FACILITATING TRAUMA-INFORMED CULTURE CHANGE IN RECOVERY-ORIENTED SYSTEMS

A CONSULTANT'S GUIDE

SAMHSA
Substance Abuse and Mental Health Services Administration

Facilitating Trauma-Informed Care in Recovery-Oriented Systems:
A Consultant's Guide

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TABLE OF CONTENTS

PROJECT TEAM & ACKNOWLEDGEMENTS v

PART A: UNDERSTANDING TRAUMA-INFORMED CARE

INTRODUCTION TO THIS GUIDE 02

CHAPTER 1: THE CASE FOR TRANSFORMING CULTURE AND PRACTICE 07

USING THE ORGANIZATION'S MOTIVATION 08

KEY TERMS AND CONDITIONS 08

EFFECTS OF TRAUMA ON INDIVIDUALS AND ORGANIZATIONS 20

CHAPTER 2: INTRODUCTION TO TRAUMA-INFORMED CARE CONSULTING 23

ORGANIZATIONAL TRANSFORMATION 24

DEFINING THE TIC CONSULTANT'S ROLE 27

CONSIDERATIONS FOR TTCS: COMPARING STAFFING CAPACITY WITH LEVELS OF TECHNICAL ASSISTANCE NEEDED 29

PART B: PATHWAY TO TRAUMA-INFORMED CULTURE

INTRODUCTION TO PART B 31

CHAPTER 3: PRE-IMPLEMENTATION 33

THE RELATIONSHIP-BUILDING PHASE 35

THE DESIGN PHASE 42

CHAPTER 4: IMPLEMENTATION 52

THE TRAUMA AWARENESS PHASE 54

THE TRAUMA SENSITIVITY PHASE 62

THE TRAUMA RESPONSIVENESS PHASE 70

CHAPTER 5: SUSTAINABILITY 78

THE TRAUMA-INFORMED CARE PHASE 80

CONCLUSION 87

TABLE OF CONTENTS

APPENDIX

GLOSSARY OF TERMS 91

PRINCIPLES OF TRAUMA-INFORMED CARE FROM THE MISSOURI MODEL 96

COMPANION TO PART A: RESOURCES FOR “UNDERSTANDING TRAUMA-INFORMED CARE” 97

COMPANION TO PART B: RESOURCES FOR “PATHWAY TO TRAUMA-INFORMED CULTURE 98

TRAUMA-INFORMED CULTURE CHANGE CHECKLISTS 100

ENDNOTES 107

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PART A
UNDERSTANDING TRAUMA-INFORMED CARE

INTRODUCTION TO THIS GUIDE

CHAPTER 1: THE CASE FOR TRANSFORMING CULTURE AND PRACTICE

- USING THE ORGANIZATION'S MOTIVATION
- KEY TERMS AND CONDITIONS
- EFFECTS OF TRAUMA ON INDIVIDUALS AND ORGANIZATIONS

CHAPTER 2: INTRODUCTION TO TRAUMA-INFORMED CARE CONSULTING

- ORGANIZATIONAL TRANSFORMATION
- DEFINING THE TIC CONSULTANT'S ROLE
- CONSIDERATIONS FOR TTCS: COMPARING STAFFING CAPACITY WITH LEVELS OF TECHNICAL ASSISTANCE NEEDED

INTRODUCTION TO THIS GUIDE

In the past three decades, the substance use disorder (SUD) field has gradually grown in its understanding of the pivotal nature of trauma in:

- the development of SUD and other behavioral health conditions,
- the complexity of the challenges that clients face, and
- the connection with treatment and recovery support services.

This growing understanding is the beginning of a significant process of healing and recovery—for clients and for systems and organizational service providers. This Guide is for trauma-informed care (TIC) consultants who are preparing to facilitate progress toward a trauma-informed SUD field.

TRAUMA

In the Developmental Framework created by the Missouri Trauma Roundtable (2022)[1], "trauma" is described as "adverse events or circumstances that [overwhelm] a person's internal and external capacities, leading to long-term negative impact in the areas of affective, cognitive, social, and physiological functioning. The event, circumstances, and response to must be conceptualized together, as a holistic approach to trauma is critical to effective intervention at all practice levels. Understanding the traumatic response means acknowledging the structural inequities that exist in our society, which explicitly and implicitly oppress based on status."[2]

Several models, concepts, and practices of TIC have been developed to help service providers address these and other deep and complex challenges associated with trauma. The approaches offered in this Guide are rooted in the "Missouri Model" developed by the Missouri Trauma Roundtable. That model offers a developmental continuum that builds from basic awareness of trauma to a state of being trauma informed.[3]

In its Developmental Framework, the Missouri Trauma Roundtable offers several examples of potentially harmful organizational behavior, including:

- policies and behaviors that are based on a blaming and shaming approach toward the individuals they serve—and even toward their own staff;
- restrictive policies, with no room for special considerations or accommodations for people whose fears and anxieties have been intensified by trauma;
- a "one size fits all" approach that fails to take into account the many ways in which trauma can change people's views of the world, of themselves, and of others through the altering of brain structures and functioning; and
- neglect of the challenging but important duty to address the impact of biases and inequities, including the need to have honest and compassionate conversations around these issues.[4]

Along with the danger to clients and staff who have been affected by trauma, these kinds of approaches can also lead to reductions in client engagement, program completion, and employee retention. In many cases they can also bring about disruption within the organization. (Please note: in this Guide, the word "staff" includes both paid and volunteer staff.)

TRAUMA-INFORMED CARE

According to Hopper and colleagues (2010), **trauma-informed care (TIC)** is a service-delivery approach "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."[5] SAMHSA (2014) adds that this strength-based approach "also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals who already have histories of trauma, upholding the importance of consumer participation in the development, delivery, and evaluation of services."[6]

TRAUMA-INFORMED CARE (TIC): An organization- or system-wide approach, grounded in a deep understanding of trauma, that emphasizes safety for both providers and survivors, empowerment for clients, and avoidance of practices that lead to retraumatization.

IMPLEMENTATION: Described in the Missouri Model as "an ongoing and [intense] organizational change process."

In the words of SAMHSA's TIP 57, *Trauma-Informed Care in Behavioral Health Services*:

> *"TIC is a strengths-based service delivery approach '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, p. 82). It also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals who already have histories of trauma, and it upholds the importance of consumer participation in the development, delivery, and evaluation of services."*[7]

The Missouri Model describes the **implementation** of a trauma-informed approach as "an ongoing and [intense] organizational change process. A 'trauma-informed approach' is not a program model that can be implemented and then simply monitored by a fidelity checklist. Rather, it is a profound paradigm shift in knowledge, perspective, attitudes, and skills that continue to deepen and unfold over time."[8]

The Missouri Model is also guided by SAMHSA's "Four Rs" of trauma-informed care, which explain that a trauma-informed approach:

1. **Realizes** the widespread impact of trauma and understands potential paths for recovery;
2. **Recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3. **Responds** by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. Seeks to actively **Resist** Retraumatization.

Using five principles drawn from the "Five Key Concepts of Trauma-Informed Services" developed by Roger D. Fallot, PhD,[9] and Maxine Harris, PhD, the Missouri Roundtable further adapted this material "to include an understanding based on structural inequities. Being a member of a marginalized community means diminished access to opportunities and resources. It also signifies a lived experience without power, privilege, and assured safety that is potentially traumatic."[10]

Here are the five principles as adapted for the Missouri Model:

1. "**Safety**: Ensure physical and emotional safety; recognize and respond to [ways in which] racial, ethnic, religious, gender or sexual identity may impact safety across the lifespan."
2. "**Trustworthiness:** Foster genuine relationships and practices that build trust; make tasks clear, maintain appropriate boundaries, and create norms for interactions that promote reconciliation and healing. Understand and respond to ways in which explicit and implicit power can affect the development of trusting relationships. This includes acknowledging and mitigating internal biases and recognizing the historic power of majority populations."
3. "**Choice:** Maximize choice; address how privilege, power, and historic relationships impact both perceptions [of] and ability to act upon choice."
4. "**Collaboration:** Honor transparency and self-determination, and seek to minimize the impact of the inherent power differential, while maximizing collaboration and sharing responsibility for making meaningful decisions."
5. "**Empowerment:** Encourage self-efficacy, identify strengths, and build skills which lead to individual pathways for healing, while recognizing and responding to the impact of historical trauma and oppression."[11]

In this Guide, the role of the TIC consultant has been developed—and equipped with considerable concrete information, suggestions, and referral to additional resources—so the consultant can help each organization make the long journey to trauma-informed care.

THE ROLE OF THE TIC CONSULTANT

As important as TIC is to the success of treatment and recovery support services, many organizations may experience challenges in implementation, despite their strong desire and willingness. TIC implementation is a complex, long-term process that affects every part of an organization's practice and care delivery.

The role of the TIC consultant has grown to meet these challenges, providing important resources for willing organizations that need information, guidance, and encouragement. This Guide offers an outline of the activities that a TIC consultant works through with providers as they follow the implementation process. It models a TIC Implementation approach that is based on:

TIC implementation is a complex, long-term process that affects every part of an organization's practice and care delivery.

- the collected research on trauma and TIC, and
- accepted guidelines that have been effective in the field.

THE SCOPE OF TIC TRANSFORMATION

The most successful settings for trauma-informed care will be provider organizations that are motivated to seek and work on organizational culture change. According to Harris and Fallot (2001), trauma-informed organizations embody "a shared philosophy about trauma, services and the service relationship, and consumers that reflects a sensitivity to trauma and its importance in the lives of men and women who seek services."

Transformation on this scale requires that staff and leadership learn new ways of understanding and responding to the people they serve, the people they work with, and the people they are.

The effects of trauma on individuals, organizations, and societies are complex and wide ranging, so trauma-informed care is rooted in a deep foundation of understanding, skill, and attitude. TIC implementation involves much more than a few trainings and a series of small adaptations. Transformation on this scale requires that staff and leadership learn new ways of understanding and responding to the people they serve, the people they work with, and the people they are. This kind of collective "paradigm shift" takes:

- Ongoing planning,
- Proactive guidance toward change,
- New ways of engaging all of the individuals who interact with the organization, and
- Meaningful reflection on the organization's purpose.[12]

For SUD treatment and recovery support service providers, full implementation of TIC will require—at the very least—an organizational commitment to:

TRAUMA-SPECIFIC TREATMENT:
Clinical services designed to help individuals with post-trauma conditions recover from those conditions.

- Ongoing all-staff training on trauma, SUD, and the medical model of addiction;
- A physical environment and clinical practices that empower clients to actively shape their own treatment and recovery plans;
- Human resources practices and organizational policies that support and reinforce TIC and are not coercive for clients or for staff; and
- Options for **trauma-specific services**, within and/or outside the organization.

NOTE: More information on trauma-specific treatment, including ways in which it differs from trauma-informed care, can be found on **Page 18**.

RESOURCES IN THIS GUIDE

Part A of this Guide, "Understanding Trauma-Informed Care," starts with Chapter 1 making a case for transforming organizational culture and practice and Chapter 2 offering an introduction to trauma-informed care consulting.

Part B, "Pathway to Trauma-Informed Culture," orients consultants to their roles in each phase of TIC implementation, defining the milestones that mark each phase of the journey and the organizational tasks that help service providers move along the TIC implementation path. Throughout the course of their work, consultants will be able to identify:

- where their client organizations are in the transformation process,
- whether or not those organizations are ready to take the next step, and
- the kinds of support that might help them move forward.

Reading these user-friendly descriptions of TIC transformation phases, milestones, and tasks, TIC consultants might feel tempted to think of implementation as a linear journey with uniform characteristics and predictable steps. However, these descriptions are just meant to help people organize their thoughts for the learning process. TIC transformation is a multi-faceted process designed to address complex human challenges, so the road will be a winding one.

CHAPTER 1

THE CASE FOR TRANSFORMING CULTURE AND PRACTICE

USING THE ORGANIZATION'S MOTIVATION

Once a TIC consultant understands a provider's motivation for pursuing a trauma-informed approach, it becomes easier to call on that motivation to help the organization through the challenges of TIC transformation.

SUD service providers have many reasons for deciding to explore TIC implementation.

- some may view TIC as a best practice aligned with their mission and vision,
- others may see TIC as a way to improve their clients' experience receiving services,
- some might think of TIC as a way to add elements of support and self-care to interactions among leadership and staff, and
- some providers are aware that staff turnover and other challenges within the organization may be related to trauma.

Three steps in exploring and encouraging the organization's motivation to do this work are to:

- listen to their stated reasons for wanting to be trauma informed;
- find out how the effects of trauma have been affecting the organization, its people (clients and staff), and its processes; and
- provide information that is relevant to the organization's stated and unstated motivation.

These kinds of conversations can be excellent first steps in the provider's engagement and orientation, but they will require a common vocabulary and an understanding of how the organization's challenges might be connected with its experience of trauma. So:

- the next section of this chapter defines a few key terms and describes the conditions they refer to (consultants are encouraged to share that section with the organization and use it as an engagement and learning tool); and
- the final section offers a brief overview of some of the effects of trauma on individuals and organizations.

KEY TERMS AND CONDITIONS

The terms defined and described in this section are not the only important ones for an SUD treatment or recovery support organization to clarify, but they offer a foundation for the knowledge you will be passing on to the organizations you serve. These terms are highlighted here because they are so pivotal to this work, and because having a shared language is critical to early conversations with providers who are considering TIC transformation.

Most of the conditions described in this section are not diagnostic categories in the "Diagnostic and Statistical Manual of Mental Disorders (DSM-5)".[13] However, they are common challenges among people in SUD treatment, and it is vitally important that clinical and recovery support staff understand them.

A few more definitions will be offered in brief throughout this Guide, and the first section of the Appendix is a glossary of terms.

RESILIENCE: The ability to thrive despite negative life experiences and heal from traumatic events.

TRAUMA: An overwhelming event, series of events, or set of circumstances experienced as harmful or life threatening, with lasting negative effects on functioning and well-being.

RESILIENCE

Understanding and cultivating resilience is a fundamental public health priority. It is also very important to TIC transformation efforts.

SAMHSA defines **"resilience"** as "the ability to thrive despite negative life experiences and heal from traumatic events."[14] A particularly rich description of resilience is "the capacity to develop, seek, and use healthy skills that help one prepare for, cope with, and grow through adversity in a way that honors and strengthens the individual's mind, body, and spirit."[15]

With or without a history of trauma, each individual has the capacity to develop and practice resilience. In a trauma-informed organization or system, staff members learn to recognize, point out, model, teach, and celebrate resilience in the individuals they serve. This kind of approach can help people:

- stabilize their automatic physical and emotional responses to past trauma,
- face life with more hope and less fear, and
- cope with and grow through present and future adversity.

TRAUMA

In the media—and even in some SUD treatment and recovery support settings—the word **"trauma"** is often used as a "catch-all term." People use it to indicate a variety of experiences and effects, including toxic stress, adverse childhood experiences (ACEs), and post-trauma conditions such as PTSD. It can be helpful to clarify these terms for all staff members.

In the words of SAMHSA, trauma occurs when "an event, series of events, or set of circumstances…is experienced by the individual as physically or emotionally harmful or life threatening and…has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."[16]

Trauma is an event, a series of events, or a set of circumstances—but it is also the fact that those events or circumstances are experienced in certain ways. Our experiences combine what happens to us with who we are and how we react in this particular situation. So trauma is not just the event itself. It also includes the emotional, physical, and neurological changes that can result from feelings of "fear, vulnerability, and helplessness."[17]

Trauma is an event, a series of events, or a set of circumstances. It is also the fact that those events or circumstances are experienced in certain ways.

In addressing trauma, is important to keep in mind that:

- what people experience as traumatic varies from individual to individual;
- because human stress responses are largely physical, trauma is not just a psychological experience, but one that many experts believe is also deeply rooted in the body;[18]
- trauma and its effects can be shared with others or passed on to others—sometimes across generations—through shared beliefs, attitudes, behaviors, and/or changes in genetic activity in response to traumatic experiences;
- an individual, a family, an organization, a culture, or a community—including specific groups within any of these—can experience trauma;
- each person's response to an event is influenced by a constellation of risk and protective factors at community, cultural, family, and individual levels; and
- this combination of factors determines whether or not the event is experienced as traumatic.

TOXIC STRESS

It is normal for adults and children to experience stress in threatening situations, whether the threats are physical, social, emotional, and/or sexual. In response to perceived threats, our bodies set in motion a physical stress reaction that includes surges of adrenaline, increased heart rate, raised blood pressure, and increased levels of the stress hormone cortisol.

Children need to develop healthy coping skills early in life, so they can learn to regulate—calm and balance—both their physical and their emotional stress responses across the lifespan. A variety of protective factors—including positive relationships with adults who protect them and help them process stressful events—play important roles in the development of healthy coping skills.

Of course, not all children have the consistent positive care they need to help them learn to regulate their stress responses. When children who lack safe social support and positive coping skills are exposed to long-term or recurring stress, the physical, developmental, and psychological effects can be serious. The physical stress responses that were meant to help them escape danger instead become a serious source of danger. For example:

- patterns of elevated adrenaline levels, heart rate, and blood pressure can put them at risk of chronic cardiovascular or gastrointestinal conditions; and
- persistently elevated cortisol can affect children's brain development, immune functioning, and metabolism, putting them at risk of learning difficulties, autoimmune disorders, overweight, and diabetes.

This extended exposure is known as **"toxic stress,"** a common effect of ongoing adversity.[19] Examples of toxic stress include experiencing child abuse and/or neglect, witnessing violence, experiencing poverty, experiencing racism and discrimination, and living with a parent who has an SUD or another behavioral health condition. Without the presence of a safe adult who can comfort the child, validate the child's experience, and help the child learn self-soothing, repeated exposure to toxic stress can have serious effects on the child's life, health, and behavior.[20]

> ***TOXIC STRESS:*** Prolonged or repetitive stress and/or adversity experienced without sufficient social support or skills and resources for coping.

This is particularly true in terms of emotional and behavioral regulation. For example, patterns of high anxiety or angry "acting out" can make it hard for children to form and sustain positive social, educational, and care connections. So, the children most in need of care, kindness, and positive role models might often avoid the social or educational support they need, and/or might behave in ways that jeopardize those connections.

Patterns of thought, emotion, and behavior can continue into adulthood, with each disappointment increasing individuals' sense of anxiety, anger, grief, and hopelessness—and raising their vulnerability to SUDs and mental health conditions. When people have increased sensitivity to stress, lack of healthy coping skills, and a tendency toward risk-taking behaviors, they can be particularly vulnerable to additional high stress (especially during early recovery) and trauma.

One final note: Though the term "toxic stress" is usually used to refer to the complex interplay between childhood adversity and development, that term is also sometimes applied to long-term or recurring stress later in life. It is important to remember that prolonged exposure to stress in adulthood is also harmful.[21]

ADVERSE CHILDHOOD EXPERIENCES (ACES)

The concept and importance of adverse childhood experiences (or ACEs) were first explored and mapped out by Robert F. Anda, MD, of the federal Centers for Disease Control and Prevention and Vincent J. Felitti, MD, of Kaiser Permanente. ACEs can include:

- experiencing violence, abuse, or neglect;
- witnessing violence in the home or community;
- having a family member attempt or die by suicide;
- parental SUD or mental illness; and
- instability when parents are separated or a member of the household is incarcerated.[22]

In Anda's and Felitti's first ACE study, and in several replications of that study, the investigators found that early exposure to these traumatic experiences was associated with higher risk of a

variety of adverse health outcomes and chronic illnesses, including the onset of substance use in adolescence and development of SUD later in life.[23] They also found that, the more different kinds of ACEs people had, the more likely they were to develop SUD and a number of other physical and behavioral health conditions.

There is abundant information about the ACE study, its findings, and its implications on a number of websites, including the *CDC's Adverse Childhood Experiences page.*

POSTTRAUMATIC STRESS DISORDER (PTSD)

As mentioned earlier, "PTSD" is not another term for extreme stress or trauma, though outside the behavioral health field it is often mistaken for one. Posttraumatic stress disorder is only one of many behavioral health conditions that might follow the experience of trauma. A condition is considered PTSD if it meets a specific set of diagnostic criteria defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).[24] These criteria include:

- having experienced a traumatic event;
- having disturbing symptoms such as nightmares or flashbacks, or having symptoms that are activated by memories associated with the traumatic event;
- avoiding thinking about or being reminded of the trauma; and
- experiencing changes in thinking and mood, including emotional numbing, isolation, and issues with memory related to the traumatic event.

Traumatic experiences can make people vulnerable to many different physical and behavioral health conditions, not just PTSD. Substance use disorders, depressive disorders, anxiety disorders, and chronic physical illnesses are also common in people who have experienced trauma.

Traumatic experiences can make people vulnerable to many different physical and behavioral health conditions, not just PTSD.

