.

- **Chronic** trauma response: Chronic trauma is described as exposure to trauma repeatedly over long periods of time and can encompass a variety of traumatic events. Individuals who have experienced chronic trauma can have a range of responses, from fear, guilt and shame, to loss of trust in others and they become less able to tolerate normal stress. Because each traumatic event serves as a reminder of another traumatic event, the effects accumulate and each event reinforces the negative impact of the previous trauma.

- **Complex** trauma response: Complex trauma describes both children's exposure to multiple traumatic events, often of an invasive, interpersonal nature, and the wide-ranging, long-term impact of this exposure. These events are severe and pervasive, such as abuse or profound neglect. They usually begin early in life and can disrupt many aspects of the child's development and the very formation of a self.

  Since these traumatic events often occur in the context of the child's relationship with a caregiver, they interfere with the child's ability to form a secure attachment bond. Traumatic events associated with the failure of those charged with protecting and nurturing a child have profound and far-reaching effects on nearly every aspect of a child's life. This child's experience has been labeled "toxic stress" to more fully describe this impact.

  Toxic stress results from strong, frequent or prolonged activation of the body's stress response, in the absence of a buffering supportive adult relationship. Multiple stressors frequently resulting in a toxic stress response are child abuse or neglect, parental substance abuse, and maternal depression.

  Complex trauma can have devastating effects on a child's physiology, emotions, ability to think, learn, and concentrate, impulse control, self-image, and relationships with others. **Across the life span**, complex trauma is linked to a wide range of problems, including chronic physical conditions, addiction, depression and anxiety, self-harming behaviors, and other psychiatric disorders. Changes in the brain and in emotional development can result in self-initiated isolation, and/or inability to get or remain connected to potentially supportive people in the community, further impacting the individual.

Trauma-informed services: Trauma-informed services are services and supports that are

informed about and sensitive to trauma-related issues present in individuals who have experienced trauma. The service system has been reconsidered and evaluated in regard to understanding the impact of trauma in the lives of people seeking mental health and addictions services. A standard of "universal precautions" (see definition) exists where people are assumed to have experienced trauma and treated accordingly, rather than the inverse approach. Service systems accommodate the vulnerabilities of individuals who have experienced trauma, and deliver services in a manner that avoids inadvertent re-traumatization, and facilitates their participation in treatment. Collaboration with other practitioners with trauma related clinical expertise takes place. Clinicians and others are encouraged and assisted to address their own vicarious traumatization in working with individuals who have experienced trauma.

Trauma-specific services: Trauma-specific services refer to treatment or treatment programs specifically designed to treat individuals who have experienced trauma. Consistency in several areas is paramount: the need for respect, information, connection, and hope for individuals, recognition of the adaptive function of any symptoms that are present; and working collaboratively and in a person-directed empowering manner with individuals who have experienced trauma. Treatment providers recognize a person's right to services in the most integrated community setting available.

Universal Precautions: "*Universal precautions"* is a term used in medical settings to describe the need to assume all individuals seeking services have been exposed to negative conditions. In trauma informed care, universal precautions means *assuming that all individuals presenting for services may have experienced trauma* and may have symptoms from this exposure that are not immediately obvious. Some individuals may not be comfortable to disclose or able to recall their trauma. The high prevalence of trauma exposure in the general population and especially in mental health and addictions populations dictates that a universal precautions approach be used.

Vicarious Traumatization: Vicarious trauma is a stress reaction that may be experienced by professionals and peer support specialists who are exposed to disclosures of traumatic images and events by those seeking help. Helping persons may experience long lasting changes in how they view themselves, others, and the world. The symptoms of vicarious trauma are similar to, but usually not as severe as those of posttraumatic stress disorder, and can affect the lives and careers of even those with considerable training and experience in working with disaster and individuals who have experienced trauma.

