University at Buffalo
School of Social Work

TRAUMA-INFORMED ORGANIZATIONAL CHANGE MANUAL

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THE INSTITUTE ON TRAUMA AND TRAUMA-INFORMED CARE (ITTIC)

The Institute on Trauma and Trauma-Informed Care (ITTIC) is a part of the Buffalo Center of Social Research and University at Buffalo School of Social Work. ITTIC is dedicated to providing the public with knowledge about individual, systemic, and historical trauma and their impact, and promoting the implementation of Trauma-Informed Care across various disciplines and service settings. Recognizing the centrality of trauma and need for universal precaution is the key to accomplishing ITTIC's overall mission of establishing a multidisciplinary trauma-informed system of care, thus ensuring that organizations and systems are not re-traumatizing the individuals, workforces, and communities within them.

ITTIC was started at the University at Buffalo in 2012 by Research Professor Thomas Nochajski, Ph.D., and Clinical Professor Susan A. Green, LCSW, out of the need for additional trauma-related services, training, and support within the community. The works of Dr. Sandra Bloom (Sanctuary Model), Dr. Roger Fallot, and Dr. Maxine Harris (*Using Trauma Theory to Design Service Systems: New Directions for Mental Health Services*), Dr. Lisa Najavits (Seeking Safety), Dr. Ann Jennings (The Anna Institute), and Dr. Ricky Greenwald (Phase Model of Trauma-Informed Treatment) built the foundation for and influence ITTIC's work. Samantha Koury and Sue Green published the first version of their *Trauma-Informed Organizational Change Manual* in January of 2019 as a means of operationalizing a model for trauma-informed organizational culture change.

Since its inception, ITTIC has provided education, training, consultation/coaching, and evaluation across national and international venues. We have been fortunate to work with those in the fields of mental health, addiction, criminal justice, law enforcement, developmental disabilities, education, social services, and health care. Collaboration with community partners, graduate students, faculty affiliates, and a team of consultants has allowed us to continue to do this important work.

DISCLAIMER

This manual is a product of our many years of research and experience in academic and clinical settings. While our work has shown us the positive impact trauma-informed approaches can have in all organizations, we understand they do not replace the need for individualized care and treatment decisions. Rather, they are intended to work in tandem with other services that can lead to desired outcomes.

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Foreword

We are thrilled to publish the full second version of the *Trauma-Informed Organizational Change Manual*. It is our pleasure to introduce Dr. Ineke Way as the third author of the manual, as she has made substantial contributions in helping us consider the new structure and overall framework presented in version 2.0.

The manual has undergone a few changes since the last version. The trauma-informed organizational change model includes all 10 key development areas in each of the three stages, which are now informed by the process of envisioning change. The bulk of the manual narrative is now organized by key development area rather than stage to best reflect this change. In addition to new implementation examples, we continue to deepen our commitment to diversity, equity, inclusion, and accessibility (DEIA) by integrating the work into the narrative and providing various appendices to assist organizations in their application of a trauma-informed approach with intentional focus on DEIA. By functioning and responding in ways that are anchored in the guiding values and principles of a trauma-informed approach, organizations can realize a culture that embodies anti-racism and anti-oppression.

As stated in our 1.5 version of the manual, there is continued importance to all of our acknowledging the centrality of self view and worldview to the work, as well as a necessity for intentionally naming anti-racism and anti-oppression within the overarching umbrella of a trauma-informed approach. Looking beyond the lens of individual trauma, professionals, organizations, and systems can help avoid re-traumatization of individuals and communities that have experienced trauma resulting from interpersonal, systemic, and structural racism and oppression. It is not possible to be a trauma-informed organization without also committing to a culture of DEIA.

We continue to notice the flexibility of the trauma-informed model in our work. No matter the individual, role, or system, the trauma-informed values and principles can be the lens for any interaction and inform every decision. Being trauma-informed is an ongoing, collaborative movement that requires all of us—and the movement continues to grow. The increase in local, state, and federal legislation and regulations, as well as an increase in recommendations or requirements for Trauma-Informed Care in grant funding is encouraging.