It is important to note that not everyone who shows some of the symptoms listed above after a potentially traumatic event will develop PTSD. Those symptoms might instead resolve within several months of the event. On the other hand, some people may develop "delayed onset" PTSD, meaning they do not begin to experience symptoms until more than six months after the event.[25]

DEVELOPMENTAL TRAUMA

"Developmental trauma" is sometimes used as a synonym of "complex trauma," a condition defined as "the pervasive impact, including developmental consequences, of exposure to multiple or prolonged traumatic events."[26] Developmental trauma is linked to traumatic experiences that take place during key developmental stages in childhood. Those experiences can "influence later development, adjustment, and physical and mental health."[27]

> ***DEVELOPMENTAL TRAUMA:*** Also known as "complex trauma," linked to traumatic experiences that take place in key developmental stages in childhood and influence later development, attachment, adjustment, and health.

When very young children are first learning to trust, to feel safe, to self-soothe, and to connect with other human beings, living with danger and disruption can interrupt that learning process. When the child's primary caregivers cannot stop the danger and disruption—and especially when the caregivers themselves are sources of danger and disruption—the effects can be particularly challenging. These experiences can lead to chronic difficulties in many areas of life, including trouble:

- regulating stress responses,
- tolerating emotions,
- trusting people, and
- navigating relationships.[28]

> *In developmental trauma, chronic challenges with stress regulation, emotions, trust, and relationships can sometimes raise people's vulnerability to behavioral health conditions and make it harder to tolerate treatment and recovery settings and relationships.*

Developmental trauma is often related to ACEs, though SAMHSA notes that events at any life stage that "create significant loss and have life-altering consequences" might also lead to developmental trauma.[29]

Although developmental trauma is not yet a diagnostic category in DSM-5, it is important for SUD providers to understand this kind of trauma and its effects, because it is so common in SUD treatment populations. In developmental trauma, chronic challenges with stress regulation, emotions, trust, and relationships can sometimes:

- raise people's vulnerability to SUD and other behavioral health conditions, and
- make it harder for the individual to tolerate treatment and recovery settings and relationships.

INTERGENERATIONAL TRAUMA

As the behavioral health field's understanding of stress and trauma has grown, so has the field's awareness of "intergenerational trauma," post-traumatic effects that are passed from one generation to the next. There are many ways in which this happens, including:

One common form of intergenerational trauma is the flow of social, psychological, learning, mental health, and substance-related challenges from one generation to the next, often affecting multiple generations within the family.

- unconscious beliefs, values, principles, and behaviors that an individual has taken on in response to traumatic experiences, and the influence of these factors on the well-being and belief systems of the next generation;
- counterproductive survival skills (e.g., rage, avoidance, manipulation, trouble forming healthy attachments, high levels of anxiety) learned in response to trauma, and the effects that these behaviors can have on the social and psychological well-being of children and other family members; and
- genetic vulnerabilities encoded through changes in gene functioning that the body develops in response to traumatic experiences and passes down to the next generation—vulnerabilities that can raise the risk of mental health conditions, substance use disorders, chronic physical health problems, and other post-trauma effects.[30]

In SUD treatment and recovery support settings, one common form of intergenerational trauma is the flow of social, psychological, learning, mental health, and substance-related challenges from one generation to the next, often affecting multiple generations within the family.

Intergenerational trauma is also an important factor in the experience described directly below, "historical trauma."

HISTORICAL TRAUMA

In far too many cases, intergenerational trauma also carries with it the weight of historical traumatic experiences, often related to the oppression of one culture by another (or others). This might be related to colonization, dispossession of property and status, genocide (or "acts of genocide"), enslavement, dissolution of families, war, and/or other forms of social and political subjugation.[31]

The word "culture" here might indicate people of a particular nationality, racial category, religion, region, subculture, gender, sexual identity or orientation, etc., or any combination of these.

Aggression by another culture need not be open and blatant to result in historical trauma, and many forms of oppression that exist in history are not confined to history. Oppressive policies,

> *Shared cultural experiences can be a strengthening force, as people pool their strength, grief, healing, and wisdom. However, the effects of historical trauma can also deplete scarce resources and leave people with a powerful sense that danger is everywhere.*

attitudes, and actions often continue down the generations, even if they become more subtle over time.

Not all historical trauma is related to aggression or oppression by another culture. Trauma can follow the descendants of any culture that has experienced large-scale or repeated adversity (e.g., famine, disease, disaster). However, the impact of a natural disaster is often profoundly affected by the level of wealth and other resources available to the culture, and those resources may have been affected by the ways in which the culture has been treated by more powerful cultures.

The ways in which other forms of intergenerational trauma are passed down (examples described above under "intergenerational trauma") are often at work in historical trauma, too. However, in historical trauma, there is also a culture-wide sharing of both the trauma and its consequences.[32] This sharing of cultural experiences can be a strengthening force, as people pool their strength, grief, healing, and wisdom. However, the effects of historical trauma can also deplete scarce resources and leave people with a powerful sense that danger is everywhere.[33]

A number of other psychological and interpersonal factors can also inflict particularly deep pain that passes from generation to generation. For example:

- The sudden loss of home, culture, and language that enslaved Africans suffered—and the systematic erasure of culture and language that America's indigenous nations have endured—have robbed many individuals of the backbone of cultural strength and community that human beings need.[34]
- The loss of family members, especially children, has inflicted some of the deepest injuries at all levels. There are many examples of this on a large scale, including the sale or murder of enslaved family members (particularly children), the forced enrollment of Native American children in abusive "boarding schools," the separation of asylum-seeking parents and children at the border, and the desperate acts of some refugees in flight (e.g., trying to save children's lives by handing them to strangers who are able to escape the violence).
- When members of a culture are widely defined and categorized as defective, inferior, unclean, disgusting, and so on—as many people are in a caste system or a system of racial or cultural ranking—this experience can attack and invade their fundamental sense of self-worth and confidence. Even apart from the ill effects that these perceptions can have on people's financial and vocational well-being, they can reduce resilience and hope in individuals, families, and communities.[35]

These kinds of challenges often contribute to the next form of trauma described in this section: "racial trauma."

RACIAL TRAUMA

Trauma is, among other things, a reaction to powerlessness due to overwhelming circumstances. We live in a country that for centuries openly denied the power, rights, and basic freedoms of many people of color. This has been an enormous source of historical trauma, compounded by the fact that many inequities continue.

Trauma is, among other things, a reaction to powerlessness due to overwhelming circumstances.

Even today, subtle and overt expressions of racial prejudice, scorn, discrimination, and White supremacy are common in American society, and they are painful no matter how often they occur. If one has not been a member of a racial or cultural group that has been singled out as "inferior," one might never know how frequent or how harmful these experiences can be.[36]

In a society where prejudice and inequity have continued for centuries, the enculturated attitudes and automatic reactions often referred to as "unconscious bias" can hang on long after people's conscious, chosen beliefs have changed. There are many common ways in which insults can come from individuals who mean well. And this happens over and over again in the everyday lives of people of color, each time contributing to an accumulating supply of toxic stress,[37] including physical stress on the autonomic nervous system.[38]

Racism goes far beyond the attitudes and behaviors of individual people. It is often encoded in formal and informal policies and practices, in systems on many levels. The cumulative effects of these inequities—and the discrimination and deprivation they can lead to—can add to an overarching sense of powerlessness and hopelessness.

When the system that is being harmful or unfair is one that provides physical or behavioral health services, the harm inflicted can include deep and abiding mistrust of health-related systems and practitioners. When it happens on a large scale, as it has in the United States, this mistrust can follow the generations and spread throughout the community.

Clients of color who are ready, willing, and able to talk about non-racial forms of toxic stress and trauma may still be hesitant to talk about racial trauma, particularly in the presence of individuals whom clients perceive as privileged and/or unable to relate to their experience.

Denial of an insult or injury can be even harder to take than the incident itself.

Many people in marginalized groups have learned not to confront or complain about these experiences, to avoid being told they are

"too sensitive," "making it up," or "imagining things."[39] Denial of an insult or injury can be even harder to take than the incident itself. However, this important area of traumatic experience is often in need of acknowledgment and healing by clinicians and peers who truly understand.[40]

MORAL DISTRESS AND MORAL INJURY

Moral distress is a common human condition, whether that distress is linked to something we have done that has broken our values and moral codes, something we have witnessed, something we have failed to do, or something someone else has done or left undone. Like most forms of distress, it lives on a continuum, from mild "twinges" to **moral injuries** that are truly traumatic.

MORAL INJURIES: Extreme and in some cases traumatic forms of moral distress, whether that distress is linked to something we have done that has broken our values and moral codes, something we have witnessed, something we have failed to do, or something someone else has done or left undone.

When the values and codes that hold the human being and the human community together have been broken, people can experience a deep sense of separation from the community, from themselves, and/or from their moral and spiritual connections.[41] This can be true whether they have broken their own values, witnessed something they find morally unacceptable, or been betrayed by others in ways that are morally or spiritually painful.[42]

People who suffer from moral injuries may or may not be aware of the moral dimensions of their distress. They might not even be aware of the deep importance of their moral codes or the way these codes connect them with the human community, but they might still be affected very deeply. [43]

Starting with the work of Jonathan Shay, MD, PhD, after the Vietnam War, military behavioral health professionals have pioneered the study of moral injury in their work with service members and veterans.[44] However, in the years since then, a number of other populations have been identified who are also particularly susceptible to moral injury, including healthcare workers, who can feel overwhelmed by the suffering of patients whose conditions they cannot cure and whose pain they cannot relieve.[45]

> *When the values and codes that hold the human being and the human community together have been broken, people can experience a deep sense of separation from the community, from themselves, and/or from their moral and spiritual connections*

Research on moral injury is still in very early stages, but it can be helpful to keep this concept in mind when you are working with:

- people who are struggling with SUD, who may be carrying a considerable burden of guilt due to the consequences of their actions; and

- people from oppressed cultures, who may have experienced betrayal by multiple individuals and systems established for their well-being or for the common good.

RETRAUMATIZATION

People who have experienced trauma are often particularly vulnerable to stress, perceived threat, conflict, aggression, unexpected pain, and sensory cues (e.g., sights, sounds, images, odors, flavors, physical sensations) that remind them of their past trauma.[46]

It is also not uncommon for individuals with this history to experience a return of symptoms, called “retraumatization.” This might be the result of seeing or hearing something that reminds them of their own trauma history, or it might be a reaction to real or perceived aggression.[47] An essential goal of TIC implementation is to reduce the risk of retraumatization within treatment and recovery support relationships and settings.

VICARIOUS TRAUMATIZATION

Often referred to as “secondary trauma”—or confused with less scientific terms such as “compassion fatigue” or “burnout”—vicarious trauma has been an official diagnostic category since the DSM-5 was published. The DSM-5 description outlines criteria for diagnosing people who are experiencing harmful effects from repeatedly witnessing or hearing stories of traumatic experiences and their aftermath. (Note: This diagnosis does not cover people who have had negative effects from exposure through electronic or print media.)

The DSM-5 lists a number of symptoms of vicarious traumatization. Many of these symptoms are similar to those of posttraumatic stress disorder, though the symptoms of vicarious trauma may be milder.[48]

Addressing vicarious trauma effectively is an important responsibility of a trauma-informed organization, so TIC transformation plans include a variety of strategies for building staff resilience and offering or referring people to qualified help for this condition.

TRAUMA-SPECIFIC TREATMENT

One common area of confusion for many organizations and staff is the difference between trauma-informed care and “trauma-specific” services.

As this Guide makes clear, TIC is a global, wide-ranging approach to policies, practices, approaches, attitudes, and relationships that affects the whole organization, everyone who works there, and everyone who receives services there. The journey from traditional treatment to trauma-informed care often requires an organization-wide process of culture change like the one described in these pages.

Trauma-specific services are interventions on a much smaller scale, designed for and delivered to individuals who have experienced trauma. They are developed to help these individuals avoid, heal from, and/or recover from the effects of the trauma they have experienced. Delivered by qualified professionals who have been trained in one or more trauma-specific practices,

these services involve only those professionals and the individuals or groups participating in the services.

SAMHSA defines "trauma-specific treatment" as "evidence-based and promising practices that facilitate recovery from trauma" and the larger category of "trauma-specific services" as "prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders (including substance use and mental disorders) that developed during or after trauma."[49]

There is a wide variety of trauma-specific treatment options, with many differences among them, particularly in terms of:

- how much evidence there is of their effectiveness;
- the group(s) (e.g., age, gender, race, culture, and other life experiences) whose use of these interventions has been studied;
- how accessible, acceptable, and culturally safe and relevant these models are for the individual;
- how much exposure to trauma-related stimuli the individual has to be able to tolerate in order to stay engaged and participate safely and effectively;
- how well these models help clients build up their resilience and their exposure tolerance (e.g., by teaching them and giving them time to practice grounding and mindfulness skills) before the exposure to begins; and
- how well and how safely these models engage the body (e.g., breathing relaxation exercises, eye movement and other bilateral elements in Eye Movement Desensitization and Reprocessing).

EFFECTS OF TRAUMA ON INDIVIDUALS AND ORGANIZATIONS

Trauma can have wide-ranging and long-lasting effects on both the individuals who have experienced it and the organizations in which they seek and receive help. These can include effects on:

- clients' health and need for health services,
- clients' ability to engage and stay in treatment and recovery support,
- client success in treatment and recovery support,
- treatment and support relationships,
- the quality and durability of recovery, and
- the stress that their work places on staff.

Trauma can have wide-ranging and long-lasting effects on both the individuals who have experienced it and the organizations in which they seek and receive help.

Effects of Trauma on the Need for SUD Treatment

One reason for the global nature of TIC transformation is that trauma is so common in SUD settings. Studies show that, not only can a history of trauma make people more vulnerable to developing SUDs,[50] but individuals with SUD are also at greater risk of experiencing injury and violence.[51]

Effects of Trauma and PTSD on SUD and Other Quality-of-Life Outcomes

Trauma frequently affects an individual's quality of life. Both trauma and PTSD are associated with lower quality of life and higher levels of SUD-related impairment across many life domains,[52] though individuals with PTSD diagnoses tend to experience more severe outcomes and debilitation.

This impairment can have significant effects on treatment. According to SAMHSA, "PTSD can limit progress in substance [use disorder] recovery, increase the potential for relapse, and complicate a client's ability to achieve success in various life areas."[53] For example:

- Some studies connect trauma exposure with difficulty completing treatment and with more severe relapse experiences.[54]
- In one study, clients who had both SUD and PTSD experienced more impairment—and less improvement—from alcohol use and most SUD-related psychological problems before, during, and after treatment.[55]

- SAMHSA also cautioned that, "If individuals engage in mental health and substance [use] treatment without addressing the role that trauma has played in their lives, they are less likely to experience recovery in the long run."[56]

According to SAMHSA, having PTSD can interfere with an individual's recovery from substance use disorders, make relapse more likely, and limit success in many other areas of life.

Exposure to trauma in childhood or adult years is also associated with many chronic health conditions, including depression, diabetes, anxiety, coronary heart disease, hypertension, chronic pain, arthritis, and a variety of autoimmune conditions. These health challenges can arise right after the traumatic experience and/or later in life.

Effects of Trauma on Engagement and Participation in Treatment

So many factors contribute to a client's ability to engage and participate in treatment, and so many human traits can be activated by or traced back to traumatic experiences, that any discussion of the effects of trauma on treatment is bound to be incomplete. However, the literature has begun to map out some of these connections. SAMHSA offers these examples:

> *The knowledge that anyone might be carrying a history of trauma is one of the core understandings of trauma-informed care.*

> *"Clients in behavioral health treatment who have histories of trauma can respond negatively to or seem disinterested in treatment efforts. They may become uncomfortable in groups that emphasize personal sharing; likewise, an individual who experiences brief bouts of dissociation (a reaction of some trauma survivors) may be misunderstood by others in treatment and seen as uninterested. Providers need to attend to histories, adjust treatment to avoid re-traumatization, and steer clear of labeling clients' behavior as pathological."*[57]

The knowledge that anyone might be carrying a history of trauma is one of the core understandings of trauma-informed care. If clinicians and recovery supporters treat each client with understanding, care, and respect, they are more likely to respond in ways that lead to more stable participation in treatment and support activities.

Prevalence of Vicarious Trauma Among SUD Treatment and Recovery Service Providers

As mentioned earlier in this chapter, vicarious or secondary trauma is an important issue for employers to address. Staff who are experiencing vicarious traumatization can have PTSD-like symptoms because they have been exposed repeatedly to traumatic material their clients have shared.

Studies have indicated that 10-15% of counselors and case managers have received this diagnosis as a result of repeated exposure to the stories of the people they serve.[58] In one study of vicarious trauma among SUD counselors, almost 75% had experienced at least one symptom, and 19% met the diagnostic criteria for PTSD.[59]

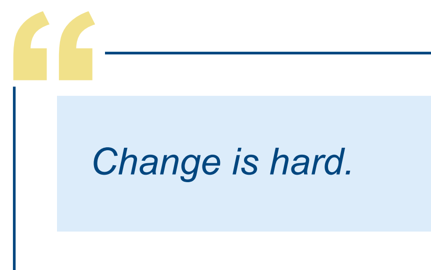
Impact of Trauma and PTSD on the SUD Treatment and Recovery Service Workforce, Staff Retention, and Service Safety and Quality

If an organization lacks the supports needed to help staff and the organization manage vicarious traumatization, staff performance can suffer. Clients can experience more retraumatization, and staff turnover can rise.

One study found that "Secondary trauma can lead to difficulty responding appropriately to clients' feelings and/or cause clinical mistakes in judgment resulting from a failure to understand what the client is trying to express."[60] Both staff and clients benefit from sources of support that reinforce their sense of "safety, trust, esteem, intimacy, and control."[61]

Impact of Trauma on Clients' Ability to Stabilize During Change, Crisis, and Disruption

Crisis and structural or environmental change can be hard for anyone to weather, particularly for people in early or unstable recovery. For people with trauma histories, disruption in the surrounding environment can be particularly disturbing. These kinds of events might range from health crises, financial crises, and natural disasters to structural changes at home, in the service environment, and even in organizational staffing or leadership.



Change is hard. The experience of trauma is characterized by extreme fear and lack of control, and crisis and change can also be frightening, raising feelings of confusion and helplessness. It is important to have, not only disaster and sustainability plans, but also plans for helping clients stabilize through other kinds of disruptions.

The following chapter (Chapter Two) introduces trauma-informed care consulting, including:

- a section on the transformation process itself,
- a section on the TIC consultant's role, and
- a set of considerations for Technology Transfer Centers (TTCs) in the process of deciding whether or not to take on a TIC consulting project.

CHAPTER 2

INTRODUCTION TO TRAUMA-INFORMED CARE CONSULTING

ORGANIZATIONAL TRANSFORMATION

TIC transformation often includes rewriting policies, working to change the organizational culture, and changing physical environments and services to reflect the language and practices of trauma-informed care.

SAMHSA has included Trauma-Informed Care (TIC) among its designated best practices for many reasons. TIC can bring about, not just change, but an actual transformation process that takes place on many levels of a system or an organization. This transformation can make services and service relationships much safer for both clients and staff.

TIC transformation often includes rewriting policies, working to change the organizational culture, and changing physical environments and services to reflect the language and practices of trauma-informed care. As a result:

- Organizations and their staff learn how to avoid retraumatizing clients; and
- Staff learn and use practices that help both clients and staff become more resilient.

In an SUD treatment and recovery support organization or system, the goals of TIC transformation include:

- raising the whole organization's awareness of the relationship between SUD and trauma;
- giving staff and clients a greater understanding of how treatment and recovery environments can promote safety and healing;
- helping staff recognize and respond more effectively to signs of trauma among their clients and coworkers;
- gathering client input on services they have received and using that input to improve treatment planning, program planning, and review/revision of organizational policies;
- supporting clients and staff in their recovery from trauma and SUD; and
- providing services that can help both clients and staff cultivate resilience.

BUILDING ON STAFF STRENGTHS

Each SUD treatment or recovery support service setting has a unique set of circumstances, and each individual, each organization, each community has a wide range of strengths. TIC adds to those strengths a transformation process that is "holistic," reaching into many aspects of the individual and the individual's larger life context.

An important step in the journey toward transformation is to give staff an in-depth understand

ing of trauma and its complex relationship with mental health and substance-use challenges. This will help staff find and create unique opportunities to cultivate safety and healing.

An important step in the journey toward transformation is to give staff an in-depth understanding of trauma and its complex relationship with mental health and substance-use challenges.

Staff members also build a stronger understanding of the many ways in which trauma might be affecting the language and behavior of clients and staff. This understanding can form a foundation for the skills and practices staff will use to process trauma safely as they interact with clients and coworkers every day.

In a trauma-informed organization, supervisors learn to give staff members ongoing support for taking care of their own well-being. This kind of support can also help staff recognize and accept help for any vicarious trauma they might be experiencing.

CLIENT INPUT IN THE PLANNING PROCESS

Clients and alumni can be important sources of guidance in many areas of the organization's work, including program design, reviewing the safety of treatment and recovery support environments, and developing standards of professional practice.

When an organization or a system implements TIC:

- clients have more choice and a stronger voice in the treatment-planning process;
- it is easier for clients to engage and stay engaged in treatment and recovery support services, and
- their overall experience receiving services is more positive.

However, as crucial as this collaborative approach is for the individual client, it is equally important for the safety and effectiveness of services—and for the success of the TIC transformation as a whole. As part of the transformation process, organizations and their staff use policies, training programs, and everyday practices to develop strong and flexible ways of:

- making sure clients have the power to participate in their treatment-planning processes; and
- welcoming feedback from people with lived experience of SUD, trauma, and recovery.