Resources:
Reference(s):

Revised OARs 309-018-0100, 309-022-0100 and 309-019-0100
SAMHSA Strategic Initiative[1]
ACES study[2]
SAMHSA document on trauma[3]
Building Resiliency: Preventing Adverse Childhood Experiences [ACEs] OHA Public Health

[1] http://store.samhsa.gov/shin/content/SMA11-4629/04-TraumaAndJustice.pdf
[2] http://www.ajpm-online.net/article/PIIS0749379798000178/abstract
[3] http://store.samhsa.gov/product/Helping-Children-and-Youth-Who-Have-Experienced-Traumatic-Events/SMA11-4642

Division July 2013.[4]

Contact(s):

Name: Amy Baker, Child/Family Mental Health Manager
Phone: 503-779-6803
Email: AMY.BAKER@state.or.us

Policy History:

Version 1.0:

9/16/2013

[4] http://public.health.oregon.gov/HealthyPeopleFamilies/DataReports/Documents/OregonACEsReport.pdf

STANDARDS OF PRACTICE FOR TRAUMA INFORMED CARE

The following Standards of Practice for Trauma Informed Care in Oregon are based on nationally recognized principles of trauma informed care (TIC) and are in alignment with SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.[1] Each section of the Standards references specific elements in the SAMHSA Guidance document. In addition, the Standards reflect what we are learning about implementation from partners around the state and were reviewed by a workgroup from the Trauma Informed Oregon Collaborative that included family members, youth, and individuals with lived experience as well as providers from different fields of practice. The Standards are intended to provide benchmarks for planning and monitoring progress and a means to highlight accomplishments. **We recommend use of this tool by multi-level teams within organizations.**

Please keep the following in mind in using the Standards tool:

1) The Standards of Practice are intended to help agencies communicate to their constituencies (individuals seeking services, community partners, contracting or funding entities, etc.) how and to what extent they are working to build trauma informed care within their program, clinic, agency or system. **This is a voluntary process.** We are not attempting at this time to develop metrics or a system of accountability.

2) Moreover, there is no assumption that the Standards will be equally useful across all organizations or systems. **Culturally specific organizations, for example, may describe how they effectively provide care for trauma survivors in quite different ways** than what appears in the Standards. Health care providers also may need different language, and possibly alternative or added Standards as well.

3) Individual Standards also will be interpreted differently in different contexts. For this reason, **the Standards invite a qualitative (descriptive) response** rather than a yes/no answer.

4) However, in order to assist agencies to assess strengths and weaknesses and to set goals, we have included a simple set of ratings. These are for internal communication and planning purposes only. **The ratings cannot be used to compare one program or agency to another**. Note that although the highest rating (4) says "we're stellar in this area," there is always room for improvement, and perspectives may vary depending on who is making the rating.

---

[1] Substance Abuse and Mental Health Services Administration, *SAHMSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* HHS Publication NO. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

5) **There is no expectation that an agency or program will be able to respond affirmatively to every item listed.** We hope the Standards will support planning and ongoing quality improvement. Furthermore, **agencies may be doing any number of other things to create trauma informed care** that we have not captured here. Space is provided for this additional information.

6) In using the Standards tool for planning, **it may be helpful to summarize the self-ratings into areas of strength and areas where work is needed** and to consider whether to build on existing strengths (moving ratings from a 2 or 3 to a 4, for example) or to address significant gaps (areas where self-ratings are low). In addition, **we strongly encourage efforts to address issues that affect the workforce as well as those that affect individuals seeking or receiving services** and to look for low cost/high impact opportunities.

7) Finally, **we recognize that the experience of individuals seeking services (and of the workforce as well) often comes down to personal interactions that reflect (or don't) sensitivity, respect, caring, transparency, an understanding of trauma, etc.** We are not able to capture the quality of those individual interactions in a set of agency-level Standards. We hope that procedures for inviting and using feedback, commitment to training, supervision, and the involvement of individuals with lived experience in the service system(s) will help fill in those gaps. And, again, we encourage the use of this tool to stimulate discussion that includes multiple perspectives and experiences.

The Standards of Practice will be reviewed annually, based on feedback from participating programs, agencies and systems.

###

For more information or to offer feedback on the Standards, contact:
Diane K. Yatchmenoff, PhD
yatchmd@pdx.edu
Or email: info@traumainformedoregon.org

STANDARDS OF PRACTICE FOR TRAUMA INFORMED CARE

I. Agency Commitment and Endorsement. Agency leadership acknowledges that an understanding of the impact of trauma is central to effective service delivery and makes operational decisions accordingly [includes **Governance and Leadership, Policy, Financing**, and aspects of **Engagement and Involvement***].