Our hope is that in the next several years, being trauma-informed as a universal precaution will just be how people think, and how systems operate.

Sue, Samantha & Ineke

We welcome any feedback, suggestions and lessons learned as you continue the work of being trauma-informed. https://goo.gl/forms/frcYk1aipkl3l2bl1

Samantha P. Koury and Susan A. Green from the Institute on Trauma and Trauma-Informed Care (ITTIC) developed the *Trauma-Informed Organizational Change Manual* in 2019 as a labor of love. This 2.0 version was created in collaboration with our colleague and friend Ineke Way.

Acknowledgements

ITTIC gives a special thank you for the support of:

University at Buffalo, School of Social Work

University at Buffalo, Buffalo Center for Social Research

ITTIC has had the privilege to be guided by those who began to do the work before us

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Pre-Implementation

Implementation

Sustainability

The logo depicts a phoenix rising from the ashes
with a mandala in the background.

At ITTIC we are committed to working toward healing and rebirth
for individuals and communities that have experienced interpersonal, historical,
and systemic trauma in their lives. This image speaks to our work: believing in
the strength and resiliency of people to rise out of ashes into wholeness,
and believing our systems of care can change to incorporate greater safety,
trust, choice, empowerment, and collaboration in their work.

To read more about the logo, click on the link here.

**We have been privileged to be guided
by so many who began to do the work before us
and support our efforts now. Thank you to all
who have let us be witnesses to their stories and
have invited us to be part of the journey
to healing, resilience, growth.**

-The ITTIC Team

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	Safety		Trauma-Informed Educational Practice
	Trauma-Informed Care (Any System)		Trauma-Informed Policing
	Trauma-Informed Medicine		

Abbreviations and Acronyms

CPT: Cognitive Processing Therapy

EMDR: Eye Movement Desensitization and Reprocessing

PE: Prolonged Exposure

SS: Seeking Safety

TF-CBT: Trauma-Focused Cognitive Behavioral Therapy

TIP: Trauma-Informed Policing

Terminology

Adverse Childhood Experiences (ACE) Study – A groundbreaking research study conducted by Dr. Vincent Felitti, Dr. Rob Anda, and colleagues that showed the high prevalence of adversity in childhood (ACEs), and a relationship between ACEs and negative health outcomes through the life span.

Anti-Racism – Active change processes and practices that work to challenge and eliminate racism at individual, organizational, structural, and systemic levels.

Anti-Oppression – Active change processes and practices that promote equity and mitigate the impacts of oppression at individual, organizational, structural, and systemic levels.

Burnout – A gradual process of a staff member's experiencing feelings of hopelessness, fatigue, and being overwhelmed as a result of a lack of support, excessive workloads, and unrealistic expectations.

Champion – An individual or individuals who are trained specifically to take on roles such as educator, trainer, mentor, coach, and/or advocate for a trauma-informed approach in order to ensure overall sustainability.

Compassion Fatigue (CF) – A combination of secondary traumatic stress, vicarious trauma, and/or burnout that manifests in a worker.

Compassion Resilience – Ability to maintain one's own physical, emotional, and mental well-being while compassionately doing the work with individuals, families, and co-workers.

Complex PTSD (C-PTSD) – Describes children's exposure to prolonged and/or multiple traumatic events, and the immediate and long-term impacts of such exposure. The trauma is invasive and interpersonal in nature, resulting in impaired capacity to self-regulate and presenting challenges of shame, guilt, and attachment into adulthood. Symptoms of C-PTSD are the result of coping strategies that were originally protective. For example, C-PTSD is believed to be correlated with the fawning response personality, which is hallmarked by a reflex to apologize, be useful, offer care instead of asking for help, and mitigate conflict that grows out of the fear of retaliation by an authority figure.

Decision Fatigue – A decrease in decision-making capacity after a long period of making multiple, sometimes rapid decisions.