It is particularly important for organizations and staff to gather and consider feedback and guidance from people who have participated in services within their own organizations—people with first-hand experience of what actually happens there.

Clients and alumni can be important sources of guidance on many areas of the organization's work, including program design, reviewing the safety of treatment and recovery support environments, and developing standards of professional practice.

Finally, two particularly important areas for gathering and learning from client input are:

- becoming more aware of "coercive" language and practices—ways in which people might be feeling intimidated or bullied into changing their behavior; and
- learning how to make physical environments safer and more accessible, both for staff and for all who receive services there.

TIME NEEDED FOR THE TIC TRANSFORMATION PROCESS

TIC transformation is not a temporary or a time-limited change process.

- It starts with a 3-to-5-year process for initial implementation. Training is an important first step, but it is not enough to bring about the full culture change needed to sustain practices that are trauma informed.
- After implementation, the organization works to sustain TIC through continuing efforts, learning, and growth. This will require ongoing organizational attention, reflection, and resources.

TIC transformation is not a temporary or a time-limited change process.

The next section offers a brief overview of the TIC consultant's role and responsibilities.

DEFINING THE TIC CONSULTANT'S ROLE

Given the complex scope of the transformation required for TIC, consultants can play a powerful role in supporting this process. The TIC consultant offers ongoing feedback, reflection, data, and recommendations—information that individuals within the organization may not have the time, capacity, or perspective to come up with themselves. The consultant can offer an unbiased external perspective as the organization moves through each phase of transformation.

The consultant can offer an unbiased external perspective as the organization moves through each phase of transformation.

Unlike organizational staff, TIC consultants have the unique ability to focus on implementation. Staff may be juggling many unrelated priorities while they facilitate the organizational transformation process. Consultants, on the other hand, have a focus and an awareness that allows them to:

- share and guide project-management tasks,
- identify needed resources, and
- actively engage in a problem-solving process with the organization.

THE TIC CONSULTANT'S RESPONSIBILITIES

The first and most important responsibility of a TIC consultant is to model a trauma-informed approach, including the values, attitudes, behaviors, and self-care practices that are central to the TIC paradigm.

The first and most important responsibility of a TIC consultant is to model a trauma-informed approach, including the values, attitudes, behaviors, and self-care practices that are central to the TIC paradigm.

In TIC transformation, consultants engage in a range of activities, including activities needed for:

- relationship and rapport building;
- gathering information through individual interviews, focus groups, and assessment tools;
- facilitating strategy development;
- helping with communication and change management;
- providing intensive problem-solving assistance through coaching and modeling; and
- offering education and evidence on best practices.

TIC consulting is a highly collaborative process that "involves helping rather than telling. It

Consultants and organizations should meet regularly to review each individual's role and their work together.

is not a process of providing resources and stepping back or simply telling someone what to do. Rather, it requires the creation of a supportive environment in which knowledge may be exchanged, barriers to implementation identified, and processes to overcome those barriers developed, applied and refined. [Consulting] also involves both doing and enabling."[62]

This approach not only reflects the collaborative nature of TIC, but also lets the consulting relationship evolve with the organization's changing needs and capacity. Like consultants in other fields, TIC consultants in SUD contexts support the organization's "ability to design and conduct a process for (1) building an agreement about what steps are necessary and (2) establishing the momentum to see these steps through."[63]

One thing the TIC consultant will not be expected to do is to have expertise in all areas that are important to TIC transformation. This Guide and the resources listed here offer much vital information about trauma, trauma-informed care, and TIC transformation. However:

- trauma can affect many facets of human life, relationships, organizations, and processes in many different ways, so few people in the world know enough about all facets of this subject to cover every possible need;
- TIC transformation includes a number of functions that might be done more effectively with help from specialists (e.g., by bringing in a monitoring and evaluation consultant during the Trauma-Informed Care phase); and
- to respect diversity, it may at times be important to learn from someone with special expertise on DEI (diversity, equity, and inclusion) or racial/historical/intergenerational trauma, or someone with insight based on lived experience and/or cultural identity.

Important qualities in TIC consultants include the humility to know the limits of their own expertise and the readiness and willingness to bring in other experts who can supplement their efforts.

Throughout the phases of TIC implementation, consultants and organizations should meet regularly to review each individual's role and their work together. Part of this review is to decide how they should adjust their roles and responsibilities to keep making progress.

In the final section of Part A, we review some staffing considerations that Technology Transfer Centers might face in their decisions about prospective TIC consulting projects.

CONSIDERATIONS FOR TTCS: COMPARING STAFFING CAPACITY WITH LEVELS OF TECHNICAL ASSISTANCE NEEDED

The journey to trauma-informed care is long but rewarding.

When an Addiction, Mental Health, or Prevention Technology Transfer Center (TTC) considers taking on a TIC project, the first step is to evaluate the TTC's knowledge of and capacity to lead a project that may take many years and require regular, intensive contact with the organization(s) in question. To staff the TIC technical assistance process, the Technology Transfer Center might draw upon existing TTC staff or build a team of external contractors/consultants to deliver these services.

The journey to trauma-informed care is long but rewarding. In choosing staffing strategies, TTCs should be well informed, both about their own capacity and about the needs of the organizations seeking assistance.

For example, some organizations might just be looking for awareness training rather than TIC transformation, so they may not need extensive TTC staff time. On the other hand, what if the organization wants to take on a policy review and environmental assessment to inform organizational change? Those steps—and the organization's ability to use the insights revealed in those steps—would require a more intensive relationship and more extensive support.

Finding out if an organization's needs will fit the TTC's capacity is a critical early step in conversations about TIC consulting. Asking targeted questions in these first interactions is vital to building an understanding and establishing rapport. Learning about the organization's needs and expectations also helps the TTC:

- have an internal (within the TTC) conversation to decide whether or not the TTC will be able to meet the organization's needs, and
- communicate effectively with the organization about the levels of trauma-informed care implementation that the TTC can and cannot support at this time.

With this basic grounding in trauma, trauma-informed care, and TIC transformation established, it is time to learn more about the phases, goals, tasks, and benefits of the TIC implementation process.

In choosing staffing strategies, Technology Transfer Centers should be well informed, both about their own capacity and about the needs of the organizations seeking assistance.

PART B
THE PATHWAY TO TRAUMA-INFORMED CULTURE

INTRODUCTION TO PART B

CHAPTER 3: PRE-IMPLEMENTATION

- THE RELATIONSHIP-BUILDING PHASE
- THE DESIGN PHASE

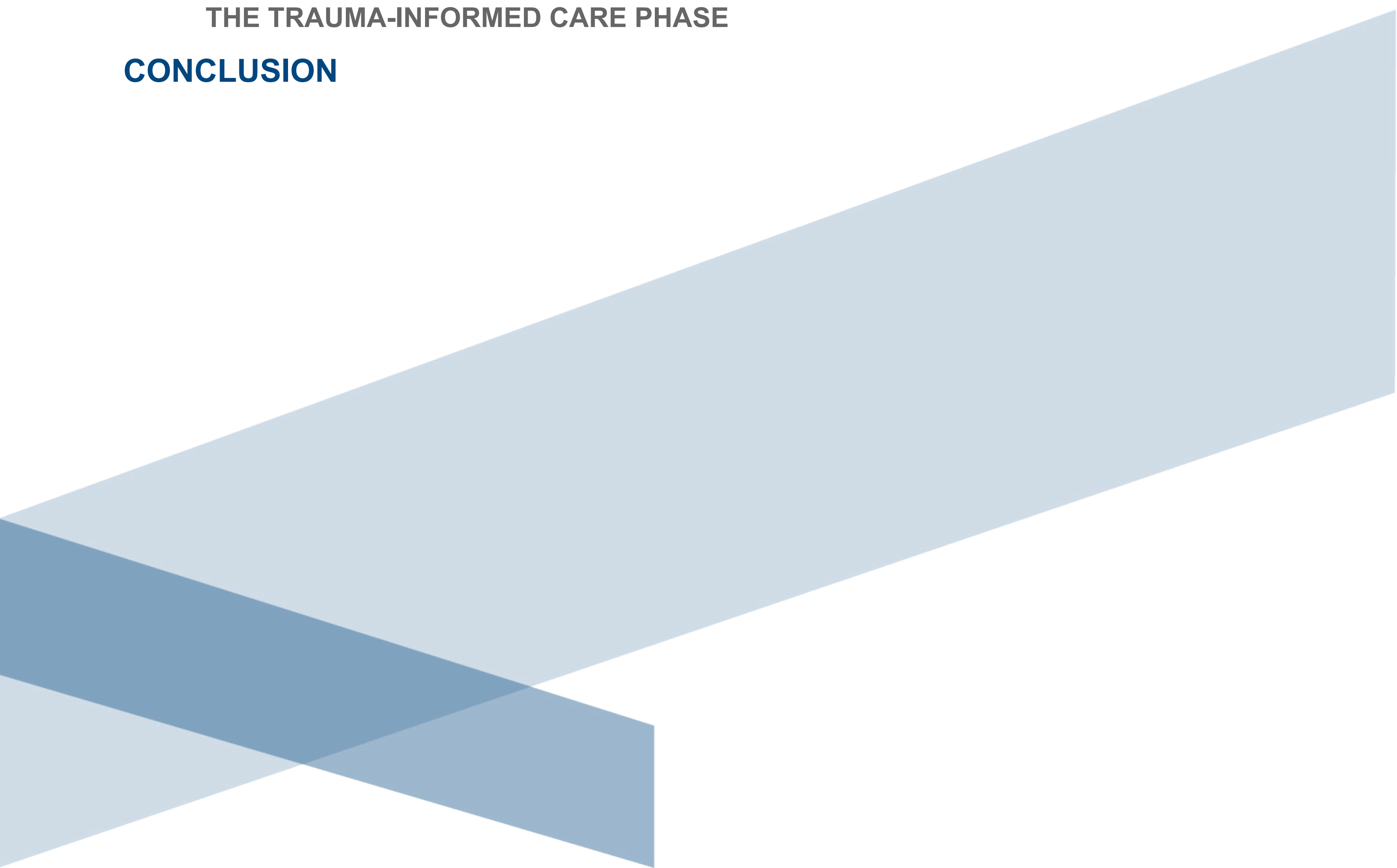
CHAPTER 4: IMPLEMENTATION

- THE TRAUMA AWARENESS PHASE
- THE TRAUMA SENSITIVITY PHASE
- THE TRAUMA RESPONSIVENESS PHASE

CHAPTER 5: SUSTAINABILITY

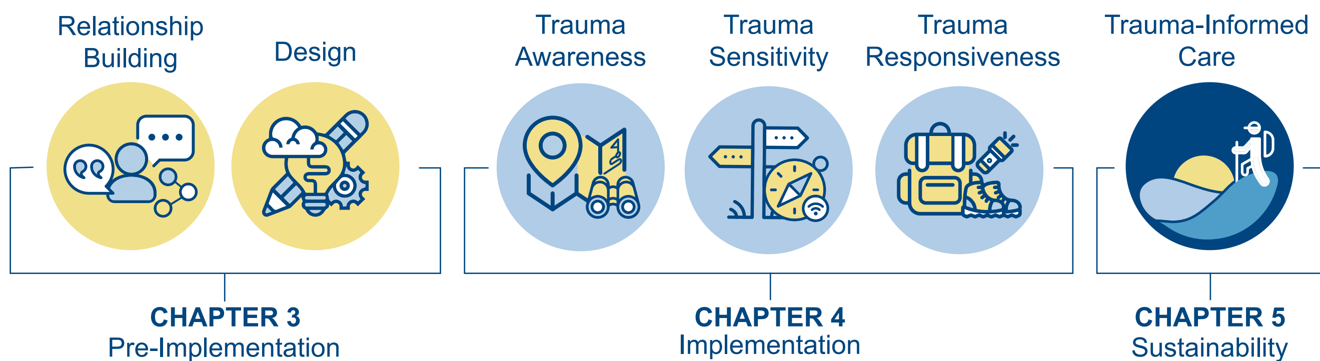
- THE TRAUMA-INFORMED CARE PHASE

CONCLUSION



INTRODUCTION TO PART B

Part B of this Guide provides brief guidelines for organizations and consultants in navigating the phases of trauma-informed care transformation:



For each phase, Part B outlines activities for organizations and for consultants, followed by a brief discussion of the changes those activities are designed to foster.

As mentioned early in this Guide, the phases are discussed in a linear sequence, as if they were steps to be completed and then left behind. But, in reality, organizations and consultants might cycle through some of these activities again and again to sustain change. Here are two examples:

- While "Relationship Building" is the name of the first phase of TIC transformation, relationship building is certainly not completed in the first weeks or months of this process. Effective transformation calls for complex change in the organizational culture, the kind of change that is supported by ongoing changes in relationships. Consultants will want to continue to nurture and build new relationships with staff throughout the organization—and throughout the implementation process.
- When TIC transformation is just beginning, consultants might focus most of their relationship-building efforts on organizational leadership. In later phases, though, consultants will do some intensive relationship and rapport building with TIC implementation workgroups, including client-facing staff who have been tasked with implementing new practices.

When this kind of "cycling" takes place, the consulting goals and activities that applied to the initial experience of a phase will also inform later cycles of the work of that phase. Ongoing curiosity, flexibility, and commitment to delivering a safe, respectful, and connected experience should drive organizational activities at each phase, and in each cycle.

Part B has three chapters, "Pre-Implementation," "Implementation," and "Sustainability." Within these chapters you will find a section for each of the six phases of trauma-informed care.

Each of those phase-specific sections includes:

- an overview page listing some key goals for the organization and tasks for the organization and the consultant;
- an introduction to the phase;
- tasks for the organization to accomplish;
- tasks for the consultant;
- ways in which the organization is likely to change during the phase; and
- a checklist for keeping track of progress on organizational goals, organizational activities, and consulting activities during the phase.

CHAPTER 3

PRE-IMPLEMENTATION

CHAPTER 3: PRE-IMPLEMENTATION

Pre-implementation is, of course, the process of getting ready to implement trauma-informed care transformation. It includes the first two phases:

- Relationship Building
- Design

A common human tendency is to want to rush into action while motivation is high, so these two phases give the organization and the consultant some time and some structure for the all-important preparation process. Like the foundation of a house or the planning stage of a long journey, the phases that make up this level of transformation are absolutely crucial to the success of TIC transformation.

1

THE RELATIONSHIP-BUILDING PHASE

ORGANIZATIONAL GOALS

1 Leadership has a clear sense of the resources that are likely to be needed for each phase of TIC implementation.

2 Leadership has knowledge of the potential effects TIC implementation will have on staff and clients, from individual safety to structural equity.

ORGANIZATIONAL TASKS

- This phase includes an internal process of reflection, an informal needs assessment, exploration of organizational goals and internal capacity for change, and consideration of how a TIC consultant might support the change process.
- Leadership discusses motivations, barriers, and concerns about TIC implementation.
- Leadership starts exploring TIC alignment with the organization's mission and strategy, staff and client cultures, and organizational culture.

TIC CONSULTING TASKS

- Informal assessment: develop a detailed, objective, and compassionate understanding of what motivates stakeholders within the organization.
- Build rapport with leadership, to develop an initial understanding of the organization's culture, its need for support in implementing TIC, and how this aligns with the consultant's capacity and availability.
- Provide information on the phases of TIC implementation, the scope of areas affected, and the need for a workgroup that reflects diversity.
- Support leadership in understanding how transformation can disrupt an organization.

ABOUT THE RELATIONSHIP-BUILDING PHASE

In SUD treatment and recovery, there is ample evidence that understanding, compassionate, collaborative human relationships are often powerful forces for positive change.

In SUD treatment and recovery, there is ample evidence that understanding, compassionate, collaborative human relationships are often powerful forces for positive change. This can be as true for an organization seeking guidance through complex challenges as it can for an individual seeking relief from a behavioral health condition.

During the relationship-building phase of TIC transformation, consultants provide deep listening, reflection, ideas, information, resources, and activities. Organizational representatives and the consultant are exchanging information that is vital to the foundation of the TIC transformation efforts that will follow.

Even more important, they are building a human foundation—learning how each can trust the other's knowledge, understanding, honesty, flexibility, and willingness to do what it takes.

Following are some activities that characterize this phase of implementation.

RELATIONSHIP BUILDING: ORGANIZATIONAL ACTIVITIES

Throughout their early contacts with a TIC consultant, SUD treatment and recovery service providers are likely to be thinking about how TIC implementation might affect the organization's culture and climate. To do this, they will engage in a process of:

- reflection,
- informal needs assessment, and
- deeper exploration of the organization's goals and its capacity for change.

Talking about their thoughts with the TIC consultant and asking questions about implementation is an important task of the Relationship-Building phase.

Organizational Culture

The culture of an organization includes the norms, values, and basic assumptions that help guide people's decisions and influence their behavior.[64] During the Relationship-Building phase of TIC transformation, the thoughts of the agency's leadership, change agents, and change champions will often turn to questions about how TIC might fit the organization's mission, service strategies, standard practices, service environment, and organizational culture, also taking into consideration the cultures and cultural influences of staff and clients.

If leadership and change supporters can speak openly about their reasons for wanting this change

and their hopes and fears about how it might change the staff/client experience, these conversations can have excellent effects on the developing relationship between the consultant and the organization.

> *The TIC consultant will often find that some staff members have already been expressing a desire to move toward TIC organizational change.*

Organizational Climate

The climate of the organization might be a little more complicated. "Climate" is used here to mean the impact that the organization's operation (policies, procedures, and practices) has on staff's ability to learn and implement a complex change process.[65] The TIC consultant will often find that some staff members have already been expressing a desire to move toward TIC organizational change, but a number of barriers and/or concerns have kept that from happening.

So, at this phase, an important part of the organization's work will be to provide many opportunities for inclusive internal discussion about:

- how they want to use the TIC consultant,
- how the organization's resources might be used to implement TIC, and
- what kinds of outcomes they want for staff and clients.

RELATIONSHIP BUILDING: CONSULTING ACTIVITIES

While the organization engages in honest introspection in the Relationship-Building phase, the TIC consultant will have three main responsibilities:

- to illustrate and model TIC principles by embodying those principles in all interactions;
- to learn enough about the organization to know if the organization's needs fit the consultant's capacity to address them; and
- to give providers a clear sense of both the benefits and the challenges of the TIC transformation process, so they will have realistic expectations and make wise decisions.

Embodying TIC principles

It is important for the consultant to embody the five principles of TIC throughout the transformation process, but this is particularly important in the Relationship-Building phase, because trust is so new and so easily lost. No human being can perfectly embody TIC or any other set of values or principles, but the consultant can be mindful of these responsibilities and quick to acknowledge mistakes and repair their effects.

As it is in other roles in the behavioral health field, self-care is particularly important for the

As it is in other roles in the behavioral health field, self-care is particularly important for the TIC consultant.

TIC consultant. Self-care increases the consultant's resilience, makes it easier to stick to TIC principles, and offers the organization a steady example of self-care and resilience—two qualities that leadership and staff would all do well to make part of their overall approach.

Understanding the Organization's Needs and the Consultant's Capacity

If a provider embarks on TIC transformation, only to find out that the consultant did not have the resources to meet organizational needs, leadership might not be willing to try again. So the relationship-building phase is a time to proceed slowly and find out how the provider's transformation needs fit the consultant's capacity.

This means the consultant's role includes building a detailed, objective, compassionate understanding of what drives the organization's policies and practices and what motivates client and staff choices and behaviors.

To start piecing together this "internal landscape" of an organization, a consultant may use observation and/or direct questioning. Here are some examples of questions the consultant might ask:

- What prompted you to create—or to explore creating—an organizational culture that includes TIC principles and practices?
- What do the decision makers in your organization identify as problems that will be addressed by TIC?
- What do the organization's decision makers identify as their most transformative practices or services for clients?
- If you imagine yourself in a client's shoes, what part of your organization's services might activate your trauma symptoms or retraumatize you?
- How does your organization currently involve clients in organizational planning?

Of course, the consultant will continue to gain information—and might even correct first impressions about the answers to some of these key questions. However, exploring these issues with leadership in the Relationship-Building phase is vital to building rapport, starting to understand the organizational culture, and deciding whether or not to proceed with plans for TIC transformation.

Helping Providers Develop Realistic Expectations

In the Relationship-Building phase, it can be helpful to start by giving the organization basic information about:

- the phases of TIC transformation,
- what the consultant and the organization might be doing in each phase,
- what kinds of organizational changes might be involved in moving from one phase to the next,
- the scope of the areas of organizational functioning that are likely to be affected by TIC implementation, and
- the need for an implementation workgroup that will reflect both the diversity of work roles in the organization and the cultural diversity within the staff and client base.

This discussion of TIC phases, activities, and changes is also a crucial opportunity to empower leadership with the information they will need to decide what is feasible for their organization and what kinds of consulting resources they will need. From the start, the consultant speaks an important truth: Implementing TIC may be transformative, but it is also disruptive and time-intensive.