1= we haven't started yet **2= we've done a little** **3= we've done quite a bit** **4= we're stellar!**

Ia. Leadership team (including administration and governance) has received information/training on trauma and trauma informed care. *Describe the process.*	1 2 3 4
Ib. Trauma Informed Care appears as a core principle in agency policies, mission statement, written program/service information. *Describe or provide examples*: √	1 2 3 4
Ic. Individuals with lived experience in your service system have leadership roles in the organization. *What roles?* √	1 2 3 4
Id. There is a process in place for regular feedback and suggestions from staff and service recipients related to trauma informed care, e.g., perceived safety, welcoming environment, transparency, shared decision making, helpful/supportive staff, etc. *Describe process. Examples of feedback and change(s) that resulted?* √	1 2 3 4
Ie. Decisions about changes in policy, practices, procedures, and personnel are made in a way that minimizes negative impact on workforce and on individuals/families receiving services. *How do you achieve this? What processes are in place?*	1 2 3 4
If. Agency budget reflects a commitment to trauma informed care (e.g., resources for specialized training, flexible funding for staff wellness, peer specialists, staff time to coordinate or serve on workgroup, etc.). *How is this commitment reflected in the budget?*	1 2 3 4
Ig. Agency-wide workforce wellness program is in place. *Describe the program. How many staff participate?* √	1 2 3 4
Ih. The organization has made a commitment to diversity and equity within the organization and with the population served. *How is this reflected in policy and practice?* √	1 2 3 4

*Substance Abuse and Mental Health Services Administration, *SAHMSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* HHS Publication NO. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014

II. Environment and Safety. There is demonstrated commitment to creating a welcoming environment and minimizing and/or responding to perceived challenges to safety [includes **Physical Environment** and aspects of **Engagement and Involvement***].

1= we haven't started yet 2= we've done a little 3= we've done quite a bit 4= we're stellar!

IIa. Physical space (external environment, exits and entrances, waiting room, offices, halls, lighting, restrooms, etc.) has been reviewed (see NOTE below) for actual and perceived safety concerns that may affect staff and individuals receiving services. *What was the process? Who was involved? When did this last occur? What changes were made as a result?* √	1 2 3 4
IIb. Physical environment has been reviewed for "welcoming" quality, e.g., cleanliness, odor, color, furniture (in good repair and arranged for comfort), access to water, etc. *What changes have been implemented?* √	1 2 3 4
IIc. Physical environment has been reviewed for cultural responsiveness. *Describe modifications made.*	1 2 3 4
IId. There is a designated "safe space" (permanent or temporary) for staff to practice self-care. *Describe.*	1 2 3 4
IIe. Physical safety and crisis protocols for staff and for individuals receiving services are in place and are regularly practiced. *What's the protocol? How do you ensure information is available when needed?*	1 2 3 4
IIf. Individuals who have received services from the agency have helped develop and/or have reviewed decisions about physical environment and/or safety protocols. *What was the process?*	1 2 3 4
IIg. There is a process in place to hear and respond to safety concerns that arise. *Describe the process and how it is trauma informed.* .	1 2 3 4

NOTE: The term "reviewed" can mean many things. Please consider, throughout this document, who was involved in the process of reviewing aspects of the physical environment or practices/policies, and what perspectives were represented.

*Substance Abuse and Mental Health Services Administration, *SAHMSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* HHS Publication NO. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014

III. Workforce Development. Human Resource policies and practices reflect a commitment to trauma informed care for staff and the population served [includes **Training and Workforce Development***].

1= we haven't started yet **2= we've done a little** **3= we've done quite a bit** **4= we're stellar!**

Training **IIIa.** Employees have received core training in Trauma Informed Care. Check the content that staff has had: A= all staff; M = management/admin; DS= direct service staff. ○ The Adverse Childhood Experiences study ___ ○ The prevalence and impact of trauma on individuals in our agency ___ ○ The neurobiology of trauma___ ○ Issues of power and oppression related to the experience of trauma____ ○ Historical oppression; intergenerational trauma ___ ○ Principles and implementation of Trauma Informed Care___ ○ The role and benefits of peer support services___ ○ Trauma in the workforce; secondary trauma___ *If you provide (or make available) more in-depth training, please describe.* *Other trauma-related training regularly offered/required (including on trauma specific services)?* √	1 2 3 4
IIIb. Core training is offered at least annually. *Which modules? How frequently? How many staff attend? How is annual training delivered, by whom?* √	1 2 3 4
IIIc. Training is provided on supporting, managing, and responding to reactivity (e.g., de-escalation training). *Describe. How often is this training offered and to whom? How many staff have participated?*	1 2 3 4
IIId. Organization is building internal capacity to ensure that ongoing training and education for staff on trauma informed care is available. *How? What is the current status?* √	1 2 3 4
IIIe. Alternative opportunities for staff to learn about TIC (e.g., webinars or videos, community events) are offered regularly. *Examples? How many staff have utilized?* √	1 2 3 4