Domains of Consideration – Domains of organizational change that the Substance Abuse and Mental Health Services Administration (SAMHSA) cross-walked with trauma-specific content, and the values and principles of Trauma-Informed Care. These domains provide a framework for organizational change structures within each of this manual's key development areas.

Guiding Values and Principles – A framework and a lens proposed by Dr. Roger Fallot and Dr. Maxine Harris for individuals, organizations, and systems to consider their day-to-day activities in a way that prevents re-traumatization. Includes safety, trustworthiness, choice, collaboration, and empowerment.

Historical Trauma – Individual and collective responses to trauma that is experienced by a group of people who share an identity or circumstance (e.g., race, gender, religious affiliation, etc.), and the subsequent impact across generations. Includes a nuanced layering of individual and group narrative, epigenetic transmission, and repeated injustices. Historical trauma is a link between past experiences of a particular group and present-day health outcomes.

Institutional and Interpersonal Oppression – The perpetuation of the idea that one group is better than, and therefore has power to disempower and marginalize, others. Interpersonal refers to when individual members of the dominant group personally disrespect or mistreat individuals in the oppressed group, while institutional refers to oppression that is embedded into institutional structures such as laws, education, and policies.

Institutional and Interpersonal Racism – A system of racial superiority and privilege that deems other races inferior. Interpersonal refers to when individuals personally marginalize members of a particular racial or ethnic group, while institutional refers to policies and practices within and across institutions that put racial or ethnic groups at a disadvantage.

Intersectionality – The interplay of race, gender, identity, class, and historical trauma on individuals, families, groups, and communities.

Key Development Areas - Ten specific aspects of organizational functioning that need to be addressed through a trauma-informed lens to best create overall trauma-informed organizational change; a key component of the trauma-informed organizational model.

Moral Injury and Moral Distress - An injurious experience that occurs when the worker engages in, fails to prevent, or witnesses acts that conflict with their values or beliefs, which can lead to feelings of moral distress such as guilt, shame, and anger.

Moral Resilience - Ability to respond positively to the distress and adversity caused by an ethically complex situation.

Post-Traumatic Growth (PTG) - The process of making meaning out of one's experience of trauma and experiencing a positive change as a result.

Post Traumatic Slave Syndrome (PTSS) - A theory developed by Dr. Joy DeGruy that describes the residual impact of generations of slavery, oppression, and institutional racism on African American individuals and communities.

Racial Trauma also referred to as Race-Based Traumatic Stress (RBTS) - The stressful impact or emotional pain of one's experience with racism and discrimination.

Resilience - The process of adapting to trauma and adversity; the ability to bounce back, or return to the level of functioning before the trauma/adversity occurred.

Re-Traumatization - When a policy, procedure, interaction, or the physical environment replicates someone's original trauma literally or symbolically—triggering the emotions and thoughts associated with the original experience.

Sanctuary Model - An evidence-based approach for changing organizational culture to be more trauma-informed and responsive that was created by Dr. Sandra Bloom and her colleagues.

Secondary Traumatic Stress (STS) - The onset of trauma-related symptoms in a worker as a result of witnessing the trauma/adversity of another.

Stages - The first component of the trauma-informed organizational model that defines the things to consider, along with needs and resources for trauma-informed organizational change. Includes Pre-Implementation, Implementation, and Sustainability.

Stress/Survival Response (Fight, Flight, or Freeze) - The body's natural response to threat/danger, characterized by stress hormones readying the body to either fight (aggression), flee (escape), or freeze (inaction). This response tends to be overactive in individuals who have experienced trauma.

Structural Racism - Historical and societal structures such as policies, institutional practices, and cultural norms and dynamics that collectively legitimize and perpetuate systemic inequity and disempowerment of racially oppressed groups.

Systemic Trauma - The contextual features of environments and institutions that contribute to and perpetuate trauma.

Trauma Awareness - One of the four levels of Trauma-Informed Care; having knowledge and education on trauma and its impact.