> *All of these challenges require ongoing commitment and attention by the TIC consultant, change agents, and leadership.*

In explaining the full process of TIC implementation, the consultant describes some of the ways in which introducing new systems, practices, routines, or behaviors can destabilize working conditions that staff and leadership had always understood as normal, secure, and predictable. Some staff members might experience a loss of confidence and a diminished sense of competence when they consider the ways in which they might be asked to change.

All of these challenges require ongoing commitment and attention by the consultant, change agents, and leadership. Key tasks for the consultant include:

- identifying strategies to help staff anticipate change, and
- supporting leadership and change agents as they help staff understand and work through the disruption that change can bring.

One common challenge is the staff member whose values and practices are not compatible with the shift to TIC. While some people may simply need time to adjust and adapt, there will be others who cannot or will not make this shift.

One aspect of the consultant's role may be to support leadership and change agents in their efforts to send clear messages about:

- what is expected of staff,
- the importance of having a good fit between staff and the organizational culture, and
- the need for those who are not open to adopting TIC to explore employment opportunities elsewhere.

When these kinds of uncomfortable conversations become necessary, they may be easier and less disruptive if the consultant has empowered leadership to anticipate them, plan for them, and secure whatever kinds of resources they might need.

Although training is not a key feature of the Relationship-Building phase, leadership and the consultant might decide to schedule an informal training for leaders on their prospective roles in the TIC process.

RELATIONSHIP BUILDING: ANTICIPATED ORGANIZATIONAL CHANGE

The Relationship-Building phase of TIC consulting lasts until the organization has a clear sense of the time, resources, and activities associated with each phase of TIC implementation. Through honest exchanges of information, both the consultant and organizational leadership will have been able to establish trust and identify potential areas of strength and challenge in moving forward.

Though relationship building will continue to be a foundation and key activity of TIC implementation, the most important outcomes of this phase will have been achieved. Leadership and the consultant will share a clear understanding of:

- the organization's needs and desired outcomes;
- the capacity of the organization and the consultant to collaborate in bringing about organizational transformation; and
- the kinds of effects that TIC implementation might have on staff and clients, and on structures and policies within the organization.

The Relationship-Building phase of TIC consulting lasts until the organization has a clear sense of the time, resources, and activities associated with each phase of TIC implementation.

CHECKLIST FOR THE RELATIONSHIP-BUILDING PHASE

ORGANIZATIONAL GOALS

- Awareness of TIC implementation phases, the organization's needs, and the resources that may be needed for each phase
- Awareness of the need for diversity and inclusion in the implementation team
- Understanding of the range of areas affected by toxic stress and trauma, from individual safety to structural equity
- Understanding of the complexity of TIC implementation and its possible effects on staff and clients

ORGANIZATIONAL TASKS

- Leadership reflects on the need for TIC, their goals, what change might mean, and their potential need for support
- Leadership discusses the organization's motivation, barriers, and concerns about TIC implementation
- Leadership explores how TIC aligns with their mission, strategy, staff/client cultures, and the organizational culture

CONSULTING SERVICES

- Assess informally for a detailed, objective, and compassionate understanding of the organization's motivation
- Build rapport, to learn about their culture and how their need for support aligns with your capacity to provide support
- Give leadership information on the phases of TIC implementation
- Give leadership a sense of the scope of areas that will be affected, from individual and cultural safety to structural equity
- Tell leadership about the implementation workgroup and the need to reflect the diversity that exists in staff and clients
- Help leadership understand how transformation might lead to disruption within the organization

COMMENTS

2

THE DESIGN PHASE

ORGANIZATIONAL GOALS

1 Leadership and the work-group are aware of where the organization is on the spectrum of TIC implementation, diversity, inclusiveness, and structural equity.

2 Leadership and the work-group allocate resources (staff time, financial, space, etc.) to implementing the next phase.

3 Projected productivity and financial costs are known, so that the organization can ensure sustainable implementation.

ORGANIZATIONAL TASKS

- The implementation workgroup convenes and begins creating an implementation plan that will outline the work, formalize roles, set the vision, and identify committed resources.
- Leadership formalizes the relationship with the consultant through a contract or a Memorandum of Understanding/Agreement (MOU/MOA).
- The workgroup explores, selects, and conducts individual and organizational assessments of TIC capacity, diversity, inclusiveness, accessibility, and structural issues affecting the safety and equity of clients and staff.

TIC CONSULTING TASKS

- Guide the drafting of the MOU/MOA, to formalize relationship and scope of work.
- Help leadership select members of the implementation workgroup, help launch the group, and support group formation.
- Identify and coach the workgroup in using appropriate assessments for measuring TIC capacity, strengths, challenges, diversity, inclusion, accessibility, and structural equity.
- Facilitate the planning and creation of the organization's implementation plan.
- Provide guidance on best practices for gaining and maintaining staff ownership of TIC.
- Use a variety of facilitation, visioning, and problem-solving tools.

ABOUT THE DESIGN PHASE

DESIGN: ORGANIZATIONAL ACTIVITIES

The Design phase requires honesty, courage, and ample support from the TIC consultant.

During the Design phase, SUD treatment and recovery service providers will be spending a lot of time finding out what the treatment experience is really like for staff and clients—and what it might take to make that experience safer and more effective. This is also a time for looking closely at needs and resources, to find out what will be possible and how to make it happen.

The Design phase is highly collaborative, with individuals at all levels of the organization participating in the planning process and gathering input from the full range of stakeholders. It requires honesty, courage, and ample support from the TIC consultant.

The Agreement

Leaders of the organization may lack specific expertise in TIC transformation, and their positions and their interests might keep them from being truly objective, even if they would like to be more objective. These challenges might give them even more incentive to work in partnership with a consultant who brings both the awareness and the objectivity they lack. Due to the depth and complexity of this process, it is helpful to formalize this relationship with a Memorandum of Understanding/Agreement (MOU/MOA). This agreement:

- outlines the purpose and scope of work,
- makes clear the roles and expectations of both parties,
- describes the payment process for consulting services (if applicable),
- specifies the funding mechanisms for the financial costs of implementation,
- sets a timeline for the work, and
- identifies expected outcomes.

The Implementation Workgroup

Once the agreement is in place, leadership convenes an implementation workgroup made up of individuals in leadership, change agents, and change champions within the organization. It is important that this group reflect, not only the diversity of roles within the organization, but also the cultural diversity within the staff and client base. The first responsibility of the implementation workgroup will be to work collaboratively with the consultant to develop an implementation plan for TIC transformation at their organization.

Change agents are individuals who—because of their positions, attitudes, and/or approaches—are effective promoters of a change or transformation process. With strong leadership skills that help them inspire people to try new ways of understanding and approaching their work, change agents often have central roles in planning and implementing change.

Change champions, on the other hand, have an important but less intense role in the change process. Sometimes called "early adopters," change champions are individuals who are willing to accept and embrace change and show by their example the advantages of the change process. They are often passionate about the process, committed to change, and able to inspire others to adopt the change process as well. Whether or not they have central roles in the change planning and implementation process, change champions are often the first to adopt the new practices and interact with clients and other staff in ways that clearly reflect the new culture change.

CHANGE AGENTS: Change agents are individuals who—because of their positions, attitudes, and/or approaches—are effective promoters of a change or transformation process. Their strong leadership skills help them inspire people to try new ways of understanding and approaching their work.

CHANGE CHAMPIONS: Change champions are individuals who are willing to accept and embrace change and show by their example the advantages of the change process.

IMPLEMENTATION WORKGROUP:
The implementation workgroup should include leadership, change agents, and change champions and reflect the diversity within the staff and client base. The workgroup is first responsible for developing the implementation plan for TIC transformation and later responsible for leading, monitoring, and improving implementation.

The **implementation workgroup** is appointed by organizational leadership to represent the diverse interests of staff and clients, as well as the mission and purpose of the organization's TIC transformation. It should include leadership, change agents, and change champions and reflect the diversity within the staff and client base. In the Design phase, this group is facilitated, empowered, supported, and offered additional tools and resources by the TIC consultant. The Implementation Workgroup is first responsible for developing the implementation plan for TIC transformation, and later responsible for leading, monitoring, and improving implementation.

As emphasized in Part A of this Guide, organizational transformation is a long journey and a large, intense, and sometimes challenging process. The membership of the implementation workgroup should include people who carry with them the passion, as well as the authority, to complete this work. The workgroup will have to include executive leadership, clinical directors, supervisors, people with lived experience, and champions from other areas of the organization.

The overall size of this team will depend on how much time team members will be able to

devote to these efforts without neglecting their everyday responsibilities. In choosing workgroup members, leadership should consider:

- the organization's size and staffing patterns,
- the workload or caseload of each staff member,
- how much productivity is needed from each staff member, and
- the potential for disruption in services if particular staff members divert some of their attention to the TIC implementation workgroup.

The membership of the implementation workgroup should include people who carry with them the passion, as well as the authority, to complete this work.

The Initial Assessment

Once the implementation workgroup is created, the group will start its work with an assessment process. First, the workgroup will choose individual and/or organizational assessment instruments designed to identify existing:

- strengths;
- resources;
- barriers to change;
- current practices that are consistent or inconsistent with TIC;
- matters of diversity, accessibility, and inclusion within the organization; and
- structural issues that might affect the safety and equity of particular clients and staff (e.g., individuals in traditionally marginalized or stigmatized groups).

To provide an effective foundation for TIC transformation, it is helpful for data collected to include ample information about the current treatment and/or recovery support experience and service relationships for clients and staff members.

The organization may already have assessment data that overlap with the areas listed above, providing additional information to help establish a baseline measurement for TIC culture change.

Gathering and processing these assessments will not only inform the transformation plan and process. It will also help leadership and staff start to think differently about what they have and what needs to be changed. It will help them identify:

- attitudes and behaviors that do not align with the TIC principles,
- policies and practices that are not consistent with being trauma informed and promoting equity,

- how they might challenge some of these elements, and
- what might have to change to bring about the desired outcome.

Organizations are consistently asked to do more with limited resources. So, as implementation planning proceeds, much of it will focus on changes to existing systems and practices.

Another important role of the assessment process will be to inform the development of training plans for the organization and its staff throughout the implementation process. Assessments are designed to show the areas in which the organization and its staff need the most help to become trauma informed. These areas might then be addressed throughout the transformation process, during the phases that are most appropriate for their subject matter.

Different organizations require different levels of developmental support. Depending on their needs, it might be a matter of:

- changing or expanding existing training;
- bringing in trainers with expertise in relevant topics; and/or
- sending staff and leadership to external trainings that will fill in the gaps in their knowledge, understanding, attitudes, and practices.

The Vision Statement

The vision statement for TIC transformation has two purposes: to engage staff and keep them engaged, and to provide a sort of "beacon" to guide the implementation process so it can keep heading in the right direction.

- Creating a trauma-informed environment throughout the organization is a huge process, instilling new principles and changing many practices. It is not likely to succeed without real staff ownership. A good vision statement can engage staff's sense of compassion and purpose by describing the experience that clients and staff can have in a trauma-informed organizational culture.
- As the vision statement becomes part of the organizational culture, it can also serve as a guiding purpose and a visible goal—a point on the horizon to help the organization navigate the implementation process.

As the vision statement becomes part of the organizational culture, it can also serve as a guiding purpose and a visible goal—a point on the horizon to help the organization navigate the implementation process.

It is important that the language used in the vision statement be inspiring enough to capture people's interest and win their loyalty, but concrete enough that they can easily tell whether or not they are following it. So, for example, the use of inspiring terms from the five TIC principles might provide some overarching goals for services and service relationships.

The Implementation Plan

With its foundation in the assessment data and its purpose clearly defined in the vision statement, the implementation plan will outline and formalize:

- membership of the implementation workgroup,
- the roles of participating staff,
- what is expected of each workgroup member, and
- the commitment of agency resources to this work.

Ritchie (2017) describes the Design phase as fundamentally "…a time period for designing a customized, local plan for implementing an innovation and conducting other activities that need to occur prior to implementation."[66]

The workgroup will need the consultant to:

- look at the organization and its plan through a more objective lens, and
- support connection among workgroup members and other supporters of these efforts—the real forces driving the work of transformation.

DESIGN: CONSULTING ACTIVITIES

The Agreement

During the Design phase, the consultant starts by guiding leadership through the drafting of a contract or an MOU/MOA. This agreement:

- identifies the purpose of the work,
- lists what each party (the organization and the consultant) is responsible for accomplishing,
- describes any required payment for services (if applicable),
- sets a reasonable timeline for the work, and
- identifies any expected outcomes that either or both parties might be able to accomplish.

Creating the Implementation Workgroup

In the Design phase, the consultant's work is focused on supporting leadership's efforts to create and empower the workgroup that will develop and carry out the implementation plan. To help leadership choose the right individuals for the workgroup, the consultant:

- will need a strong understanding of what the treatment experience is like for staff and what it is like for clients, and
- will need to make sure the group reflects the diversity within the whole organization.

For example, the consultant might suggest a variety of metrics, including demographic, performance, and mission-driven considerations, that the organization can use in choosing workgroup members.

Supporting the Implementation Workgroup

The consultant will support the launch of the implementation workgroup by being part of the facilitation team for the first few workgroup meetings. Then, when the team is up and running, the consultant's priority will shift to facilitating the planning and creation of the implementation plan.

The first step in creating the implementation plan will be the initial assessment process described on **Page 45**. The results of these assessments will then be used to guide the planning process and help the organization decide which policies, practices, and training are consistent or inconsistent with TIC and with equity, diversity, and inclusion.

The consultant's role will include:

- making sure workgroup members have access to information about the implementation planning process;
- helping the workgroup identify and use appropriate assessments for measuring TIC capacity, strengths, challenges, issues of diversity and inclusion, and issues of structural equity;
- helping the workgroup dissect and interpret the data collected from the clients and staff who participated in the assessments;
- facilitating workgroup discussions of the assessment results;
- helping the workgroup translate these data into the kinds of planned changes necessary to bring about the desired transformation; and
- encouraging leaders to keep the goal of sustainability integrated into all aspects of the design process.

As leadership and the workgroup seek to foster support and a sense of ownership within the rest of the organization, the consultant may need to offer guidance on best practices for gaining and maintaining ownership among stakeholders. From a TIC perspective, both staff and clients are stakeholders to be engaged in this work. So it is important for the consultant to help the workgroup communicate the holistic vision that this inclusive group has created, agreed upon, and adopted.

- A fundamental skill for the consultant is to be able to draw from an array of facilitation, visioning, and problem-solving tools. For example, one common tool in early planning efforts is "journey mapping," a structured, collaborative way of identifying both the current and the ideal staff/client experience throughout the organization's services.
- Some agencies might decide to create smaller workgroups that focus on smaller portions of the overall plan, such as training and onboarding processes.

Throughout the design and creation of the implementation plan, the TIC consultant must be able to stimulate inclusion, creativity, collaboration, collective problem solving, and shared vision in the workgroup.

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No matter what the setting, the role of the consultant in the workgroup will be:

- to inspire and support the workgroup,
- to center the group's attention on planning, and
- to help the group identify the resources needed to achieve the desired outcome.

Addressing Sustainability Issues

The Design phase is also where sustainability issues will often surface. This phase requires both the consultant and the organization to identify the resources that can be allocated to the work set out in the contract/MOU/MOA. Resources can include financial capital, labor, and new or existing relationships that can be leveraged for help in moving toward this goal.

Engaging in an extensive transformation process will have many fiscal effects, and the Design phase offers opportunities to learn more about those potential effects. In Design, the consultant helps leadership and the workgroup learn about the organization's capacity for change and use those insights to craft TIC implementation goals. During this process, they should also work to identify any sustainability issues that might have negative effects on the organization's ability to carry out the plan. As the consultant becomes aware of these kinds of issues, it will be important to bring them to leadership. The Design phase is the optimum time for agencies to consider these possible effects and how the organization might adjust to them.

Balancing Productivity with Staff Involvement in Transformation

If leadership is aware of the importance of giving key staff enough time for their TIC transformation work, they can plan accordingly.

In this phase, one important point for consultants to raise with leadership is the importance of balancing staff productivity with staff involvement in the transformation process. If key staff involved in implementation efforts are going to be able to play effective roles in this process, they will need time and space for creative problem solving, and that will limit their face time with clients.

Sometimes financial needs prompt organizations to raise their caseloads or productivity requirements for people in revenue-producing positions. If leadership is aware of the importance of giving key staff enough time for their TIC transformation work, they can plan accordingly. And if consultants notice that productivity requirements are limiting needed staff involvement in implementation, they can bring these issues to leadership.

DESIGN: ANTICIPATED ORGANIZATIONAL CHANGE

The Design phase is too early in the implementation process to expect to see changes in practices or in the organizational environment. Instead, this is a time for leadership to become more aware of where their organization is on the spectrum of TIC implementation and what it will take to progress to the next phase of implementation. Both leadership and the workgroup will become better aware of the issues of diversity, accessibility, inclusiveness, and structural equity that exist within the organization, and how TIC implementation might be designed to address these issues effectively.

How long an organization spends in the Design phase will often depend on the size and needs of the organization being served. Given the tendency of human situations to reveal themselves in layers, there will probably be opportunities for redesign in every phase moving forward.

The Design phase is critical to TIC transformation, because it requires that all parties pay attention to important details of organizational culture and functioning. Ultimately, this phase prepares the organization to look systematically at the changes that will be necessary—changes in beliefs, policies, and practices—to bring about transformation.

For organizational leadership and change agents, a certain amount of internal vulnerability is common at this time, along with reflection on the expectations that have guided past services. The more the consultant understands, listens to, and accepts this vulnerability and ambivalence, the more surely the Design phase can contribute to the transformation that is already well underway.

The Design phase is critical to TIC transformation, because it requires that all parties pay attention to important details of organizational culture and functioning.

CHECKLIST FOR THE DESIGN PHASE

ORGANIZATIONAL GOALS

- Awareness of TIC implementation phases, the organization's needs, and the resources that may be needed for each phase
- Awareness of the need for diversity and inclusion in the implementation team
- Understanding of the range of areas affected by toxic stress and trauma, from individual safety to structural equity
- Understanding of the complexity of TIC implementation and its possible effects on staff and clients

ORGANIZATIONAL TASKS

- Leadership formalizes the relationship with the TIC consultant through a contract/memorandum of understanding/agreement
- The implementation team is convened, begins a plan that outlines their work, formalizes roles, sets the vision, and identifies resources
- The workgroup explores, selects, and conducts focused and organization-wide assessments of capacity to implement transformation
- The workgroup assesses diversity and inclusivity, structural issues affecting equity, and the cultural safety of clients and staff

CONSULTING SERVICES

- Guide the drafting of an MOU/MOA on the scope of work to be performed and elements of the consulting relationship
- Help leadership select members of the implementation workgroup and collaborate in facilitating the launching of the workgroup
- Coach the workgroup in choosing/using instruments to assess the organization on a variety of safety- and equity-related measures
- Give leadership a sense of the scope of areas that will be affected, from individual and cultural safety to structural equity
- Tell leadership about the implementation workgroup and the need to reflect the diversity that exists in staff and clients
- Help leadership understand how transformation might lead to disruption within the organization

COMMENTS

CHAPTER 4

IMPLEMENTATION

CHAPTER 4: IMPLEMENTATION

The two phases of pre-implementation—Relationship Building and Design—offered a process for crafting a solid foundation and a "trail map" for trauma-informed care transformation.

Now Chapter 4, "Implementation," covers the "action" phases that will move the transformation process farther along on the journey you planned in pre-implementation:

- Trauma Awareness floods the organization with information and the beginning of deeper understanding.
- Trauma Sensitivity helps leadership and staff integrate this new learning with their traditional experience and understanding of themselves, the people they serve, the people they work with, their relationships, their responsibilities, and their work.
- Trauma Responsiveness watches transformation come alive, as the people and practices within the organization put their new learning into practice.

3

THE TRAUMA AWARENESS PHASE

ORGANIZATIONAL GOALS

1 All staff have a basic understanding of trauma, its causes, prevalence, and impact, and are familiar with the medical model of SUD.

2 Staff are aware of the systemic nature of power and privilege and their impact on staff and client trauma.

3 Staff know the five TIC principles, compare them with current practices, and understand their relationship to the mission.

4 Staff recognize their own attitudes and may begin to shift their paradigms on co-worker and client behavior.

ORGANIZATIONAL TASKS

- The workgroup selects the TIC training curriculum and assigns and schedules awareness trainings.
- All staff attend these trainings.
- Staff ask questions, continue to explore trauma, equity, accessibility, inclusiveness, and diversity, and consider what all this new information means for their practice.
- Leadership disseminates initial messaging about TIC and the organization's mission.

TIC CONSULTING TASKS

- Deliver training or help the organization identify a trainer and curriculum to offer to staff.
- Promote trainings that are evidence-based and reflect current best practices specific to the organization's setting and/or population of focus.
- Guide the organization through planning for the training programs to be offered to staff, including identification of desired outcomes.
- Encourage leaders to explore links between inequities and trauma and identify the benefits of addressing structural inequities.
- Engage leadership in exploring what this new information means, next steps to be taken, and communication strategies for staff.
- Continue to nurture your relationship with the organization.

ABOUT THE TRAUMA AWARENESS PHASE

In the Trauma Awareness phase, the organization moves from a limited awareness of trauma and its effects to a level of awareness and knowledge that is strong enough to inform TIC implementation. Their goal in this phase is simply to gain knowledge and understanding, most commonly through all-staff training.