*Substance Abuse and Mental Health Services Administration, *SAHMSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* HHS Publication NO. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014

Hiring and Onboarding Practices **IIIf.** Screening and interviewing protocols include applicant's understanding and prior experience/training regarding the prevalence and impact of trauma and the nature of trauma informed care. *What questions are asked during the interview process? How do you gauge an applicant's ability to respond in a trauma-sensitive way to the individuals you serve (some organizations are hiring for 'warmth and emotional intelligence')?*	1 2 3 4
IIIg. Individuals with lived experience of our service system participate in the hiring process. *How? How is their feedback utilized?*	1 2 3 4
IIIh. New employee orientation and training includes the core principles of trauma informed care and affirms the agency's commitment to ongoing trauma awareness and education for staff. *Describe.*	1 2 3 4
Supervision and Support **IIIi.** Staff receives regularly scheduled supervision. *Which staff? How often does this process happen?* √	1 2 3 4
IIIj. Peer Support personnel, whether contracted or on staff, also receive regular support and guidance. *What is the process?*	1 2 3 4
IIIk. Supervision includes discussion of staff care and wellness. *Describe or provide example.* √	1 2 3 4
IIIl. Supervision includes learning and application of knowledge about Trauma and TIC. *Example of how this happens?* √	1 2 3 4
IIIm. Supervisors have had training/consultation on supervising for TIC. *When and how does this occur?*	1 2 3 4
IIIn. Performance reviews expect increased awareness, understanding and practice skills related to trauma informed care. *Describe.* √	1 2 3 4
IIIo. Supervisors and staff can explain personnel policies; disciplinary actions reflect principles of transparency, predictability, and inclusiveness insofar as possible, given legal or contractual considerations. *Examples of how this is ensured?*	1 2 3 4

*Substance Abuse and Mental Health Services Administration, *SAHMSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* HHS Publication NO. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014

IV. Services and Service Delivery. Service delivery reflects a commitment to trauma informed practice [includes activities related to **Screening, Assessment, Treatment Services,** aspects of **Engagement and Involvement**, and **Cross Sector Collaboration***].

1= we haven't started yet 2= we've done a little 3= we've done quite a bit 4= we're stellar!

IVa. The first point of contact is as welcoming and engaging as possible for individuals seeking support or services. This includes reducing distress related to referral, self-referral, intake, etc. *Describe or provide examples of how this is achieved.*	1 2 3 4
IVb. Intake and all direct service staff are able to talk with individuals seeking services about the prevalence and impact of trauma and how it can affect engagement and involvement. *How is this information delivered in a trauma informed way? Do you have a script or coaching for staff?* √	1 2 3 4
IVc. Direct service staff understand the heightened risk of suicide for trauma survivors and are able to respond appropriately and get appropriate help. *What is the protocol? What ensures that staff are able to implement?* √	1 2 3 4
IVd. Intake forms and processes have been reviewed and modified to reduce unnecessary detail that might be triggering to individuals who are seeking or entering services. *What has been modified to improve the intake process for the consumer?*	1 2 3 4
IVe. Agency has written easy-to-read documentation for staff and service recipients that explain core services, key rules and policies, and process for concerns/complaints. *Describe or provide documentation. How it is available in the agency?* *Note if service recipients have reviewed.*	1 2 3 4
IVf. Policies related to treatment services (cancellations, no-shows, other rules) have been reviewed and modified as needed to reflect an understanding of trauma and its impact. *What was the review process used? What has happened as a result of these changes?*	1 2 3 4

*Substance Abuse and Mental Health Services Administration, *SAHMSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* HHS Publication NO. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014