Trauma-Informed - One of the four levels of Trauma-Informed Care; the overarching umbrella that provides the filter for everything we do in a way that ensures universal precaution.

Trauma-Sensitive - One of the four levels of Trauma-Informed Care; the process of making adjustments to environments, policies, and protocols to respond to the presence of trauma in a sensitive manner.

Trauma-Specific - One of the four levels of Trauma-Informed Care; the trauma-specific treatment interventions provided by trained trauma therapists.

Universal Precaution - Similar to how health care professionals put on gloves to prevent the spread of bloodborne pathogens, a trauma-informed approach involves putting on metaphorical gloves (changing our interactions, policies, etc.) to prevent the possibility of re-traumatization.

Worldview and Self View – One's core beliefs about self, others, and the world that provides a lens through which all individuals experience the present.

Vicarious Post-Traumatic Growth (VPTG) - Development of positive changes and growth in a worker's worldview as a result of witnessing the post-traumatic growth of others.

Vicarious Resilience (VR) - Positive meaning-making and shift of a worker's experience as a result of witnessing the resilience of others.

Vicarious Trauma (VT) - The development of negative changes in worldview of a worker as a result of the cumulative impact of witnessing the trauma/adversity of others over time.

Introduction

The purpose of the *Trauma-Informed Care Organizational Change Manual* is to help organizations and systems plan for, implement, and sustain Trauma-Informed Care (TIC). The manual is separated into three main sections that will deliberately walk you through the stages of trauma-informed organizational change and the key development areas in each stage, and provide resources and examples that can be used for action planning. This manual serves as both a guide and a workbook by providing opportunities for you to utilize specific tools and worksheets in order to assess your organization's/system's current state and plan for next steps.

Our best hope is that this manual will:

1. Be a means of acknowledging the work your organization/system is engaging in already in response to trauma.

2. Provide a framework with guidance for moving forward.

The *Trauma-Informed Care Organizational Change Manual* is intended for: organizations, systems that are considering and/or interested in implementing a trauma-informed approach. Our framework recognizes that being trauma-informed requires that individuals, organizations, and systems of care recognize racist beliefs, oppressive thoughts, and discriminatory behavior that are often inherent in policy and daily interactions. A trauma-informed organization must position itself to proactively establish mechanisms for anti-racism and anti-oppression within the guiding values and principles of a trauma-informed approach to truly neutralize the potential for re-traumatization (De La Rue & Ortega, 2019). Being trauma-informed requires a commitment to acknowledge how one's self view and worldview influences their interpretation of present moments.

Being trauma-informed requires a commitment.

Trauma-Informed Care (TIC) is an organizational culture change process that requires the traditional power hierarchy to be a more flattened, collaborative environment, while reflecting the paradigm shift from "What is wrong with you?" to "What has happened to you?" in all that we do (Bloom, 1994; Bloom, 2013; Harris & Fallot, 2001).

Self View & Worldview

Trauma and adversity are growing public health concerns that impact everyone. Using a trauma-informed approach in organizations, systems of care, schools, hospitals, and businesses is critical to the persistence of a movement—one of ***universal precaution***, which involves all of us (Bloom & Farragher, 2013, p.29; Burke Harris, 2014). Universal precaution starts by recognizing individual, organizational, and community narratives are the lens through which individuals experience the present, and that those narratives often include adversity and trauma. These narratives, which function as a filter to how people see themselves, others, and the world, are referred to as self view and worldview. Acknowledging that both individual and historical trauma influence an individual's self view and worldview is critical. No two individuals have the same lens.

All components of a person, family, group, and community—such as race, gender, identity, and culture—must be considered both as individual concepts and those that intersect (De La Rue & Ortega, 2019). Individual traumatic experiences need to be contextualized within the larger perspective of systemic inequality (Owen et al., 2017). A trauma-informed organization has capacity and willingness to: self-reflect, build organizational awareness, and seek to understand community narratives in order to respond in ways that do not unintentionally cause more harm. The dynamic relationship between these layers will neutralize the environment, thus avoiding re-traumatization of any kind.