For SUD treatment and recovery service practitioners, this includes knowledge of:

- the distinctions and boundaries between trauma-informed care and trauma-specific treatment;
- the medical model of addiction and the neurobiology of trauma;
- the connections among SUD, trauma, and common co-occurring conditions;
- the prevalence of trauma in SUD treatment and recovery settings;
- how trauma may present in common treatment and recovery services and settings;
- the importance of psychological safety and stress-modulation skills for individuals with trauma histories and effects;
- trauma-informed language and approaches for both trauma and SUD treatment and support;
- intergenerational, historical, and racial trauma;
- the systemic nature of power and privilege and its effects on the trauma that many clients and staff members experience;
- the differences in power between SUD providers and clients, and the effects of those differences on client safety; and
- recognition of their own perceptions of and attitudes toward the behaviors of clients and co-workers.

> **NOTE:** Many of these topics are also essential for fostering trauma-informed responses in mental health or prevention services, but additional topics would also be necessary for customization to those settings.

TRAUMA AWARENESS: ORGANIZATIONAL ACTIVITIES

The Trauma Awareness phase is a busy one for organizational leadership and staff.

- Leadership and/or the implementation workgroup collaborate with the consultant to choose curricula and assign and schedule awareness trainings. These trainings are offered at strategic times that allow all staff to attend. After awareness training is over, some staff may look for additional resources (e.g., more information on the prevalence of trauma for people in treatment and recovery) to further their understanding of trauma.

- Leadership and change agents support ongoing staff education and exploration.
- Leadership and the implementation workgroup create opportunities (e.g., during all-staff meetings) for staff to:
    - ask questions;
    - continue to explore trauma, equity, issues of inclusion, accessibility, and diversity; and
    - consider what this new information means for the agency, staff, clients, and the community.

Although trauma awareness is not enough to make an organization trauma informed, it can be a source of improvement. Take, for example, the information about connections between substance use and trauma—and, in particular, connections between ACEs and SUD. Equipped with this information, many staff members come to understand that substance use disorders are often among the results of people's attempts to cope with trauma.

Although trauma awareness is not enough to make an organization trauma informed, it can be a source of improvement.

EXAMPLE

Signs of Successful Trauma Awareness

Let us look at the experience of an intake coordinator, doing an intake assessment with a new client who appears withdrawn, avoids eye contact, and seems disengaged. Before trauma awareness training, the intake coordinator might have interpreted this behavior as a sign of low motivation or resistance to treatment.

After attending trauma awareness training, the coordinator is more likely to realize that the client's affect and body language might also be:

- adaptive, self-protective behaviors that helped the client avoid conflict and protect themselves during a recent incarceration; or
- signs of anxiety and mistrust of providers, after earlier experiences with treatment left them feeling trapped in mandated groups with high levels of confrontation, shaming, and stories of other clients' traumatic experiences that activated their own trauma responses.

Even if the intake coordinator is not sure how to ask about the client's earlier experiences, they are aware that a range of factors might be influencing the individual's words, facial expressions, and body language. So they choose not to take those reactions personally or to confront the client about what seemed at first like lack of motivation. Instead, the intake coordinator responds with a calm, grounding approach, helping the client:

- feel more calm and emotionally safe,
- become more engaged in the interview process, and
- increase their sense of safety with the idea of entering treatment.

TRAUMA AWARENESS: CONSULTING ACTIVITIES

In the Trauma Awareness stage, training might be delivered by the TIC consultant or by another trainer or trainers. If the consultant is not to be the trainer, the consultant points the organization in the direction of:

- evidenced-based trainings,
- effective trainers,
- current best practices, and
- information about trauma specifically related to SUD and the medical model of addiction.

The consultant collaborates with the organization to:

- find the most appropriate content and trainers for the organization,
- set the desired outcomes for this training, and
- schedule awareness trainings at times that allow all staff to attend.

The consultant guides the organization through planning for the awareness training and continues to engage leadership in:

- exploring what this new information means for the organization and
- determining the next steps the organization will need to take.

Through the awareness trainings, leadership comes to understand that knowledge of the impact of toxic stress and trauma can greatly enhance their ability to fulfill the organization's mission and goals.

Throughout this process, the consultant regularly connects with organizational leadership and continues to actively nurture the relationship.

During this time the consultant also continues to deepen leadership's understanding of the connections between inequities and trauma and the benefits of addressing the structural inequities they find in their exploration process.

TRAUMA AWARENESS: ANTICIPATED ORGANIZATIONAL CHANGE

Through the awareness trainings, leadership comes to understand that knowledge of the impact of toxic stress and trauma can greatly enhance their ability to fulfill the organization's mission and goals.

Benefits of Trauma Awareness for Staff

For staff, the benefits of trauma awareness training are many. By the time the awareness phase is done, staff will:

- have a basic understanding of the definition of trauma, what this term refers to, its causes, its prevalence, its impact on clients in treatment, and its impact on staff;
- be aware that their knowledge of trauma frames the way they think about and interact with clients and co-workers;
- be familiar with the TIC principles of safety, choice, collaboration, trustworthiness, and empowerment and be able to talk about how these concepts are reflected in current practices;
- be aware of the systemic nature of power and privilege and its impact on trauma in the lives of clients and staff;

- begin to have informal discussions of the impact of trauma on clients and staff;
- begin to recognize how their own attitudes and perceptions may be influenced by trauma;
- begin to shift the lens with which they view themselves and their clients;
- understand the medical model of addiction; and
- begin to reflect on how their own experiences with trauma and/or substance use disorders affect their day-to-day work

Measurable Outcomes

At this stage, quantitative outcome evaluation efforts might include tracking the number of staff trained in trauma awareness or the number of informational flyers provided to clients and/or other constituencies (e.g., alumni, other individuals in recovery). Qualitative outcomes might include leadership and change agents noticing shifts in perceptions among some staff members, particularly in the interactions among staff and between staff and clients.

Some staff members might start to notice a shift in their understanding of client behavior and ways in which that behavior might be related to the effects of trauma.

Limitations of the Trauma Awareness Phase

The training that takes place in the Trauma Awareness phase has a limited scope and influence on practice. Take, for example, an SUD treatment organization serving women and children that kicks off the organization's TIC implementation with a week-long training for staff on trauma, addiction, and gender. All staff, occupying all roles in the agency, are required to complete the training before the end of the first implementation year.

The training content gives participants basic information on:

- how prevalent trauma and PTSD are among people seeking SUD treatment;
- the neurobiology of trauma and SUD;
- how symptoms of trauma may present in treatment settings (e.g., avoiding group interactions, hypervigilance, difficulty regulating emotions when trauma symptoms have been activated); and
- basic skills for supporting clients with trauma histories (e.g., using grounding and breathing exercises, asking "What happened?" rather than "What's wrong with you?").

After they have had the initial training, some staff members begin to discuss ways this information might be applied to their day-to-day work, for example:

- changing the way they conduct client case reviews,
- evaluating and strengthening the ways in which clients are greeted and supported through intake, and

- revisiting the policies that govern their responses when they learn that clients have used alcohol or drugs.

Other staff are not sure how, if at all, this information should affect their daily work.

Clients assigned to staff who have learned how to apply TIC concepts to their work are likely to have safer, more respectful, more empowering treatment experiences.

In this example:

- some staff members who were there for the initial training experience the higher level of understanding that the training brought them,

- other staff who had this training have not yet made many connections between the training content and their work, and

- staff hired after the training have had no exposure to the TIC training material.

If staff is limited to an initial awareness training phase, treatment services and experiences might improve for some clients, but not for all who need these improvements, and the improvements they do experience might be short-lived. Clients assigned to staff who have learned how to apply TIC concepts to their work are likely to have safer, more respectful, more empowering treatment experiences. And if some staff members have not learned or have not been able to apply trauma-informed information, their clients may continue to encounter disempowering, retraumatizing dynamics.

CHECKLIST FOR THE TRAUMA AWARENESS PHASE

ORGANIZATIONAL GOALS

- Basic understanding of trauma among all staff, including its prevalence, causes, and impact, and the medical model of SUD
- Staff awareness of the systemic nature of power and privilege and its impact on trauma among clients and staff
- Application of the five TIC principles to the organization's mission and practices
- Staff insight into their own attitudes toward trauma/diversity and into the factors that influence their perceptions of clients' behaviors and motivations

ORGANIZATIONAL TASKS

- The workgroup chooses and assigns a TIC curriculum and selects a trainer, and awareness training begins
- All staff, at all levels, attend the TIC trainings
- In formal and informal discussions, staff explore trauma, diversity, equity, accessibility, and inclusiveness, and consider their implications
- Leadership and the workgroup develop a TIC mission statement and develop and spread this and other TIC messaging

CONSULTING SERVICES

- Deliver the training or help the organization identify an appropriate trainer and curriculum to offer to all staff
- Promote evidence-based trainings that both reflect best practices and match the setting, its cultures, and its population of focus
- Guide the workgroup in planning for trainings to be offered to staff, including the identification of desired outcomes
- Help leadership understand links between inequities and trauma and the benefits of addressing structural inequities
- Help leadership explore what this learning means and the next steps to take, and help them plan for communication with staff about implementation
- Continue to nurture your relationship with the organization (both leadership and the workgroup)

COMMENTS

4

THE TRAUMA SENSITIVITY PHASE

ORGANIZATIONAL GOALS

1 The organization has established common goals and expectations for the new standard of care and the changes needed to achieve shared outcomes.

2 All staff are aware of and supportive of organizational commitment to a process for TIC transformation, culture change, equity, diversity, resilience, and ending structural inequities.

3 Staff and clients have a basic understanding of, and ready access to, information on trauma, ACEs, TIC principles, history, and culture.

ORGANIZATIONAL TASKS

- Conversations about the value of TIC occur at all levels of the organization.
- Staff regularly explore TIC principles, culture, diversity, implicit bias, structural inequities, and cultural humility.
- The implementation workgroup reviews assessment findings, policies and practices, and other relevant data needed to develop a detailed implementation plan with clear goals and outcomes for TIC.
- The workgroup involves clients in policy, program, and practice planning.

TIC CONSULTING TASKS

- Meet regularly with the implementation workgroup to review the implementation plan and document progress.
- Communicate with staff about the design process, making sure everyone understands.
- Support leadership in developing a message that conveys reasons for prioritizing transformation.
- Help the workgroup create a monitoring and reporting system to track implementation. Be ready to bring in consultants with additional expertise whenever it is needed.
- Support ongoing DEI self-assessment, including effects of policies and practices on opportunities for staff and clients.
- Use coaching to ensure true knowledge transfer for behavior and culture change, identify barriers, and facilitate problem- solving and conflict resolution.

ABOUT THE TRAUMA SENSITIVITY PHASE

The overarching goal of the Trauma Sensitivity phase is for leadership and the implementation workgroup to lay the groundwork for TIC transformation.

Much of the activity in this phase stems from work begun during the Design phase. Some design work will enter into the beginning of any phase of the relationship between a consultant and an organization. However, the design work that takes place during Trauma Sensitivity is intensely focused on:

- the ways in which specific services and practices will need to change, and
- how those changes should be reflected in the detailed plan for transformation.

If organizational leaders have not yet convened an implementation workgroup (as described in the Design phase, starting on **Page 42**), they need to convene it now. This workgroup will collaborate with the consultant and lead implementation efforts throughout the organization. In the Trauma Sensitivity phase, leadership and the workgroup collaborate in:

- exploring the five TIC principles (safety, choice, collaboration, trustworthiness, and empowerment) within their organizational setting,
- building consensus around the ways in which these principles apply to SUD treatment and recovery services,
- considering the implications of adopting these principles within the organization, and
- preparing for change.

Though the Design and Trauma Sensitivity phases are likely to overlap, the ultimate goal of Trauma Sensitivity is for all staff to:

- internalize the understanding they gained in the Trauma Awareness phase, integrating it into their thoughts and their work;
- understand why and how the organization will move forward with TIC transformation; and
- increase their awareness of and support for the organizational commitment to TIC, to changing the organizational culture, to diversity, to increasing resilience and equity within the organization, and to ending structural inequities.

TRAUMA SENSITIVITY: ORGANIZATIONAL ACTIVITIES

In Trauma Sensitivity, leadership actively engages with the TIC consultant to build a long-term relationship that is strong and flexible enough to support implementation and transformation. They also work in collaboration with the implementation workgroup on several levels.

A Process of Reflection

First leadership spearheads a process of reflection that will:

- help them find out how ready the organization is for TIC implementation, and
- prepare the organization for incremental policy and practice change.

This process includes all staff participating in an organizational assessment that:

- identifies existing strengths, resources, barriers to change, and issues of culture; and
- evaluates existing policies and practices, to find out which ones are consistent and which ones are inconsistent with the TIC principles and the promotion of equity and inclusion.

Support From Supervision

Trauma-informed individuals at any level can have significant power to calm and to heal, just by virtue of the way they interact with people.

Meanwhile, supervisors are having discussions with staff at all levels on the value of a trauma-informed approach. Staff regularly explore the TIC principles, issues of culture and diversity, implicit bias, structural inequities, and ways of achieving cultural humility.

Any individual who works in the organization might have opportunities to make the experience more or less trauma informed for the people who receive services there. This includes employees and volunteers in intake, residential, peer services, clinical services, food services, facility/maintenance, security, front desk/administrative, and leadership roles. Trauma-informed individuals at any level can have significant power to calm and to heal, just by virtue of the way they interact with people.

The Implementation Workgroup

Again, if it was not completed in the Design phase, the implementation workgroup's primary task in Trauma Sensitivity is to:

- coordinate the distribution of assessments,
- review assessment findings and other relevant information, and
- develop an implementation plan for TIC transformation.

With the help of the implementation plan, the organization lives up to its commitment to actively involve clients (and other individuals with lived experience of behavioral health challenges and trauma) in service planning and in the design of trauma-informed programs and practices.

- It is impossible to overstate the importance of input from people with lived experience of trauma, substance use disorders, marginalization, and the many effects of racial and cultural prejudice and discrimination.
- Meaningful consumer involvement in the design and development process can be healing and empowering. However, even beyond that, input from people who have "been there" can also provide essential information, ideas, and warnings that people without this experience often overlook.
- So a plan for involving clients and alumni in the larger transformation and evaluation process is also crucial to the implementation workgroup's responsibilities in this phase.

It is also in the Trauma Sensitivity phase that the workgroup explores:

- ways of conducting universal screening of all clients for trauma; and
- the process or practice changes necessary to make universal screening safe, respectful, and effective.

Finally, leadership and the implementation workgroup will consider:

- ways of extending TIC awareness training to all new hires on an ongoing basis, and
- options for providing continuing trauma education to current staff.

TRAUMA SENSITIVITY: CONSULTING ACTIVITIES

Facilitating Implementation Planning

During this phase, the TIC consultant will meet regularly with the implementation workgroup to:

- facilitate the design of the implementation plan;
- document progress;
- identify intake, discharge, treatment/service planning, supervision, and HR (human resources) policies and practices that may need modification; and
- provide positive reinforcement.

To promote staff empowerment and gain support for TIC during this phase, it is vital that the consultant listen deeply and communicate mindfully, to ensure mutual understanding.

To promote staff empowerment and gain support for TIC during this phase, it is vital that the consultant listen deeply and communicate mindfully, to ensure mutual understanding.

The consultant will also help leadership create an ongoing monitoring and reporting system to track implementation steps, fulfillment of objectives, and outcomes. This can help the organization build an infrastructure for sustainability.

Crafting the Message

The consultant's other key role in the Trauma Sensitivity phase is to back leadership in its efforts to communicate with staff about TIC implementation. With the consultant's support, leadership uses trauma-sensitive language to craft a message that helps staff understand:

- why the organization is prioritizing this transformation process,
- what staff can expect of leadership during this time,
- what will be expected of staff, and
- the "end-goal" of trauma-informed care transformation.

The TIC consultant will also support leadership in deciding how to disseminate this messaging (e.g., in-person; at all-staff or team meetings; through emails, flyers, and newsletters).

Dealing with Challenges

Challenges and conflicts are normal during the Trauma Sensitivity phase. As leadership and the implementation workgroup guide the organization through the behavior and culture changes that take place in this phase, the consultant:

Challenges and conflicts are normal during the Trauma Sensitivity phase.

- helps them identify barriers,
- facilitates problem solving,
- provides ongoing coaching, and
- offers reassurances and resources.

Needed resources might include conflict management training, appreciative inquiry, motivational interviewing, empathic communication training, and mindfulness training. These may be opportunities to bring in consultants with special expertise in the kinds of challenges the organization is experiencing. It will also be important for the consultant to recommend best practices for self-care that leadership and staff can use during this time of culture change.

TRAUMA SENSITIVITY: ANTICIPATED ORGANIZATIONAL CHANGE

Signs of Successful Trauma Sensitivity

The following are some characteristics and experiences that might indicate that an organization has done the work of the Trauma Sensitivity phase effectively:

- Leadership, change agents, change champions, and the implementation workgroup are all aligned. They share common goals and expectations for the organization's new standard of care and the changes required to deliver services in a transformed organization.

- The organization has an implementation plan with clear priorities, anticipated outcomes, and the resources that will be needed for next steps.
- All staff are aware that the organization is committed to TIC and equity, and that it is embarking on a long process designed to transform the organizational culture and climate.
- Staff are discussing these early and anticipated changes with one another and with their supervisors.
- Individuals in the organization value and prioritize the TIC principles, and they begin to view and apply their own policies and practices through a trauma-informed lens.
- Leadership and management support staff resilience. They also recognize—and begin to learn how to respond appropriately to—"compassion fatigue," "burnout," and vicarious trauma (secondary trauma) in staff.
- Trauma training for all staff—including the orientation of people who are new to the organization—is part of the provider's ongoing structure and practice. This strengthens the framework of the organization for long-term sustainability.
- Basic information on trauma and ACEs is available to both clients and staff and easily visible within the organization (in posters, flyers, and handouts, and on web sites, etc.).
- Clinical staff and others in direct service roles begin to seek out opportunities to learn trauma-informed SUD treatment models and emerging best practices for people with SUD and trauma histories.
- Some staff are already beginning to make their work with clients and their interactions with one another more trauma informed.
- The organization begins to explore any issues that might be leading to structural inequities.

Measurable Outcomes

One possible way of gathering quantitative outcome data might be through improved client surveys. To gather information on qualitative outcomes during this phase, the organization might find ways of recording data on indicators such as:

- shifts in the ways in which staff are discussing client behaviors,
- observable shifts in interactions between staff and clients, and
- improvement in collaboration among staff.

EXAMPLE

Signs of Successful Trauma Sensitivity

In this example, an SUD treatment provider has a designated program serving people with SUD who have recently been released from prison. After going through TIC training, staff in this program have started to grapple with issues around mandated vs. voluntary treatment, asking themselves how the treatment environment might actually be replicating some aspects of incarceration. For example:

- Staff observed and brought up the point that the organization's furniture was all orange, the same color as the furniture and fixtures in prison.
- Some staff began to reconsider the common language around "criminal thinking" and proposed other ways of understanding client behaviors. These new ways of understanding and communicating were more focused on how client responses they had been interpreting in a negative light might actually be coping strategies or survival skills developed in traumatizing environments.
- Some staff also mentioned that the presence of probation officers who carried guns on the organization's property contributed to an environment that might feel intimidating, particularly when those officers made arrests in highly visible areas to "make a point" to other clients.
- Staff also began to stop automatically interpreting some clients' resistance to attending four hours' worth of group sessions a day as resistance to treatment. Instead, they thought of it more as an indication that some clients do not feel safe in group settings, particularly when other clients share traumatizing material in the group. Staff began to question the organization's current practice of mandating additional group time for clients who have skipped group sessions or refrained from engaging in groups as thoroughly as staff wanted them to engage.

The implementation workgroup realized that each of these environmental factors and treatment practices was creating a context that was disempowering and unsafe for many clients. It was not immediately clear to the group how they could create safety, trust, choice, collaboration, and empowerment within a mandated treatment setting. However, the team agreed that they would need to devote some attention and "brainstorming" efforts to these issues, to generate alternative practices.

CHECKLIST FOR THE TRAUMA SENSITIVITY PHASE

ORGANIZATIONAL GOALS

- Common goals and expectations for the new standard of care and the changes needed to achieve shared goals and outcomes
- Commitment to TIC, resilience, transformation, equity, and diversity expressed through words, policies, and actions
- A process for change that follows the five TIC principles
- An organizational commitment to ending structural inequities
- Awareness of provider's commitment to TIC among all staff; support for this cultural transformation and for staff resilience
- Information on trauma, ACEs, TIC principles, history, equity, and culture, readily visible to both staff and clients

ORGANIZATIONAL TASKS

- Leadership creates safe and inclusive opportunities for conversations about the value of TIC at all levels of the organization
- Workgroup promotes exploration of TIC principles, diversity, bias, structural inequities, and cultural humility
- Clients and alumni with lived experience are integrated into the planning of programs and practices
- The workgroup reviews assessment findings, policy and practice review, and other relevant data to contribute to the plan
- With leadership support, the workgroup creates a detailed implementation plan with clear goals and outcomes

CONSULTING SERVICES

- Deliver the training or help the organization identify an appropriate trainer and curriculum to offer to all staff
- Promote evidence-based trainings that both reflect best practices and match the setting, its cultures, and its population of focus
- Guide the workgroup in planning for trainings to be offered to staff, including the identification of desired outcomes
- Help leadership understand links between inequities and trauma and the benefits of addressing structural inequities
- Help leadership explore what this learning means and the next steps to take, and help them plan for communication with staff about implementation
- Continue to nurture your relationship with the organization (both leadership and the workgroup)

COMMENTS

5

THE TRAUMA RESPONSIVENESS PHASE

ORGANIZATIONAL GOALS

1 The organization has established common goals and expectations for the new standard of care and the changes needed to achieve shared outcomes.