IVg. Individuals receiving services have the opportunity to provide input/feedback and/or to grieve policies that affect them. *What is the process or structure for this to happen?* *How is the process trauma informed?*	1	2	3	4
IVh. In organizations providing direct service, the importance of the primary relationship is recognized and supported through policy and practice. *How do you work towards continuity of care?*	1	2	3	4
IVi. In organizations providing direct service, trauma specific services are offered, preferably reflecting promising or best practices. *What services are offered?* √	1	2	3	4
IVj. In organizations not providing direct services, staff has up-to-date information about trauma specific services available for referrals. *How do you ensure this information is available and used?* √	1	2	3	4
IVk. Peer support is available and routinely offered to individuals receiving services. *If yes, what services are offered? What is the role of peers in the organization (paid staff, volunteer)?* √	1	2	3	4
IVl. Individuals receiving services are not terminated without notice and direct contact (unless precluded by circumstances). *How do you ensure this? What's the protocol?* √	1	2	3	4
Cross-Sector Collaboration **IVm.** Agency is working with community partners and/or other systems to develop common trauma informed protocols and procedures. *Describe efforts and progress in this area, including any shared or cross-training that occurs.* √	1	2	3	4

*Substance Abuse and Mental Health Services Administration, *SAHMSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* HHS Publication NO. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014

V. Systems Change & Progress Monitoring. There is demonstrated commitment to planning, implementation and continuous improvement [includes **Progress Monitoring and Quality Assurance, Evaluation**, and aspects of **Engagement and Involvement***].

1= we haven't started yet 2= we've done a little 3= we've done quite a bit 4= we're stellar!

Va. The agency has a structure/process in place to further develop and sustain trauma informed care (for example, a multi-level/cross program workgroup that meets regularly). *What does this structure/process look like? Who participates?* √	1 2 3 4
Vb. Agency has initiated or completed an agency self-assessment. *What process was/is used? What priorities have been established as a result?* √	1 2 3 4
Vc. The perspective of persons with lived experience was or is being included in the agency self-assessment process. *How?*	1 2 3 4
Vd. Agency policies have been reviewed through a trauma informed lens and modified to meet TIC principles. *Example of policy change that was made? Changes that resulted?* √	1 2 3 4
Ve. There is a regular mechanism for communicating out to staff and stakeholders about emerging TIC practices and the agency's efforts to promote and sustain TIC. *How does this happen? How often?* √	1 2 3 4
Vf. Senior Management receives regular updates on progress and priorities for systems change to ensure trauma informed care. *Describe the process? How often does it occur?*	1 2 3 4
Vg. Senior Management and/or TIC implementation team is using agency data to help establish priorities and measure impact (e.g., staff retention, absenteeism, engagement and retention of service recipients, etc.). *What data?*	1 2 3 4
Vh. The self-assessment or quality assurance process for trauma informed care is ongoing. *Provide examples of objectives met and current priorities.*	1 2 3 4

VI. Please add anything else you would like stakeholders to know about how the organization/program is implementing trauma informed care.

*Substance Abuse and Mental Health Services Administration, *SAHMSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* HHS Publication NO. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014

STANDARDS OF PRACTICE FOR TRAUMA INFORMED CARE – HEALTHCARE SETTINGS

The following Standards of Practice for Trauma Informed Care in Oregon are based on nationally recognized principles of trauma informed care (TIC) and are in alignment with SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.[1] In addition, the Standards reflect what we are learning about implementation from partners around the state and were reviewed by a workgroup from the Trauma Informed Oregon Collaborative that included family members, youth, and individuals with lived experience as well as providers from different fields of practice. The Standards are intended to provide benchmarks for planning and monitoring progress and a means to highlight accomplishments. **We recommend use of this tool by multi-level teams within organizations.**

Early in 2016, we collaborated with partners in healthcare to review and adapt the Standards for primary care clinic settings. As a result, some of the language in the original Standards was changed, one or two Standards were eliminated, and several were added.

Please keep the following in mind in using the Standards tool:

1) The Standards of Practice are intended to help organizations communicate to their constituencies (individuals seeking services, community partners, contracting or funding entities, etc.) how and to what extent they are working to build trauma informed care within their program, clinic, organization, or system. **The Standards are entirely voluntary.**

2) The Standards are also intended to assist behavioral healthcare providers and any other entities in Oregon that are affected by the Oregon Health Authority's Trauma Informed Services policy, effective July 1, 2015, to comply with policy provisions.

3) However, there is no assumption that the Standards will be equally useful across all organizations or systems. **Culturally specific organizations, for example, may describe how they effectively provide care for trauma survivors in quite different ways** than what appears in the Standards.

4) Individual Standards will be interpreted differently in different contexts. For this reason, **the Standards invite a qualitative (descriptive) response** rather than a yes/no answer.