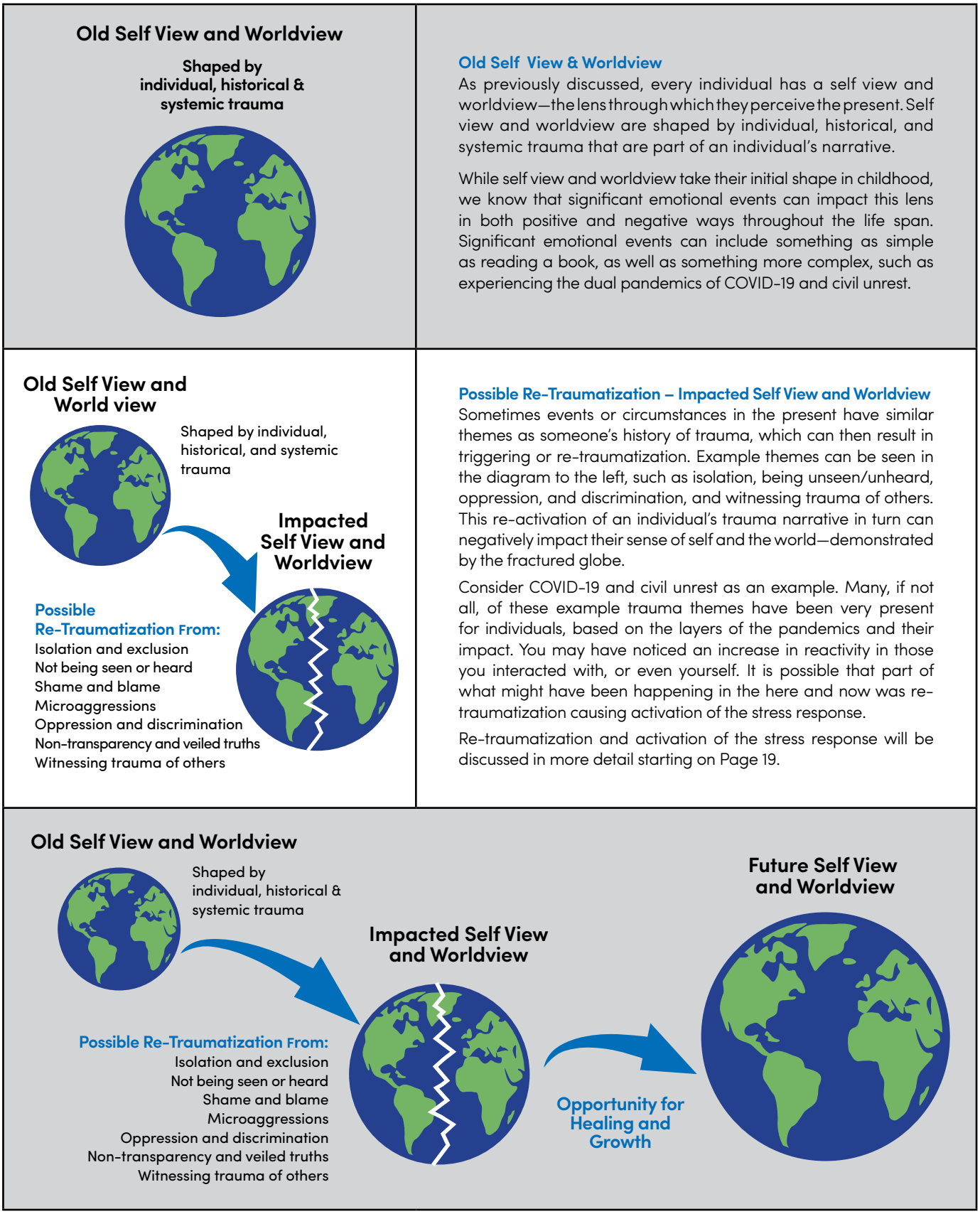
The trauma-informed approach is the overarching umbrella that provides the framework for all individuals, organizations, and systems to engage in universal precaution—to assume individual, historical, and systemic trauma are present while not knowing better than someone else, to listen, witness, and believe what is real for others, and to commit to anti-racism and anti-oppression (Brave Heart, 2017). Only by believing one's experience is truly their own and intentionally responding to everyone in ways that neutralize the potential for re-traumatization (doing more harm), is there space and opportunity for healing and growth.