2 All staff are aware of and supportive of organizational commitment to a process for TIC transformation, culture change, equity, diversity, resilience, and ending structural inequities.

3 Staff and clients have a basic understanding of, and ready access to, information on trauma, ACEs, TIC principles, history, and culture.

ORGANIZATIONAL TASKS

- The organization is the primary driver of the implementation plan, adapts policies and practices to make them trauma-informed, and disaggregates data to monitor equity and cultural relevance.
- Staff integrate TIC principles into behaviors, supervision, practices with clients, the physical environment, and hiring practices.
- The organization begins outreach to other providers who can contribute resources that support trauma recovery.

TIC CONSULTING TASKS

- Have regular check-ins with the workgroup, conducting problem solving when it is needed.
- Highlight successes and use them to empower the organization for long-term sustainability.
- Guide any modification of the plan with diverse feedback, including feedback from individuals with lived experience.
- Collaborate with quality assessment and improvement (QA/I) and evaluation teams to plan for data collection and outcome evaluation.
- Ensure that staff know and routinely consider how the social determinants of health affect staff and client outcomes.

ABOUT THE TRAUMA RESPONSIVENESS PHASE

The goal of Trauma Responsiveness is to make the organizational culture and practices consistently reflect the trauma-sensitive norms, behaviors, counseling and group modalities, and policy and practice changes that the organization has been learning about and discussing throughout the implementation process.

In this phase, organizations actively shift their policies and practices to transform the organizational culture. Transformation is really happening, and it allows the organization to meet the needs of clients and staff who are healing from trauma exposure far more effectively than ever before. At all levels of the organization, staff are changing their routines, and the very infrastructure of the organization seems to be organizing itself around the five principles of trauma-informed care. It is clear that the journey is well underway and the movement has "hit its stride."

TRAUMA RESPONSIVENESS: ORGANIZATIONAL ACTIVITIES

During this phase, the implementation workgroup, change agents, and change champions are the key drivers of the implementation plan.

Guided by the workgroup and the implementation plan, staff and leadership are taking action, integrating the five TIC principles into their behaviors, practices, policies, and supports. This might include implementing:

- measures for addressing staff trauma and self-care needs;
- supervision approaches that include active listening and thoughtful questioning by both the supervisor and the supervised staff member;
- regular policy review, inviting people with lived experience to help identify policies and practices that might lead to higher levels of power imbalance or issues of inequity;
- universal screening for trauma, supported by training on best practices for screening, referral, and preparation of clients for safe participation in trauma-specific treatment;
- skill training for clients in safe skills for recognizing and modulating their stress responses;
- examples of strength-based treatment and service planning processes, and encouragement for staff to experiment with clients in co-creating customized plans;
- client-specific safety plans and interventions, developed in collaboration with the individual client, that specify ways of responding to crisis situations that are less likely to activate their specific post-trauma symptoms and sensitivities;
- referral relationships and procedures with agencies in the community that offer trauma-specific services and/or can support the organization in helping clients work through their trauma;
- case-review processes that carefully and collaboratively plan for client needs around trauma in a variety of possible circumstances;

- staff development, training, and certification in safe application of trauma-specific clinical modalities;
- regular disaggregation of evaluation and outcome data, for more accurate assessment of the cultural accessibility, acceptability, and relevance of the organization's services;
- ways of incorporating TIC principles into the organization's performance evaluation process; and
- policies and procedures for creating and maintaining the organization's sites and facilities that are based on TIC principles, allowing for privacy wherever possible and ensuring that these spaces are safe, welcoming, and accommodating.

TRAUMA RESPONSIVENESS: CONSULTING ACTIVITIES

The consultant continues to actively engage with the implementation workgroup to advise the group, facilitate problem solving, and encourage celebration of the organization's progress. The consultant's responsibilities include:

- regular check-ins with the implementation workgroup;
- collaborating with evaluation processes and with quality-assessment/improvement teams, including the monitoring of their data;
- guidance on any modifications to the implementation plan; and
- encouraging the involvement of people with lived experience in this process.

The consultant continues to actively engage with the implementation workgroup to advise the group, facilitate problem solving, and encourage celebration of the organization's progress.

The consultant continues to actively engage with the implementation workgroup to advise the group, facilitate problem solving, and encourage celebration of the organization's progress.

The consultant can continue the mentorship role that turns the organization's attention to larger issues, trends, and outside forces that might be affecting the well-being of staff and clients. For example, in this phase, staff is ready to balance an understanding of individual experience with a broader understanding of how the social determinants of health might be affecting client outcomes and staff well-being.

Implementation-related challenges and conflicts may still arise. The consultant understands that this is normal and continues to:

- use a variety of approaches to facilitate collaborative problem solving, and

- redirect the collective focus toward creative ways of re-imagining services.

Throughout the Trauma Responsiveness phase, the consultant highlights the organization's successes, using these examples to help the organization empower itself for long-term sustainability.

However successful the organization becomes during this phase, it remains important for the consultant to practice and model self-care consistently.

However successful the organization becomes during this phase, it remains important for the consultant to practice and model self-care consistently.

TRAUMA RESPONSIVENESS: ANTICIPATED ORGANIZATIONAL CHANGE

It is when the Trauma Responsiveness phase has done its work that the transformed organization takes shape and becomes tangible to the individuals who work there, seek help there, or visit. In many cases, the first signs can be apparent before a word is spoken. The physical environment is welcoming, accommodating, and safe. The people who work there carry with them a sense of compassion, collaboration, and respect.

Characteristics of the transformed organization are also apparent throughout its processes and characteristics. Following are some examples.

The Process of Finding Safe and Appropriate Services

Unlike the traditional SUD treatment or recovery setting, the transformed organization no longer waits for concrete word that an individual's challenges are driven by a trauma history. By the Trauma Responsiveness phase, the organization assumes that all prospective clients have experienced trauma. From first contact, staff follow the TIC principles and convey safe, respectful, trauma-informed attitudes and behaviors.

Intake assessments include compassionate and non-repetitive universal trauma screening. Beyond that screening, staff members at all levels understand that trauma often reveals itself in layers, and that some of those layers may look more like resistance, anger, disengagement, or "acting out."

Where there is evidence of trauma, the evidence is not ignored. If specialized clinical services for trauma are not available on site, clients are given clear information about their options for receiving safe trauma-specific services from other agencies. Clients are wholly supported in their decisions about these options, and in any referral processes they choose.

Procedures are also in place for:

- quick connections with providers who can address clients' trauma; and
- collaborative planning and support for clients, carried out in coordination with other organizations that provide trauma-specific services.

Client Empowerment

By the time this phase begins, the implementation workgroup has effectively recruited people with lived experience to participate fully in planning, transformation, and evaluation efforts. Their knowledge and wisdom about the client experience has informed and inspired these processes. Their input remains a vibrant and influential part of ongoing planning and implementation.

A structure for client participation in treatment planning is in place and is used consistently, even in settings where treatment services are mandated. To the greatest degree possible, clients exercise autonomy in choosing how they will participate in services.

Safety and Effectiveness of Services

Trauma-informed practices are gaining greater and greater acceptance, as staff apply new trauma knowledge to their work. There is an observable shift in perspective throughout the organization. Making sure that confrontational approaches are no longer used in groups, counseling, or other services is a high priority, but it is not the only priority.

Whether or not people have a history of trauma, everyone benefits from being treated with compassion and respect—and everyone benefits from treating others with compassion and respect.

There are also new standards for staff and leadership use of inclusive and empowering language throughout the organization. More and more, people are automatically speaking in ways that support safety, choice, inclusion, respect, collaboration, trustworthiness, and empowerment. And, in general, interactions among staff and clients are more trauma informed.

In policy review, procedures are in place that:

- identify areas of change needed to mitigate negative language,
- identify structural issues that might lead to inequity, and
- offer guidelines for trauma-informed approaches in written documents.

The organizational culture reflects an understanding that, whether or not people have a history of trauma:

- everyone benefits from being treated with compassion and respect, and
- everyone benefits from treating others with compassion and respect.

Alignment of Staff with TIC Principles and Practices

By this phase, the implementation team has made considerable progress in instilling TIC throughout the organizational culture. Staff at all levels accept this new direction and actively participate in implementing TIC.

Leadership and the implementation team also have the alignment of future staff in mind. For example, interviews for new hires include questions about TIC beliefs, values, and practices.

The organization is also responsive to the trauma-related needs of staff. It has policies and practices that support measures to address staff self-care and secondary trauma.

Client Safety and Dignity

Trauma-informed principles become especially important in tense or particularly challenging situations. Here are a few examples of measures that address some of these situations:

> *Trauma-informed principles become especially important in tense or particularly challenging situations.*

- The organization has a protocol for crisis management that reflects trauma-informed values.
- Urine drug screens are administered in a manner that respects client privacy, dignity, and choice to the greatest extent possible.
- Transparent, consistent policies for discharge are in place, and they are followed.

Measurable Outcomes

Quantitative improvement might be measured through decreases in crisis calls, and improvements in survey markers for employee engagement might show that more and more staff are truly “on board” with transformation.

Qualitative changes might become apparent through:

- increases in opportunities for staff to include client voices and choices (e.g., collaborative treatment planning, inviting clients to serve in advisory positions),
- active staff participation in efforts to redesign existing policies and procedures in ways that make them more trauma sensitive,
- indications that staff are moving toward problem solving more quickly after identifying concerns, and
- positive shifts in staff’s and clients’ descriptions of “the way it feels” in the organization.

EXAMPLE

Signs of Successful Trauma Responsiveness

For examples of signs of success in this phase, here are more thoughts about the provider described at the end of the Trauma Sensitivity phase. Serving clients who had recently been released from incarceration, the organization had made some strides toward greater understanding and incorporation of TIC principles.

Over time, TIC leadership tackled three issues: the physical environment in which services are delivered, the relationship with co-located parole officers, and clinical practices and policies on group sessions. The physical environment workgroup:

- completed a building-wide assessment;
- conducted one-to-one interviews with clients; and
- facilitated focus groups with staff, to explore possible physical changes that might foster client safety and trust.

These actions led to several small modifications, including the division of a large group room into smaller rooms for private conversations between staff and clients. They turned these into quiet, calming spaces that clients could use when they felt overstimulated in group settings. A larger modification involved changing the color of the furniture (which had been orange, reminiscent of prison décor), repainting walls, and displaying artwork created by clients.

The team also began a series of discussions with the probation/parole officers (POs) co-located in their building. Educating POs on trauma-informed care turned out to be an ongoing process but an important one. Over time, they were able to reach an agreement that POs would not carry their guns outside of their offices; whenever possible, any arrests would take place away from the waiting area and group rooms.

The clinical team also reviewed practices around group attendance and participation. They decided to take a proactive approach, consulting the clients' expertise on the types of activities that worked best for them. They also held staff training on how to facilitate groups on trauma and substance use disorders. This open-minded approach yielded many positive results. For example:

- One Native American client asked if they could participate in their tribe's sweat lodge and traditional healing practices, to replace one day's worth of group hours. Staff actively supported them in this.
- Peers and clinicians engaged with clients who were not participating in groups, to see how they were doing and to suggest alternatives to group work.

Leadership and the TIC workgroup continued to grapple with the challenge of minimizing the amount of coercion in a mandated treatment setting, policies around reoccurrence of use, and ways of supporting staff who were struggling to adopt the new practices.

CHECKLIST FOR THE RELATIONSHIP-BUILDING PHASE

ORGANIZATIONAL GOALS

- Shift in organizational culture as policies, practices, and interactions change and structural inequities are addressed
- Support for the five TIC principles, reflected in the language used by staff and leadership throughout the organization
- Safe and appropriate trauma-specific treatment and/or referrals available to all clients who need these services
- A TIC and equity perspective used by staff at all levels in evaluating policies and practices within the organization

ORGANIZATIONAL TASKS

- The organization drives the transformation process, disaggregates data, and adapts policies and practices in collaborative ways
- Staff at all levels regularly re-evaluate the things they do and the policies they follow in terms of their possible effects on clients
- Staff integrate the TIC principles into behaviors, supervision, practices, the physical environment, and hiring practices
- The organization begins outreach to other community providers who can provide resources that support trauma recovery

CONSULTING SERVICES

- Conduct regular check-ins and problem-solving sessions with the implementation workgroup
- Help the organization highlight its successes and use them to empower the organization for long-term sustainability
- Guide the modification of the implementation plan and promote the gathering of feedback from clients and alumni
- Collaborate with QA/I and evaluation teams in planning for data collection and evaluation of outcomes
- Ensure that staff understand the many ways the social determinants of health affect outcomes for clients and staff

COMMENTS

CHAPTER 5

SUSTAINABILITY

CHAPTER 5: SUSTAINABILITY

This chapter covers just one phase—Trauma-Informed Care—followed by a brief conclusion section.

The Trauma-Informed Care phase includes ongoing efforts to:

- strengthen the organization's commitment to policies, processes, and resources that sustain trauma-informed culture;
- establish and fortify systems that will safeguard equity and the well-being of all clients and staff; and
- deepen and sustain the relationships that will continue to grow trauma-informed culture within the organization, the community, and the larger health and social service environment.

If TIC transformation is a journey, arriving at trauma-informed care might signal an end to the long trek, but the story is far from over. Sustainability includes continuing to deepen understanding, grow into principles and practices, and take steps to make sure this progress will not be lost.

THE TRAUMA-INFORMED CARE PHASE

ORGANIZATIONAL GOALS

1 Mission statement, goals, and objectives explicitly refer to sustaining the TIC culture and environment.

2 In policy, practice, and behaviors, the organization and its staff demonstrate a sustainable commitment to trauma-informed, equitable, and inclusive values and practices.

3 The organization collaborates regularly, often with organizations in marginalized communities.

4 Other agencies and community partners turn to the organization for expertise and leadership.

5 All staff respond to internal and external changes, barriers, and growth through a trauma-informed lens.

ORGANIZATIONAL TASKS

- All levels of the organization drive the implementation plan.
- The implementation workgroup conducts ongoing evaluation of fidelity to the TIC model, client outcomes, staff experience, addressing structural inequity, and other measures that reflect TIC principles.
- Recruitment, interviewing, hiring, onboarding, supervision, and management incorporate TIC principles and standards for diversity, inclusiveness, and equity.
- TIC training is held at regular intervals and provided to all new staff.

TIC CONSULTING TASKS

NOTE: During this stage, the consultant's role may become unnecessary. It is scaled down and available on an as-needed basis.

- Create a mechanism for continued communication.
- Encourage the implementation team to use problem-solving tools.
- Encourage regular review of policies for structural inequities.
- Monitor preservation of a culture that discusses and hires diversity.
- Remind the implementation team to regularly review their Sustainability Action Plan to reinforce TIC culture and practices.
- Request periodic progress reports, to provide ongoing encouragement/insights.

ABOUT THE TRAUMA-INFORMED CARE PHASE

TIC is accepted and thoroughly embedded throughout the organization, so sustainability no longer depends on the efforts and vigilance of a few change agents or champions.

In Trauma-Informed Care, trauma-responsive practices are the organizational norm. TIC is accepted and thoroughly embedded throughout the organization, so sustainability no longer depends on the efforts and vigilance of a few change agents or champions. The organization itself has become a change agent.

Of course, it will never be possible just to freeze TIC implementation in time and have it stay in optimum shape forever. Change is inevitable. The investment of people and organizations in TIC implementation can be successful only if it is continuously meeting the evolving needs of the organization.

The goal of this phase is to have policies and processes in place for long-term TIC sustainability.

TRAUMA-INFORMED CARE: ORGANIZATIONAL ACTIVITIES

All levels of the organization drive the implementation plan. Organizational leadership, the implementation workgroup, and change agents continue to keep their focus on trauma-related service issues within the organization.

The goal of this phase is to have policies and processes in place for long-term TIC sustainability.

Throughout the implementation processes, TIC consulting and resources have given the organization the tools it needs to support staff resilience through a variety of practices. For example, trauma-informed supervision and management practices include:

- clearly defined and consistently applied policies and role definitions;
- regular clinical supervision that provides opportunities to discuss trauma;
- ongoing peer support;
- education on trauma and effective treatments; and
- organizational support for cognitive/behavioral approaches, mindfulness, and safe somatic practices for improving calming and coping skills.[67]

TIC implementation is continually measured for fidelity to a trauma-informed model. Systems are created and implemented that regularly measure program progress and outcomes, including their effects on clients, corrective action plans, and staff retention. The organization:

- evaluates client outcomes;
- regularly reviews policies for ways of addressing structural inequity;
- revises policies and procedures, including policies that support hiring diverse staff and staff with knowledge and expertise in trauma and issues of equity; and
- maintains practices that address the potential impact of secondary trauma on staff.

The organization also continually reaches out to a variety of partners, including providers who serve marginalized cultures and communities, working to strengthen their collaborative efforts and foster mutual support around being trauma informed.

TRAUMA-INFORMED CARE: CONSULTING ACTIVITIES

In the Trauma-Informed Care phase, the consultant is available on an as-needed basis, particularly for issues related to evaluation and outcomes monitoring. However, the consultant should rarely be needed for on-site interactions, and the consultant's role may become unnecessary at some point during this stage.

The consultant still focuses on encouraging the implementation workgroup to solve problems using the tools they have learned and developed.

The consultant might encourage the implementation workgroup to submit reports to leadership regularly, presenting outcome data and signs of progress that demonstrate sustainability. The consultant might also receive those reports and help the organization celebrate and reinforce its continued progress.

In this phase, the consultant also continues to encourage regular review of policies for structural inequities, and to monitor how well the organization is preserving a culture that:

- regularly discusses diversity; and
- reflects diversity in its hiring, onboarding, career path, and promotion practices.

Of course, challenges will arise. When they do, the consultant is there for extra support if needed. However, the consultant will still focus on encouraging the implementation workgroup to solve problems using the tools they have learned and developed.

As consultants begin their transition away from provider settings, they and the organizational leaders and change agents need to set up a plan and protocol for communication among consultants, organizational leadership, and implementation workgroups.

TRAUMA-INFORMED CARE: ANTICIPATED ORGANIZATIONAL CHANGE

In the Trauma-Informed Care phase, the organization is not just making a successful transition.

It is in many ways a new organization, as if it were molded in a trauma-informed model. Here are some examples of indicators that an organization might be in the trauma-informed phase:

- The organization's mission statement, goals, and objectives include a commitment to a trauma-informed, equitable, and inclusive culture and environment.
- All levels of management model trauma-informed approaches and self-care.
- All staff—regardless of their assigned duties—demonstrate skillful and effective use of trauma-informed practices with clients, visitors, and other staff.
- The organization uses data to inform decision-making at all levels and uses feedback from clients to evaluate program effectiveness.

> *In the Trauma-Informed Care phase, the organization is not just making a successful transition. It is in many ways a new organization, as if it were molded in a trauma-informed model.*

- The organization regularly reaches out in collaboration with other agencies and community partners.
- Other agencies and community partners seek out the organization because of its expertise and leadership.
- The organization has policies and procedures in place to respond to internal and external changes, challenges, and growth through a trauma-informed lens.

Commitment to TIC Principles

The entire organization demonstrates a sustainable commitment to the values and principles of trauma-informed care, equity, and inclusion, through:

- training;
- hiring and human resource practices; and
- recruitment of volunteers, including the Board of Directors, funders, committees, etc.

To sustain trauma-informed approaches among staff:

- a trauma-informed supervision model has been implemented that includes ongoing coaching and consultation,
- supervisory support is accessible and readily available to staff on site, and
- a trauma-informed process is in place to address unprofessional or insensitive words or actions by employees.

Measurable Outcomes

Qualitative data can be found in the concrete details of a safe, supportive, and trauma-sensitive environment. They are also reflected in the subjective descriptions of this environment coming from staff, clients, collaborators, and community supports. Evidence appears in the organization's mission and vision statements, organizational communications, reports of client engagement activities, staff satisfaction surveys, and other documentation.

Staff and clients are not the only ones who appear well aware of the organization's commitment. People from other agencies and from the community routinely turn to the organization for expertise and leadership in trauma-informed care.

EXAMPLE

Signs of Successful Trauma-Informed Care

For an idea of what trauma-informed care might look like in action, we return to the organization whose work was highlighted in our discussions of the Trauma Sensitivity and Trauma Responsiveness phases. As mentioned earlier, this provider serves people who have recently been released from prison. This example is from the organization's experience in 2020.