5) However, in order to assist organizations to assess strengths and weaknesses and to set goals, we have included a simple set of ratings. These are for internal communication and planning purposes

[1] Substance Abuse and Mental Health Services Administration, *SAHMSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* HHS Publication NO. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

only. **The ratings cannot be used to compare one clinic, program, or organization to another**. Note that although the highest rating (4) says "we're stellar in this area," there is always room for improvement, and perspectives may vary depending on who is making the rating.

6) In using the Standards tool for planning, **it may be helpful to summarize the self-ratings into areas of strength and areas where work is needed.** We strongly encourage efforts to address issues that affect the workforce as well as those that affect individuals seeking or receiving services and to look for low cost/high impact opportunities.

7) **There is no expectation that any clinic or organization will be addressing every Standard.** We hope the Standards will support planning and ongoing quality improvement. Furthermore, **health care sites may be doing any number of other things to create trauma informed care** that we have not captured here. Space is provided for this additional information.

8) Finally, **we recognize that the experience of individuals seeking services (and of the workforce as well) often comes down to personal interactions that reflect (or don't) sensitivity, respect, caring, transparency, an understanding of trauma, etc.** We are not able to capture the quality of those individual interactions in a set of organization-level Standards. We hope that procedures for inviting and using feedback, commitment to training, supervision, and the involvement of individuals with lived experience in the service system(s) will help fill in those gaps. And, again, we encourage the use of this tool to stimulate discussion that includes multiple perspectives and experiences.

The Standards of Practice will be reviewed annually based on feedback from participating programs, agencies, and systems.

###

For more information or to offer feedback on the Standards, contact:
Diane K. Yatchmenoff, PhD
yatchmd@pdx.edu
Or email: info@traumainformedoregon.org

STANDARDS OF PRACTICE FOR TRAUMA INFORMED CARE – HEALTHCARE SETTINGS

I. Organizational Commitment and Endorsement. Clinic leadership acknowledges that an understanding of the impact of trauma is central to effective service delivery and makes operational decisions accordingly.

1= we haven't started yet 2= we've done a little 3= we've done quite a bit 4= we're stellar!

Ia. Leadership (including administration and governance) has received information/training on trauma and trauma informed care. *Describe the process.*	1 2 3 4
Ib. Trauma Informed Care appears as a core principle in clinic policies, mission statement, strategic plan, written program/service information. *Describe or provide examples*: √	1 2 3 4
Ic. Individuals with lived experience in your service system have leadership roles at the clinic. *What roles?* √	1 2 3 4
Id. There is a process in place for regular feedback and suggestions from staff and patients/caregivers related to trauma informed care, e.g., perceived safety, welcoming environment, transparency, shared decision making, helpful/supportive staff, etc. *Describe process. Examples of feedback and change(s) that resulted?* √	1 2 3 4
Id(i). Leadership regularly visits with staff across the clinic (rounding). *Who is involved? When and how often does it happen? What has been learned that has resulted in changes?*	1 2 3 4
Ie. Decisions about changes in policy, practices, procedures, and personnel are made in a way that minimizes negative impact on workforce and on individuals/families receiving services. *How do you achieve this? What processes are in place?*	1 2 3 4
If. Clinic budget reflects a commitment to trauma informed care (e.g., resources for specialized training, flexible funding for staff wellness, peer specialists, staff time to coordinate or serve on workgroup, etc.). *How is this commitment reflected in the budget?*	1 2 3 4
Ig. Workforce wellness for all clinic employees is a priority and is addressed. *Describe. How many staff participate in wellness programs or activities?* √	1 2 3 4
Ih. The organization has made a commitment to diversity and equity within the organization and with the population served. *How is this reflected in policy and practice?* √	1 2 3 4

II. Environment and Safety. There is demonstrated commitment to creating a welcoming environment and minimizing and/or responding to perceived challenges to safety.

1= we haven't started yet 2= we've done a little 3= we've done quite a bit 4= we're stellar!