Many of us find ourselves in positions of interfacing with others managing not only their history of trauma, but also current adversity and crisis. Most of us are not trained or in the roles to treat the actual trauma. However, we do still interact with others who are impacted—sometimes over long periods of time. The compounded impact of COVID-19 and civil unrest prompted us to create the visual below in order to describe not only what might be happening in the here and now for someone when talking about re-traumatization, but also what each of us is in a position of doing when responding with universal precaution.

Being trauma-informed does not require individuals, organizations, or systems to fix what has happened to someone. In fact, it first involves recognizing that we ***cannot*** change what has happened—the trauma already happened. An active adversity or crisis—such as COVID-19—may be out of our control. What we can do something about, however, is being intentional about neutralizing the environment in the here and now to at least not make it worse. By recognizing that individuals who have experienced trauma are more likely to perceive threat or negative intention because of their impacted self view and worldview, we can choose to intentionally respond in ways that ensure physical and emotional safety, trustworthiness, choice, collaboration, and empowerment. Neutralizing the environment in this way also impacts self view and worldview by providing an opportunity for healing and growth. When individuals regularly have experiences that allow them to feel worthwhile, respected, and included and over which they have some control, their sense of self, others, and the world can begin to shift to include these beliefs.

By recognizing that individuals who have experienced trauma are more likely to perceive threat or negative intention because of their impacted self view and worldview, we can choose to intentionally respond in ways that ensure physical and emotional safety, trustworthiness, choice, collaboration, and empowerment.

Shifts in Our Sense of Self, Others, and the World



Old Self View & Worldview

As previously discussed, every individual has a self view and worldview—the lens through which they perceive the present. Self view and worldview are shaped by individual, historical, and systemic trauma that are part of an individual's narrative.

While self view and worldview take their initial shape in childhood, we know that significant emotional events can impact this lens in both positive and negative ways throughout the life span. Significant emotional events can include something as simple as reading a book, as well as something more complex, such as experiencing the dual pandemics of COVID-19 and civil unrest.

Possible Re-Traumatization – Impacted Self View and Worldview

Sometimes events or circumstances in the present have similar themes as someone's history of trauma, which can then result in triggering or re-traumatization. Example themes can be seen in the diagram to the left, such as isolation, being unseen/unheard, oppression, and discrimination, and witnessing trauma of others. This re-activation of an individual's trauma narrative in turn can negatively impact their sense of self and the world—demonstrated by the fractured globe.

Consider COVID-19 and civil unrest as an example. Many, if not all, of these example trauma themes have been very present for individuals, based on the layers of the pandemics and their impact. You may have noticed an increase in reactivity in those you interacted with, or even yourself. It is possible that part of what might have been happening in the here and now was re-traumatization causing activation of the stress response.

Re-traumatization and activation of the stress response will be discussed in more detail starting on Page 19.