Because of the excellent work this provider had done in earlier phases of transformation, by the time they reached the Trauma-Informed Care phase, staff and leadership were creative and flexible in their approaches. They were also supported by policies and protocols that reflected a clear understanding of what it takes to create safety and equity, including a comprehensive disaster plan and a business continuity plan.

On March 11, 2020, the World Health Organization declared COVID-19 a pandemic. By then, the staff had grown so used to an attitude of vigilance and care that they had been following the news closely. They had already started to develop an informal preliminary plan for keeping clients safe and addressing the many social and behavioral health implications of this mass-contagion event. For the plan they gathered information on various topics (e.g., risk factors and precautions, availability of tests and other supplies, telehealth options and restrictions), and they shared the information they had gathered with local partners.

Knowing that human connection—with staff and with their peers—is among clients' strongest sources of resilience, staff and leadership started thinking in terms of maximizing interpersonal connection while keeping people safe. In listening to clients' concerns and answering their questions, staff members took a low-drama, solution-oriented approach that combined honesty and deep listening with calming techniques.

As decisions had to be made, all leadership and staff members supported individualized recommendations about the safest and most effective ways of meeting these challenges for each client. As far as it was possible—and safe—clients were given the dignity of making their own choices about how to meet this crisis.

During the initial waves, many clients experienced high levels of anxiety, fear, loss, grief, anger, loneliness, helplessness, and hopelessness. For many, the pandemic really "hit close to home." They were all too well aware that it was particularly brutal for many communities of color, and for people experiencing incarceration, where they were often trapped in cramped quarters with high rates of contagion.

Throughout this experience, staff and leadership were able to provide safety and serve as compassionate witnesses for clients who were struggling with the effects of the pandemic. Their focus on resilience and empowerment increased the physical safety, the psychological safety, and the effectiveness of their services.

CHECKLIST FOR THE TRAUMA-INFORMED PHASE

ORGANIZATIONAL GOALS

- Explicit references to sustaining a TIC culture and environment in the mission statement, goals, and/or objectives
- Sustainable commitment to trauma-informed, equitable, inclusive values demonstrated throughout the organization
- Trauma-informed, equitable, and inclusive values reflected in the behaviors and practices of leadership and all staff
- Requests from diverse organizations and community partners for expertise and leadership from the organization
- A trauma-informed mind-set that guides all staff responses to internal and external changes, barriers, and growth

ORGANIZATIONAL TASKS

- All levels of the organization are driving the implementation plan and the transformation process
- The workgroup conducts ongoing evaluation of TIC model fidelity, outcomes, staff experience, and other measures of TIC principles
- TIC training is held at regular intervals and provided to all new staff
- Recruitment, interviewing, hiring, onboarding, supervision, and management all follow TIC principles

CONSULTING SERVICES

- Assess the necessity of the consultant's role and any needed changes (e.g., fewer on-site visits, going to an as-needed basis)
- Create a mechanism for continued communication after the consulting role is reduced or eliminated
- Continue to provide and encourage the implementation team to use problem-solving tools
- Encourage staff and leadership to continue to review and revise policies and practices to close gaps in structural inequities
- Mentor the team in sustaining a culture that supports equitable practices and fosters inclusivity and diversity
- Remind the team to review the Sustainability Action Plan on an ongoing basis, to reinforce TIC culture and practices
- Request periodic progress reports and other measurements, to provide insight and encouragement

COMMENTS

CONCLUSION

CONCLUSION

For the trauma-informed care consultant, facilitating TIC transformation in a provider organization is a substantial project and a long-term commitment that requires:

- openness, patience, diplomacy, flexibility, and an ability to empathize and understand the needs of others;
- skills in communication, facilitation, relationship building, problem solving, and conflict management;
- a steady regimen of self-care;
- willingness to deal with challenge, complexity, barriers, discouragement, and the occasional ambivalence of individuals who are working through uncertainty and fear; and
- time, effort, and attention available to focus on the provider organization and its people over a period of years.

FACILITATING TRAUMA-INFORMED CULTURE CHANGE IN RECOVERY-ORIENTED SYSTEMS

This Guide has focused on the critical importance of trauma-informed care transformation in SUD service settings, considerations for consultants preparing to lead TIC transformation, and a six-phase model for implementing TIC in organizations.

The most important audience for this document is the new or prospective TIC consultant. We have touched on a number of topics that are critical to TIC implementation, including:

- the wide variety of effects that trauma can have on individuals, families, communities, and the organizations and systems that seek to serve them;
- principles and terminology that organizations might find helpful;
- the importance of understanding and addressing the organization's needs and motivation for change;
- the importance of setting clear and realistic expectations from the start and matching plans to the resources available;
- the role of the TIC consultant and considerations for TTCs sponsoring TIC transformation efforts;
- the depth, breadth, and scope of TIC transformation and the commitment of time and resources necessary to carry it out; and
- the non-linear phases of TIC transformation in the Missouri Model.

This Guide is, of course, just an outline of some key considerations and general responsibilities for the organization and the consultant. It reveals very little about trauma, TIC, SUD, treatment,

and recovery, compared to the many essential resources listed in the Appendix under the heading, "Additional Resources."

AN INVITATION AND A CHALLENGE

By fostering trauma-informed approaches in the SUD treatment and recovery field, you can help seed stronger awareness, earlier intervention, and more effective responses to trauma and its many effects.

This Guide is both an invitation and a challenge—perhaps one of the most important challenges facing behavioral health and our larger healthcare and social systems. By fostering trauma-informed approaches in the SUD treatment and recovery field, you can help seed stronger awareness, earlier intervention, and more effective responses to trauma and its many effects—perhaps far beyond the organizations and systems you serve.

By reducing the impact of trauma and preventing retraumatization, trauma-informed care can be a powerful tool for the safety, success, and equity of SUD treatment and recovery support. However, even beyond treatment and recovery environments, TIC concepts and practices might also contribute to lower levels of stress, trauma, and illness in families, communities, and allied service systems. By looking for opportunities to learn more, share ideas, and collaborate, TIC consultants might well become agents of a wider healing process.

So this Guide is an invitation for you, not only to become a trauma-informed care consultant and advocate, but also to keep listening, keep noticing, keep questioning, keep learning, and keep connecting. It will take all of us working together to rise through our assumptions and find the ideas that will bring us closer to health and dignity, for the people we serve and for the whole community.

By looking for opportunities to learn more, share ideas, and collaborate, TIC consultants might well become agents of a wider healing process.

APPENDIX

GLOSSARY OF TERMS

PRINCIPLES OF TRAUMA-INFORMED CARE FROM THE MISSOURI MODEL

COMPANION TO PART A: RESOURCES FOR UNDERSTANDING TRAUMA-INFORMED CARE

COMPANION TO PART B: RESOURCES FOR PATHWAY TO TRAUMA-INFORMED CULTURE

TRAUMA-INFORMED CULTURE CHANGE CHECKLISTS

ENDNOTES

GLOSSARY OF TERMS

PLEASE NOTE: In this Guide, the word "provider" refers to an organization, rather than to an individual.

Adverse Childhood Experiences (ACEs): ACEs are highly stressful and potentially traumatic experiences in the lives of individuals under the age of 18. These include chronic family conditions such as having a parent with a mental health condition or a substance use disorder; losing a parent or caregiver due to death, divorce, abandonment, or incarceration; witnessing domestic violence; not feeling loved or not feeling close to other family members; not having enough food or clean clothing; and/or direct verbal, physical, or sexual abuse.

Burnout: Burnout is a term for a level of physical and/or psychological exhaustion resulting from excessive and prolonged emotional, physical, and/or mental stress. These experiences are often related to extreme and unrelenting demands connected with high-stress jobs, caregiving roles and other overwhelming situations.

Change Agents: Change agents are individuals who, because of their positions, attitudes, and/or approaches, are effective promoters of a change or transformation process. Change agents often have strong leadership skills that help them inspire others to try new ways of understanding and approaching their work. They have often been given central responsibility for implementing change.

Change Champions: Change champions, sometimes called "early adopters," are individuals who are willing to accept and embrace change and show by their example the advantages of the change process. Change champions are often passionate about the process, committed to change, and able to inspire others to adopt the change process as well.

Culture: In this Guide, the term "culture" is used generically, to indicate nationality, racial category, caste, religion, region, country of origin, subculture, gender, age group, sexual identity or orientation, etc., or any combination of these.

Design: The Design phase of transformation is the phase in which leadership and the TIC consultant complete their pre-implementation agreements and the implementation workgroup conducts a comprehensive organizational assessment process and begins to develop a customized plan for implementing TIC transformation.

Developmental Trauma: This term is sometimes used as a synonym of "complex trauma," a condition defined as "the pervasive impact, including developmental consequences, of exposure to multiple or prolonged traumatic events."[68] Developmental trauma is linked to traumatic experiences that take place during key developmental stages in childhood. Those experiences can "influence later development, adjustment, and physical and mental health."[69]

Facilitation: Facilitation is the approach that TIC consultants use with the organizations they serve. When consultants facilitate processes or activities, they provide whatever resources, support, encouragement, and guidance organizational staff and leadership need to complete those processes and activities successfully. However, the leadership, initiative, and decision-making processes are in the hands of the organization.

Five Principles of Trauma-Informed Care: Safety, Trustworthiness, Choice, Collaboration, and Empowerment. These reflect the "Five Key Concepts" developed by Roger Fallot and Maxine Harris and adapted by the Missouri Trauma Roundtable.

Four Rs of Trauma-Informed Care: 1) Realize the impact of trauma and potential paths for recovery; 2) Recognize the signs and symptoms of trauma; 3) Respond by integrating TIC knowledge into policies, procedures, practices; and 4) Resist re-traumatization of clients and staff. These were developed by the Substance Abuse and Mental Health Services Administration.

Historical Trauma: "Historical trauma" is a term usually applied to abiding and culturally shared effects of an earlier generation's traumatic experiences. These experiences might be related to colonization, dispossession of property and status, genocide (or "acts of genocide"), enslavement, dissolution of families, war, other forms of social and political subjugation, or to any large-scale or repeated adversity (e.g., poverty, disease, disaster).

Implementation of a Trauma-Informed Approach: In the Missouri Model of Trauma-Informed, implementation is "an ongoing and [intense] organizational change process. A 'trauma-informed approach' is not a program model that can be implemented and then simply monitored by a fidelity checklist. Rather, it is a profound paradigm shift in knowledge, perspective, attitudes, and skills that continue to deepen and unfold over time."[70]

Implementation Plan: As early as the Design phase, the implementation workgroup is given the responsibility of developing a comprehensive plan for implementation of TIC transformation. This process starts with a global assessment and continues through awareness training and the development and adoption of the plan. Throughout the implementation and sustainability processes, the plan continues to be reviewed and improved.

Implementation Workgroup: This is the workgroup that will develop and carry out the implementation plan. Appointed by organizational leadership, this group includes members of leadership, change agents, and change champions who reflect the diversity within the staff and client base. The implementation workgroup is first responsible for developing the implementation plan for the TIC transformation, and later responsible for leading, monitoring, and improving implementation and sustainability.

Intergenerational Trauma: This experience includes post-trauma effects that are passed from one generation to the next, often through stories, belief systems, attitudes, customs, behaviors, and genetic changes resulting from the effects of trauma. Common forms of intergenerational trauma found in SUD treatment and prevention include historical trauma and trauma related to mental health conditions and substance use disorders.

Moral Distress: Moral distress is a common human condition, whether that distress is linked to something we have done that has broken our values and/or moral codes, something we have witnessed, something we have failed to do, or something someone else has done or left undone. Like most forms of distress, it lives on a continuum, from mild "twinges" to experiences that are truly traumatic (often referred to as "moral injuries").

Organizational Assessment: In this Guide, the term "organizational assessment" refers to a planned systematic review of an organization's processes, work environment, and organizational structure through a trauma-informed lens.

Organizational Climate: In this Guide, the term "organizational climate" refers to the impact that the organization's operation (policies, procedures, and practices) has on staff's ability to learn and implement a complex change process.

Organizational Culture: This term refers to the norms, values, and basic assumptions that help guide people's decisions and influence their behavior within the organization.[71]

Organizational Environment: In this Guide, the term "environment" or "organizational environment" includes the human environment (e.g., relationships, interactions), physical environment (e.g., building, grounds, décor), and policy environment (e.g., rules, requirements, practices, protocols) that surround each client, staff member, and visitor.

Posttraumatic Stress Disorder (PTSD): PTSD is one of many behavioral health conditions that might follow the experience of trauma. It is considered PTSD if it meets a specific set of diagnostic criteria defined in the Diagnostic and Statistical Manual of Mental Disorders. These criteria include having experienced a traumatic event; having nightmares, flashbacks, or symptoms activated by memories associated with the traumatic event; avoiding thinking about or being reminded of the trauma; and experiencing changes in thinking and mood, including emotional numbing, isolation, and issues with memory related to the traumatic event.[72]

Racial Trauma: Sometimes called "race-based traumatic stress" (RBTS), racial trauma "refers to the mental and emotional injury caused by encounters with racial bias and ethnic discrimination, racism, and hate crimes…a mental injury that can occur as the result of living within a racist system or experiencing events of racism."[73] Each exposure to racial trauma contributes to an accumulating supply of toxic stress, including physical stress on the autonomic nervous system.

Retraumatization: Retraumatization is a return of post-trauma symptoms, often the result of seeing or hearing something that reminds one of traumatic memories, or a reaction to real or perceived aggression.

Relationship-Building: In the Relationship-Building phase of TIC transformation, organizational representatives and the TIC consultant build trust and exchange information that is vital to the foundation of the TIC transformation efforts that will follow. This includes an informal assessment of the organization's motivation toward TIC and a frank discussion of the breadth and depth of the change process involved and the disruption it might cause.

Resilience: SAMHSA defines "resilience" as "The ability to thrive despite negative life experiences and heal from traumatic events."[74] A particularly rich description of resilience is "the capacity to develop, seek, and use healthy skills that help one prepare for, cope with, and grow through adversity in a way that honors and strengthens the individual's mind, body, and spirit."[75]

Secondary Trauma: See "vicarious trauma."

SUD Recovery Support Service Provider: A recovery support service provider is a community-level provider of non-professional recovery support services (e.g., peer support), often delivered by people with lived experience of substance use disorders.

SUD Treatment Provider: An SUD treatment provider is a clinically licensed provider of therapeutic services for substance use disorders.

Sustainability: A program's or an organization's sustainability is its ability to meet its own needs without depleting the material, social, and economic resources that might be needed to keep it going in the future.

Technical Assistance: Also known as "TA" and often referred to as "consulting," technical assistance is targeted support offered to an organization to assist in the development of a program or project.

TIC Consultant: The role of the TIC consultant described in this Guide is that of a Technology Transfer Center (TTC) representative who provides technical assistance and facilitation services to organizations considering or engaged in trauma-informed care transformation.

Toxic Stress: When individuals experience prolonged or repeated exposure to stress in the absence of sufficient social support and coping skills, we experience "toxic stress." In response to these threats (real or perceived), our bodies set in motion a physical stress reaction that includes surges of adrenaline, increased heart rate, raised blood pressure, and higher levels of the stress hormone cortisol.

Trauma: Trauma occurs when "an event, series of events, or set of circumstances…is experienced by the individual as physically or emotionally harmful or life threatening and…has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."[76]

Trauma Awareness: In the Trauma Awareness phase of TIC transformation, the organization moves from a limited awareness of trauma and its effects to a level of awareness and knowledge that is strong enough to inform TIC implementation. The goal in this phase is simply to gain that knowledge and understanding, most commonly through all-staff training.

Trauma Responsiveness: In the Trauma Responsiveness phase of TIC transformation, organizations actively shift their practices and policies to transform the organizational culture. The goal of this phase is to make the organizational culture and practices consistently reflect the trauma-sensitive norms, behaviors, counseling and group modalities, and policy and practice changes that the organization has been learning about and discussing throughout the implementation process.

Trauma Sensitivity: In the Trauma Sensitivity phase of TIC transformation, leadership and staff integrate their understanding of trauma with their traditional experience and understanding of themselves, the people they serve, the people they work with, their relationships, their responsibilities, and their work. Trauma Sensitivity is intensely focused on the ways in which specific services and practices will need to change and how those changes should be reflected in the detailed plan for transformation. The overarching goal of the Trauma Sensitivity phase is for leadership and the implementation workgroup to lay the groundwork for TIC transformation.

Trauma-Informed Care (the final phase of TIC Transformation): In the Trauma-Informed Care phase, trauma-responsive practices are the organizational norm. TIC is accepted and thoroughly embedded throughout the organization, so sustainability no longer depends on the efforts and vigilance of a few change agents or champions. The goal of this phase is to have processes and policies in place for long-term TIC sustainability.

Trauma-Informed Care (TIC) (the general concept and approach): Trauma-informed care is a global approach to organizational functioning and service provision "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."[77] This sensitive and compassionate service-delivery approach acknowledges the effects of inequity, trauma, and imbalances of power. "It also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals who already have histories of trauma, and it upholds the importance of consumer participation in the development, delivery, and evaluation of services."[78]

Trauma-Specific Treatment: Unlike trauma-informed care—which is a global approach affecting all facets of an organization, its services, and its people—Trauma-specific treatment is a narrow category of clinical interventions affecting only the staff and clients participating in those specific services. SAMHSA defines trauma-specific treatment as "evidence-based and promising practices that facilitate recovery from trauma" and the larger category of "trauma-specific services" as "prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders (including substance use and mental disorders) that developed during or after trauma."[79]

Vicarious Trauma: Also called "secondary trauma" and sometimes confused with less scientific terms such as "compassion fatigue" or "burnout," vicarious trauma has been an official diagnostic category since it was first published in DSM-5. The DSM-5 description outlines criteria for diagnosing people who are experiencing harmful effects after repeatedly witnessing or hearing stories of traumatic experiences and their aftermath. The symptoms of vicarious trauma are similar to those of PTSD, but they tend to be shorter-lived and less severe.[80]

PRINCIPLES OF TRAUMA-INFORMED CARE

FROM THE MISSOURI MODEL

These five principles were initially based on Fallot, R.D and Harris, M. (2009). Creating Cultures of Trauma-Informed Care (CCTIC): A self-assessment and planning protocol. Washington, D.C.: Community Connections.

The following revised principles of trauma-informed care were approved in October, 2018 by the Missouri State Trauma Roundtable.

1 SAFETY

Ensure physical and emotional safety, recognizing and responding to how racial, ethnic, religious, gender, or sexual identity may affect safety across the lifespan.

2 TRUSTWORTHINESS

Foster genuine relationships and practices that build trust, making tasks clear, maintaining appropriate boundaries, and creating norms for interaction that promote reconciliation and healing. Understand and respond to ways in which explicit and implicit power can affect the development of trusting relationships. This includes acknowledging and mitigating internal biases and recognizing the historic power of majority populations.

3 CHOICE

Maximize choice, addressing how privilege, power, and historic relationships affect both perceptions about and ability to act upon choice.

4 COLLABORATION

Honor transparency and self-determination, and seek to minimize the impact of the inherent power differential while maximizing collaboration and sharing responsibility for making meaningful decisions.

5 EMPOWERMENT

Encourage self-efficacy, identify strengths, and build skills, which leads to individual pathways for healing while recognizing and responding to the impact of historical trauma and oppression.