IIa. Physical space (external environment, exits and entrances, waiting room, offices, halls, lighting, restrooms, etc.) has been reviewed (see NOTE below) for actual and perceived safety concerns that may affect staff, patients, and families or caregivers. *What was the process? Who was involved? When did this last occur? What changes were made as a result?* √	1 2 3 4
IIb. Physical environment has been reviewed for "welcoming" quality, e.g., cleanliness, odor, color, furniture (in good repair and arranged for comfort), access to water, etc. *What changes have been implemented?* √	1 2 3 4
IIc. Physical environment has been reviewed for cultural responsiveness. *Describe modifications made.*	1 2 3 4
IId. There is a designated "safe space" (permanent or temporary) for staff to practice self-care. *Describe.*	1 2 3 4
IIe. Physical safety and crisis protocols are in place and are regularly practiced, including debriefing and care of staff. *What's the protocol? How do you ensure protocol is available and used when needed?*	1 2 3 4
IIf. Individuals who have received services from the clinic have helped develop and/or have reviewed decisions about physical environment and/or safety protocols. *What was the process?*	1 2 3 4
IIg. There is a process in place to hear and respond to safety concerns that arise. *Describe the process and how it is trauma informed.*	1 2 3 4

NOTE: The term "reviewed" can mean many things. Please consider, throughout this document, who was involved in the process of reviewing aspects of the physical environment or practices/policies, and what perspectives were represented.

III. Workforce Development. Human Resource policies and practices reflect a commitment to trauma informed care for staff and the population served.

1= we haven't started yet **2= we've done a little** **3= we've done quite a bit** **4= we're stellar!**

Training **IIIa.** Employees have received core training in trauma informed care. Check the content that staff has had: A= all staff; M= management/admin; DS= direct service staff. ○ The Adverse Childhood Experiences study ___ ○ The prevalence and impact of trauma on individuals in our agency ___ ○ The neurobiology of trauma___ ○ Issues of power and oppression related to the experience of trauma____ ○ Historical oppression; intergenerational trauma ___ ○ Principles and implementation of Trauma Informed Care___ ○ The role and benefits of peer support services___ ○ Trauma in the workforce; secondary trauma___ *If you provide (or make available) more in-depth training, please describe.* *Other trauma-related training regularly offered/required (including on trauma specific services)?* √	1 2 3 4
IIIb. Core training is offered at least annually. *Which modules? How frequently? How many staff attend? How is annual training delivered, by whom?* √	1 2 3 4
IIIc. Training is provided for all staff on supporting, managing, and responding to reactivity (e.g., de-escalation training). *Describe. How often is this training offered? How many staff have participated?*	1 2 3 4
IIId. Organization is building internal capacity to ensure that ongoing training and education for staff on trauma informed care is available. *How? What is the current status?* √	1 2 3 4
IIIe. Alternative opportunities for staff to learn about TIC (e.g., webinars or videos, community events) are offered regularly. *Examples? How many staff have utilized?* √	1 2 3 4

Hiring and Onboarding Practices **IIIf.** Screening and interviewing protocols include applicant's understanding and prior experience/training regarding the prevalence and impact of trauma and the nature of trauma informed care. *What questions are asked during the interview process? How do you gauge an applicant's ability to respond in a trauma-sensitive way to the individuals you serve (some organizations are hiring for "warmth and emotional intelligence")?*	1 2 3 4
IIIg. Individuals with lived experience of trauma and our service system participate in the hiring process. *How? How is their feedback utilized?*	1 2 3 4
IIIh. New employee orientation and training includes the core principles of trauma informed care and affirms the agency's commitment to ongoing trauma awareness and education for staff. *Describe.*	1 2 3 4
Supervision and Support **IIIi.** Clinic staff receives regularly scheduled supervision. *Which staff? How often does this process happen?* √	1 2 3 4
IIIj. Peer Support personnel, whether contracted or on staff, also receive regular support and guidance. *What is the process?*	1 2 3 4
IIIk. Supervision includes discussion of staff care and wellness. *Describe or provide example.* √	1 2 3 4
IIIl. Supervision includes learning and application of knowledge about Trauma and TIC. *Example of how this happens?* √	1 2 3 4
IIIm. Supervisors have had training/consultation on supervising for TIC. *When and how does this occur?*	1 2 3 4
IIIn. Performance reviews expect increased awareness, understanding, and practice skills related to trauma informed care. *Describe.* √	1 2 3 4
IIIo. Supervisors and staff can explain personnel policies. Disciplinary actions reflect principles of transparency, predictability, and inclusiveness insofar as possible, given legal or contractual considerations. *Examples of how this is ensured?*	1 2 3 4

IV. Services and Service Delivery. Service delivery reflects a commitment to trauma informed practice**.**

1= we haven't started yet 2= we've done a little 3= we've done quite a bit 4= we're stellar!