Figure 2 - Possible Shifts in Our Sense of Self, Others and the World

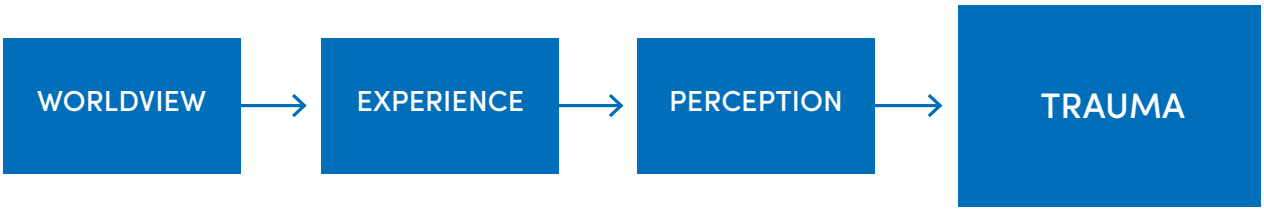


Figure 3 – What Shapes Trauma

Trauma and Adversity: What We Know

Trauma is conceptualized by considering the events/circumstances that occur, the characteristics of those events/circumstances, and the negative effect(s) they have on the individual's well-being. More important is the individual's perception of the event/circumstances, which is ultimately what determines if it is traumatic or not (SAMHSA, 2014a).

Our understanding of trauma has evolved over the last 40 to 50 years with increased research and clinical knowledge. While there was some conversation and noticing of trauma by experts in the field of mental health prior, the main clinical diagnoses for trauma - **Post-Traumatic Stress Disorder (PTSD)** and **Acute Stress Disorder (ASD)** – were first added to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) in 1980. In 2013, the fifth edition of the DSM (the DSM-5) expanded the clinical considerations to be given when diagnosing. We now know that it is critical to pay attention to issues of attachment, dissociation, suicidal risk, co-morbidity (e.g., PTSD occurring with addiction), culture and gender, adjustment disorder, etc. when considering trauma (American Psychiatric Association, 2013).

Complex trauma, also known as **Complex PTSD (C-PTSD)** is used to describe children's exposure to prolonged and/or multiple traumatic events, usually interpersonal and invasive in nature, and the long-term impact of that exposure (Blue Knot Foundation, 2020; NCTSN, 2016). The hallmark symptoms associated with C-PTSD are impaired self-regulation, and challenges with shame, guilt, and attachment (Blue Knot Foundation, 2020; Pappas, 2019). Given the difference in symptom presentation from PTSD, **developmental trauma disorder** was proposed by Dr. Bessel van der Kolk (2005) as a diagnosis to describe the pervasive effects of complex trauma on child development, but it was not included in the DSM-5.

Another important development in our understanding of trauma is acknowledgement of individual and community trauma resulting from experiences such as oppression, discrimination, and genocide of racial, cultural, and ethnic groups. Dr. Maria Yellow Horse Brave Heart (1998) was the first to conceptualize historical trauma and its impact—focusing specifically on Native populations. **Historical trauma** is the individual and collective responses to trauma that is experienced by a group of people who share an identity or circumstance (e.g., race, gender, religious affiliation, etc.), and the subsequent impact across generations, including a nuanced layering of individual and group narrative, epigenetic transmission, and repeated injustices (Mohatt et al., 2014). Dr. Joy DeGruy (2005) defined **Post Traumatic Slave Syndrome (PTSS)** as a theory to describe the experience of African American communities as a result of multigenerational oppression and centuries of slavery. Carter (2007) and many others have continued to contribute to our understanding of **racial trauma**, also known as **Race-Based Traumatic Stress (RBTS)**, as a means of naming the emotional pain associated with racism and discrimination. Systemic trauma is also important to note here, describing the contextual features of environments and institutions that both contribute to and perpetuate trauma.

Another important development in our understanding of trauma is acknowledgement of individual and community trauma resulting from experiences such as oppression, discrimination, and genocide of racial, cultural, and ethnic groups.