COMPANION TO PART A: RESOURCES FOR UNDERSTANDING TRAUMA-INFORMED CARE

ADDITIONAL TRAUMA-INFORMED CARE RESOURCES:

- *The Missouri Model: A Developmental Framework for Trauma-Informed (Revised Edition, 2022)*
- *Missouri Model Principles of Trauma-Informed Care*
- *SAMHSA's TIP 57: Trauma-Informed Care in Behavioral Health Services (2014)*
- *Addressing Stress and Trauma in Recovery-oriented Systems and Communities: A Challenge to Leadership*
- *Trauma-Informed Oregon*

ADDITIONAL RESILIENCE RESOURCES

- *Building Resiliency and Compassion in the Workforce, from the ATTC Network*
- *Compassion Doesn't Make You Tired: Unmasking and Addressing "Compassion Fatigue"*
- *Developing Your Self-Care Plan*
- *Greater Good in Action, from the Greater Good Science Center*
- *The MHTTC Provider Well-Being Initiative*
- *Wellness and Resilience Strategies*

ADDITIONAL TRAUMA RESOURCES

- *Centers for Disease Control and Prevention: Adverse Childhood Experiences*
- *SAMHSA: Trauma and Violence*
- *How Childhood Trauma Affects Health Across a Lifetime, TED Talks (2015)*
- *Trauma Types, National Child Traumatic Stress Network (2018)*

ADDITIONAL ORGANIZATIONAL CHANGE MANAGEMENT RESOURCES

- *Managing Complex Change (Adapted from Grant Lichtman, 2014; expanded from M. Lippett, 1987 and T. Knoster, 1991)*
- *Fostering Resilience and Recovery: Change Management Strategies, National Council for Mental Wellbeing*

ADDITIONAL IMPLEMENTATION FACILITATION RESOURCES

- *Using Implementation Facilitation to Improve Healthcare, Implementation Facilitation Training Manual (Version 3, 2020, December 1)*
- *Fostering Resilience and Recovery: A Change Packet for Advancing Trauma-Informed Primary Care (2022, February 18)*
- *Trauma-Informed Care Implementation Resource Center, from the Center for Healthcare Strategies*
- *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, Prepared by SAMHSA's Trauma and Justice Strategic Initiative, (2014, July)*
- *Key Ingredients for Successful Trauma-Informed Care Implementation*
- *Trauma-Informed Organizational Change Manual*

COMPANION TO PART B: RESOURCES FOR PATHWAY TO TRAUMA-INFORMED CULTURE

ADDITIONAL PRE-IMPLEMENTATION RESOURCES

Relationship-Building Phase

- *Active Listening (Greater Good Science Center)*
- *Harvard University's Project Implicit Bias Testing*
- *Understanding Motivational Interviewing*
- *Trauma-Informed Care Workgroup Meeting Guidelines*
- *Trauma Informed Facilitator's Guide*

Design Phase

- *Agency Environmental Components for Trauma-Informed Care*
- *Alive and Well Organizational Assessment*
- *ProQOL*
- *Trauma-Informed Supervisor Assessment, National Council for Mental Wellbeing*
- *Guide for Completing the Agency Self-Assessment for Trauma-Informed Care*

ADDITIONAL IMPLEMENTATION RESOURCES

Trauma Awareness Phase (also see Companion to Part A: Additional Trauma Resources)

- *Conscious Discipline Brain States Model*
- *A Guide to Toxic Stress, Harvard University's Center on the Developing Child*
- *Policy Guidance on Screening for Trauma, Missouri Trauma Roundtable (2015)*
- *National Child Traumatic Stress Network*
- *Brain Story Toolkit, Alberta Family Wellness*
- *Resilient Wisconsin: Trauma-Informed Practices (all stages)*

Trauma Sensitivity Phase

- *Center for Community Resilience*
- *Resources from the African American Behavioral Health Center of Excellence*
- *Healing History: Where History Meets Behavioral Health Equity for African Americans*
- *Center of Excellence, LGBTQ+ Behavioral Health Equity*
- *Handbook on Sensitive Practice for Health Care Practitioners*
- *Peer Recovery Center of Excellence*
- *Trauma Informed Practices*

Trauma Responsiveness Phase

- *Enhanced Culturally and Linguistically Appropriate Services (CLAS) Standards*
- *Human Resource Practices to Support TIC*
- *Trauma-Informed Care Human Resource Policies – Templates*
- *Policy Guidance for Trauma Informed Human Resources Practices, Missouri Trauma Roundtable (2017)*
- *Essential Conversations Podcast, Trauma Informed Caring Series, Mid-America ATTC*

ADDITIONAL SUSTAINABILITY RESOURCES

Trauma-Informed Care Phase

- *Trauma-Informed Primary Care (TIPC) Sustainability Guide, National Council for Mental Wellbeing*
- *Trauma-Informed Primary Care Policy Audit Tool, National Council for Mental Wellbeing*
- *Standards of Practice for Trauma-Informed Care*

APPENDIX

TRAUMA-INFORMED CULTURE CHANGE CHECKLISTS

CHECKLIST FOR THE RELATIONSHIP-BUILDING PHASE

ORGANIZATIONAL GOALS

- Awareness of TIC implementation phases, the organization's needs, and the resources that may be needed for each phase
- Awareness of the need for diversity and inclusion in the implementation team
- Understanding of the range of areas affected by toxic stress and trauma, from individual safety to structural equity
- Understanding of the complexity of TIC implementation and its possible effects on staff and clients

ORGANIZATIONAL TASKS

- Leadership reflects on the need for TIC, their goals, what change might mean, and their potential need for support
- Leadership discusses the organization's motivation, barriers, and concerns about TIC implementation
- Leadership explores how TIC aligns with their mission, strategy, staff/client cultures, and the organizational culture

CONSULTING SERVICES

- Assess informally for a detailed, objective, and compassionate understanding of the organization's motivation
- Build rapport, to learn about their culture and how their need for support aligns with your capacity to provide support
- Give leadership information on the phases of TIC implementation
- Give leadership a sense of the scope of areas that will be affected, from individual and cultural safety to structural equity
- Tell leadership about the implementation workgroup and the need to reflect the diversity that exists in staff and clients
- Help leadership understand how transformation might lead to disruption within the organization

COMMENTS

CHECKLIST FOR THE DESIGN PHASE

ORGANIZATIONAL GOALS

- Awareness of TIC implementation phases, the organization's needs, and the resources that may be needed for each phase
- Awareness of the need for diversity and inclusion in the implementation team
- Understanding of the range of areas affected by toxic stress and trauma, from individual safety to structural equity
- Understanding of the complexity of TIC implementation and its possible effects on staff and clients

ORGANIZATIONAL TASKS

- Leadership formalizes the relationship with the TIC consultant through a contract/memorandum of understanding/agreement
- The implementation team is convened, begins a plan that outlines their work, formalizes roles, sets the vision, and identifies resources
- The workgroup explores, selects, and conducts focused and organization-wide assessments of capacity to implement transformation
- The workgroup assesses diversity and inclusivity, structural issues affecting equity, and the cultural safety of clients and staff

CONSULTING SERVICES

- Guide the drafting of an MOU/MOA on the scope of work to be performed and elements of the consulting relationship
- Help leadership select members of the implementation workgroup and collaborate in facilitating the launching of the workgroup
- Coach the workgroup in choosing/using instruments to assess the organization on a variety of safety- and equity-related measures
- Give leadership a sense of the scope of areas that will be affected, from individual and cultural safety to structural equity
- Tell leadership about the implementation workgroup and the need to reflect the diversity that exists in staff and clients
- Help leadership understand how transformation might lead to disruption within the organization

COMMENTS

CHECKLIST FOR THE TRAUMA AWARENESS PHASE

ORGANIZATIONAL GOALS

- Basic understanding of trauma among all staff, including its prevalence, causes, and impact, and the medical model of SUD
- Staff awareness of the systemic nature of power and privilege and its impact on trauma among clients and staff
- Application of the five TIC principles to the organization's mission and practices
- Staff insight into their own attitudes toward trauma/diversity and into the factors that influence their perceptions of clients' behaviors and motivations

ORGANIZATIONAL TASKS

- The workgroup chooses and assigns a TIC curriculum and selects a trainer, and awareness training begins
- All staff, at all levels, attend the TIC trainings
- In formal and informal discussions, staff explore trauma, diversity, equity, accessibility, and inclusiveness, and consider their implications
- Leadership and the workgroup develop a TIC mission statement and develop and spread this and other TIC messaging

CONSULTING SERVICES

- Deliver the training or help the organization identify an appropriate trainer and curriculum to offer to all staff
- Promote evidence-based trainings that both reflect best practices and match the setting, its cultures, and its population of focus
- Guide the workgroup in planning for trainings to be offered to staff, including the identification of desired outcomes
- Help leadership understand links between inequities and trauma and the benefits of addressing structural inequities
- Help leadership explore what this learning means and the next steps to take, and help them plan for communication with staff about implementation
- Continue to nurture your relationship with the organization (both leadership and the workgroup)

COMMENTS

CHECKLIST FOR THE TRAUMA SENSITIVITY PHASE

ORGANIZATIONAL GOALS

- Common goals and expectations for the new standard of care and the changes needed to achieve shared goals and outcomes
- Commitment to TIC, resilience, transformation, equity, and diversity expressed through words, policies, and actions
- A process for change that follows the five TIC principles
- An organizational commitment to ending structural inequities
- Awareness of provider's commitment to TIC among all staff; support for this cultural transformation and for staff resilience
- Information on trauma, ACEs, TIC principles, history, equity, and culture, readily visible to both staff and clients

ORGANIZATIONAL TASKS

- Leadership creates safe and inclusive opportunities for conversations about the value of TIC at all levels of the organization
- Workgroup promotes exploration of TIC principles, diversity, bias, structural inequities, and cultural humility
- Clients and alumni with lived experience are integrated into the planning of programs and practices
- The workgroup reviews assessment findings, policy and practice review, and other relevant data to contribute to the plan
- With leadership support, the workgroup creates a detailed implementation plan with clear goals and outcomes

CONSULTING SERVICES

- Deliver the training or help the organization identify an appropriate trainer and curriculum to offer to all staff
- Promote evidence-based trainings that both reflect best practices and match the setting, its cultures, and its population of focus
- Guide the workgroup in planning for trainings to be offered to staff, including the identification of desired outcomes
- Help leadership understand links between inequities and trauma and the benefits of addressing structural inequities
- Help leadership explore what this learning means and the next steps to take, and help them plan for communication with staff about implementation
- Continue to nurture your relationship with the organization (both leadership and the workgroup)

COMMENTS

CHECKLIST FOR THE RELATIONSHIP-BUILDING PHASE

ORGANIZATIONAL GOALS

- Shift in organizational culture as policies, practices, and interactions change and structural inequities are addressed
- Support for the five TIC principles, reflected in the language used by staff and leadership throughout the organization
- Safe and appropriate trauma-specific treatment and/or referrals available to all clients who need these services
- A TIC and equity perspective used by staff at all levels in evaluating policies and practices within the organization

ORGANIZATIONAL TASKS

- The organization drives the transformation process, disaggregates data, and adapts policies and practices in collaborative ways
- Staff at all levels regularly re-evaluate the things they do and the policies they follow in terms of their possible effects on clients
- Staff integrate the TIC principles into behaviors, supervision, practices, the physical environment, and hiring practices
- The organization begins outreach to other community providers who can provide resources that support trauma recovery

CONSULTING SERVICES

- Conduct regular check-ins and problem-solving sessions with the implementation workgroup
- Help the organization highlight its successes and use them to empower the organization for long-term sustainability
- Guide the modification of the implementation plan and promote the gathering of feedback from clients and alumni
- Collaborate with QA/I and evaluation teams in planning for data collection and evaluation of outcomes
- Ensure that staff understand the many ways the social determinants of health affect outcomes for clients and staff

COMMENTS

CHECKLIST FOR THE TRAUMA-INFORMED PHASE

ORGANIZATIONAL GOALS

- Explicit references to sustaining a TIC culture and environment in the mission statement, goals, and/or objectives
- Sustainable commitment to trauma-informed, equitable, inclusive values demonstrated throughout the organization
- Trauma-informed, equitable, and inclusive values reflected in the behaviors and practices of leadership and all staff
- Requests from diverse organizations and community partners for expertise and leadership from the organization
- A trauma-informed mind-set that guides all staff responses to internal and external changes, barriers, and growth

ORGANIZATIONAL TASKS

- All levels of the organization are driving the implementation plan and the transformation process
- The workgroup conducts ongoing evaluation of TIC model fidelity, outcomes, staff experience, and other measures of TIC principles
- TIC training is held at regular intervals and provided to all new staff
- Recruitment, interviewing, hiring, onboarding, supervision, and management all follow TIC principles

CONSULTING SERVICES

- Assess the necessity of the consultant's role and any needed changes (e.g., fewer on-site visits, going to an as-needed basis)
- Create a mechanism for continued communication after the consulting role is reduced or eliminated
- Continue to provide and encourage the implementation team to use problem-solving tools
- Encourage staff and leadership to continue to review and revise policies and practices to close gaps in structural inequities
- Mentor the team in sustaining a culture that supports equitable practices and fosters inclusivity and diversity
- Remind the team to review the Sustainability Action Plan on an ongoing basis, to reinforce TIC culture and practices
- Request periodic progress reports and other measurements, to provide insight and encouragement

COMMENTS

APPENDIX
ENDNOTES

ENDNOTES

1 The Missouri Trauma Roundtable is a group of Missouri organizations and trauma experts who have been and continue to be active champions in addressing the impact of trauma and helping organizations become trauma informed. These experts represent a variety of organizations that serve children, youth, families and/or adults in a variety of settings, including healthcare, inpatient psychiatric care, Substance Use Disorder treatment/recovery, and community-based mental health services.

2 Missouri Trauma Roundtable. (2022). *The Missouri Model: A developmental framework for trauma informed.* Jefferson City, MO: Author.

3 Ibid.

4 Ibid.

5 Hopper, E.K., Bassuk, E.L., and Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal* (p. 82), 3, 80–100.

6 Substance Abuse and Mental Health Services Administration. (2014a). *Trauma-informed care in behavioral health services* (p. xix). Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration; Hopper, Bassuk, and Olivet (2010), loc. cit.

7 Substance Abuse and Mental Health Services Administration (2014a), op. cit; Hopper, Bassuk, and Olivet (2010), op. cit.

8 Missouri Trauma Roundtable (2022), op. cit. (p. 1).

9 Fallot, R.D. and Harris, M. (2006). *Trauma-informed self-assessment scale*. Washington, DC: Community Connections.

10 Missouri Trauma Roundtable (2022), op. cit. (p. 1).

11 Missouri Trauma Roundtable (2022), op. cit. (pp. 1-2).

12 Harris, M. and Fallot, R. (2001). *Using trauma theory to design service systems: New directions for mental health services*. Hoboken, NJ: Wiley Publishing (p. 10).

13 American Psychiatric Association. (2014). *Diagnostic and statistical manual of mental disorders-DSM 5.* (5th ed.) Arlington, VA: American Psychiatric Association.

14 Substance Abuse and Mental Health Services Administration (2014a), op. cit. (p. 55).

15 Adapted from the work of Michael Unger, PhD, Director of the Resilience Research Center at Dalhousie University and Wordmaker International.

16 Substance Abuse and Mental Health Services Administration (2014a), op. cit. (p. 7).

17 Ibid.

18 van der Kolk, B. (2014). *The body keeps the score*. New York: Penguin.

19 Center on the Developing Child. (2007). InBrief: The impact of early adversity on children's development. Cambridge, MA: Harvard Center for the Developing Child. Retrieved February 24, 2020 from https://developingchild.harvard.edu/resources/inbrief-the-impact-of-early-adversity-on-childrens-development/

20 Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma.* New York: Free Press.

21 Center on the Developing Child (2007), op. cit.

22 Anda, R.F., Whitfield, C.L., Felitti, V.J., et al. (2002). Adverse childhood experiences, alcoholic parents, and later risk of alcoholism and depression. *Psychiatric Services*, *53*(8),1001-1009. Retrieved June 30, 2021 from https://www.cdc.gov/violenceprevention/aces/fastfact.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Facestudy%2Ffastfact.html

23 Ibid.; Banducci, A.N., Hoffman, E., Lejuez, C.W., Koenen, K.C. (2014). The relationship between child abuse and negative outcomes among substance users: Psychopathology, health, and comorbidities. *Addictive Behaviors*, *39*(10),1522-1527.

24 American Psychiatric Association (2014), op. cit.

25 Ibid.

26 Substance Abuse and Mental Health Services Administration (2014a), op. cit. (pp. xvi-xvii).

27 Substance Abuse and Mental Health Services Administration (2014a), op. cit. (p. 42).

28 van der Kolk (2014), op. cit.

29 Ibid.

30 Substance Abuse and Mental Health Services Administration (2014a), op. cit.

31 Leary, J. DeGruy. (2005). *Post traumatic slave syndrome: America's legacy of enduring injury and healing.* Milwaukie, OR: Uptone Press.

32 Substance Abuse and Mental Health Services Administration (2014a), op. cit.

33 Menakem, R. (2017). *My grandmother's hands: Racialized trauma and the pathway to mending our hearts and bodies*. Las Vegas, NV: Central Recovery Press.

34 Ibid.

35 Wilkerson, I. (2020). *Caste: The origins of our discontents.* New York: Random House.

36 Ibid.

37 Oluo, I. (2019). *So you want to talk about race*. Cypress, CA: Seal Press.

38 Wilkerson (2020), op. cit.

39 Oluo (2019), op. cit.

40 Harrison, N. (2021). Cultural/Clinical factors affecting health of BIPOC, queer and trans, and communities with disabilities. Recorded presentation. Atlanta, GA: African American Behavioral Health Center of Excellence. Retrieved March 13, 2022 from https://www.youtube.com/watch?v=nGo0vUNAqH4.

41 Woll, P. (2019). *Compassion doesn't make you tired: Unmasking and addressing "compassion fatigue."* Kansas City, MO: Addiction Technology Transfer Center (ATTC) Network.

42 Shay, J. (1994). A*chilles in Vietnam: Combat trauma and the undoing of character*. Cambridge, MAL Athenaeum Press; Nash, W. and Litz, B. (2013). Moral injury: A mechanism for war-related psychological trauma in military family members. *Clinical Child and Family Psychology Review*, *16*(4), 365-375.

43 Woll (2019), op. cit.

44 Shay (1995), op. cit.; Litz, B.T., Stein, N., Delaney, E., Lebowitz, L., Nash, W.P., Silva, C., and Maguen, S. (2009). Moral injury and moral repair in war veterans: A preliminary model and intervention strategy. *Clinical Psychology Review*, *29*, 695-706.

45 Hines, S.E., Chin, K.H., Glick, D.R., and Wickwire, E.M. (2021). Trends in moral injury, distress, and resilience factors among healthcare workers at the beginning of the COVID-19 pandemic. *International Journal of Environmental Research and Public Health*, *18*(2), 488. Retrieved May 28, 2022 from https://www.mdpi.com/1660-4601/18/2/488

46 Scaer, R.C. (2005). *The trauma spectrum: Hidden wounds and human resiliency*. New York: Norton.

47 Substance Abuse and Mental Health Services Administration (2014a), op. cit.

48 American Psychiatric Association (2014), op. cit. (p. 105).

49 Substance Abuse and Mental Health Services Administration (2014a), op. cit. (p. xix).

50 Substance Abuse and Mental Health Services Administration (2014a), op. cit.

51 Ibid.

52 Substance Abuse and Mental Health Services Administration (2014b), op. cit. (p. 56).

53 Substance Abuse and Mental Health Services Administration (2014a), op. cit. (p. 87).

54 Substance Abuse and Mental Health Services Administration (2014a), op. cit.

55 Najavitz, L.M., Harned, M.S., Gallop, R.J., Butler, S.F., Barber, J.P., Thase, M.E., and Crits-Christoph, P. Six-month treatment outcomes of cocaine-dependent patients with and without PTSD in a multisite national trial. *Journal of Studies on Alcohol and Drugs*, *68*(3), 353-361.

56 Substance Abuse and Mental Health Services Administration (2014a), op. cit. (p. 21).

57 Substance Abuse and Mental Health Services Administration (2014b), op. cit. (pp. 53-54).

58 Arvay, M.J. and Uhlemann, M.R. (1996). Counsellor stress in the field of trauma: A preliminary study. *Canadian Journal of Counselling and Psychotherapy*, (30), 193–210; Meldrum, L., King, R., and Spooner, D. (2002). Secondary traumatic stress in case managers working in community mental health services. In C. R. Figley (Ed.), *Treating compassion fatigue* (pp. 85–106). New York: Brunner-Routledge.

59 Bride, B., Choi, Y., Olin, I., and Roman, O. (2015). Patient violence towards counselors in substance use disorder treatment programs: Prevalence, predictors, and responses. *Journal of Substance Abuse Treatment*, *57*, 9-17.

60 Substance Abuse and Mental Health Services Administration (2014b), op. cit. (p. 105).

61 Substance Abuse and Mental Health Services Administration (2014b), op. cit. (p. 106).

62 Ritchie, M. (2017). *Implementation facilitation training manual: Using implementation facilitation to improve care in the Veterans Health Administration. Second Edition*. Washington, DC: Veterans Health Administration, Quality Enhancement Research Initiative (QUERI) for Team-Based Behavioral Health. Retrieved September 20, 2021 from https://www.queri.research.va/gov/tools/implementation/Facilitation-Manual.pdf

63 Turner, A. (1982). Consulting is more than giving advice. *Harvard Business Review*, September, 1982. Retrieved on April 1, 2021 from https://hbr.org/1982/09/consulting-is-more-than-giving-advice.

64 Ritchie (2017), op. cit. (p. 10).

65 Ibid.

66 Ritchie (2017), op. cit.

67 Substance Abuse and Mental Health Services Administration (2014b), op. cit. (p. 107).

68 Substance Abuse and Mental Health Services Administration (2014a), op. cit. (pp. xvi-xvii).

69 Substance Abuse and Mental Health Services Administration (2014a), op. cit. (p. 42).

70 Missouri Trauma Roundtable (2022), op. cit. (p. 1).

71 Ritchie (2017), op. cit. (p. 10).

72 American Psychiatric Association (2014), op. cit.

73 Mental Health America (n.d.). Racial trauma. Retrieved June 13, 2022 from https://www.mhanational.org/racial-trauma.

74 Substance Abuse and Mental Health Services Administration (2014a), op. cit. (p. 55).

75 Adapted from the work of Michael Unger, PhD, Director of the Resilience Research Center at Dalhousie University and Wordmaker International.

76 Substance Abuse and Mental Health Services Administration (2014a), op. cit. (p. 7).

77 Hopper, Bassuk, and Olivet, (2010), op. cit. (p. 82).

78 Substance Abuse and Mental Health Services Administration (2014a). (p. xix). Hopper, Bassuk, and Olivet (2010), loc. cit.

79 Substance Abuse and Mental Health Services Administration (2014a), op. cit. (p. xix).

80 American Psychiatric Association (2014), op. cit.