IVa. The first point of contact is as welcoming as possible for new patients and their caregivers, including reducing distress related to the setting and circumstances. *Describe or provide examples of how this is achieved.*	1 2 3 4
IVb. All staff are able to talk with patients about the prevalence and impact of trauma and how it can affect engagement and involvement. *How is this information delivered in a trauma informed way? Do you have a script or coaching for staff?* √	1 2 3 4
IVc. All staff understand the heightened risk of suicide for trauma survivors and are able to respond appropriately and get appropriate help. *What is the protocol? What ensures that staff are able to implement?* √	1 2 3 4
IVd. Required forms and processes have been reviewed and modified to reduce unnecessary detail that might be triggering to individuals who are seeking or entering services. *What has been modified to improve the intake process for the patient/caregiver?*	1 2 3 4
IVe. Clinic has written easy-to-read documentation that explains core services, key rules and policies, and process for concerns/complaints. *Describe or provide documentation. How is it available in the agency?* *Note if service recipients have reviewed.*	1 2 3 4
IVf. Policies related to treatment services (cancellations, no-shows, other rules) have been reviewed and modified as needed to reflect an understanding of trauma and its impact. *What was the review process used? What has happened as a result of these changes?*	1 2 3 4
IVg. Patients have the opportunity to provide input/feedback and/or to grieve policies that affect them. *What is the process or structure for this to happen?* *How is the process trauma informed?*	1 2 3 4
IVh. The importance of the patient's relationship with a primary care team is recognized and supported through policy and practice. *How do you work towards continuity of care? How are transitions between staff and providers handled to increase a sense of safety and engagement?*	1 2 3 4

IVi. Clinic regularly assesses for trauma history and the need for trauma specific services. *Describe when and how this occurs and who is responsible.* √	1 2 3 4
IVi(i) Clinic procedures reflect an understanding of the potential triggers related to physical touch and close contact for patients affected by histories of trauma. *How is this managed? What kinds of choices are patients offered to reduce potential distress?*	1 2 3 4
IVj. Clinic staff has up-to-date information about trauma informed providers and services in the community. *How do you ensure this information is available and used?* √	1 2 3 4
IVk. Peer support is available and routinely offered to patients. *If yes, what services are offered? What is the role of peers in the organization (paid staff, volunteer)?* √	1 2 3 4
IVk(i) Clinic reaches out to patients in the community and provides assistance in navigating healthcare and other systems. *Which staff members are assigned to outreach and navigation tasks? How many patients utilize this service?*	1 2 3 4
IVl. If/when clinic services are denied, patients are provided assistance in connecting with other resources in the community. *How do you ensure this? What's the protocol?* √	1 2 3 4
Cross-Sector Collaboration **IVm.** Agency is working with community partners and/or other systems to develop common trauma informed protocols and procedures. *Describe efforts and progress in this area, including any shared or cross-training that occurs.* √	1 2 3 4

V. Systems Change & Progress Monitoring. There is demonstrated commitment to planning, implementation, and continuous improvement.

1= we haven't started yet 2= we've done a little 3= we've done quite a bit 4= we're stellar!

Va. The clinic has a structure/process in place to further develop and sustain trauma informed care (e.g., a multi-level/cross program workgroup that meets regularly). *What does this structure/process look like? Who participates?* √	1 2 3 4
Vb. Clinic has initiated or completed an organizational self-assessment. *What process was/is used? What priorities have been established as a result?* √	1 2 3 4
Vc. The perspective of patients and/or former patients was or is being included in the clinic's self-assessment process. *How?*	1 2 3 4
Vd. Clinic policies have been reviewed through a trauma informed lens and modified to meet TIC principles. *Example of policy change that was made? Changes that resulted?* √	1 2 3 4
Ve. There is a regular mechanism for communicating out to staff and stakeholders about emerging TIC practices and the clinic's efforts to promote and sustain TIC. *How does this happen? How often?* √	1 2 3 4
Vf. Leadership receives regular updates on progress and priorities for systems change to ensure trauma informed care. *Describe the process? How often does it occur?*	1 2 3 4
Vg. Leadership and/or trauma informed care implementation team is using agency data to help establish priorities and measure impact (e.g., staff retention, absenteeism, engagement and retention of service recipients, etc.). *What data?*	1 2 3 4
Vh. The self-assessment or quality assurance process for trauma informed care is ongoing. *Provide examples of objectives met and current priorities.*	1 2 3 4