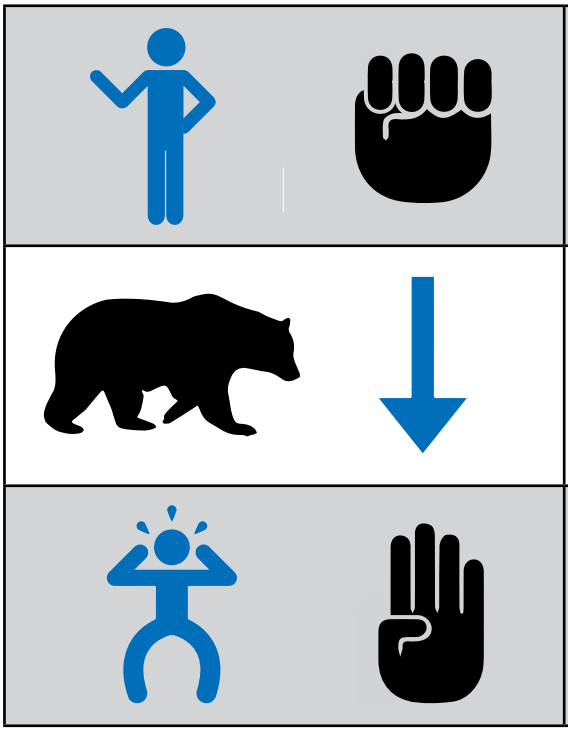
The **Adverse Childhood Experience (ACE) Study** is an important landmark in our understanding of childhood adversity and trauma. The original study was published by Felitti and colleagues (1998), and looked at the relationship between adversity in childhood and negative health outcomes in adulthood. The 10 types of childhood adversity they looked at included physical, emotional, and sexual abuse; physical and emotional neglect; and growing up in a household with a caretaker who had a mental illness, abused substances, was incarcerated, was a victim of domestic violence, or was separated/divorced. Since then, much research has been done on childhood adversity—both on the original 10 categories studied and the acknowledgement of many more. We now also recognize the importance of **adverse community environments**, such as poverty, discrimination, lack of opportunity, etc. that contribute to and compound adversity (Ellis et al., 2017; Spitfire Strategies & Center for Health and Health Care in Schools, 2017). We ask that readers pay particular attention to language when thinking about trauma and adversity. While adversity may be considered traumatic, experiencing adversity does not necessarily equal trauma.

While having language to name what has happened or is happening to someone is useful, what we know is most important about trauma and adversity is the acceptance of when someone does experience something adverse or traumatic. We recognize that adversity and trauma have significant effects on the lives of individuals. As is stated by the title of one of van der Kolk's (2015) most influential books, "The body keeps the score." Trauma and adversity impact physical and mental health, how individuals relate to others, how they navigate their dailiness, and their perceptions of self and the world.

Survival Response

Organizations and systems looking to be trauma-informed need to understand both how the body's survival response works, and how trauma can alter this process in ways that result in reacting to what may seem like benign experiences as ones that are threatening. Our brains are responsible for detecting danger and organizing a response (van der Kolk, 2015). A critical part of the brain that is involved in this process is the amygdala—which is part of the emotion brain and is what interprets whether incoming sensory information is a threat. The other part of the brain that is impacted by trauma is the prefrontal cortex—this allows for executive functioning, impulse control, learning, thinking ahead, etc. This is also the part of the brain that eventually lets us know that there is no longer a threat so that the amygdala can cease sending the alarm.

We find that Dr. Dan Siegel's (2017) hand model of the brain is a useful image for understanding the survival response. In other words, the activation that occurs when there is a real or perceived threat.



Regulated or "Full Brained"
When regulated, an individual has access to the full brain. You can see in the image of the hand to the left that the fingers (representing the prefrontal cortex) are wrapped over the thumb (the amygdala). The prefrontal cortex is "online," and therefore, the individual is capable of executive functioning, impulse control, reasoning, and logic.

Real or Perceived Threat
The survival response is activated when an individual is threatened. The brain activates this response in the face of a real or perceived threat.

For example, consider walking in a forest and seeing a bear.

Highly Dysregulated or "Flipped Lid"
The amygdala rapidly fires in order to activate the survival response—similar to sounding an alarm. As a result, the amygdala firing causes the lid to "flip," as can be seen in the diagram to the left. The prefrontal cortex is now "offline," as the amygdala becomes the body's driving force in order to react to the threat (either fight, run, or freeze).

Figure 4 – The Flipped Lid Response Adapted from Siegel (2017)

Once the threat subsides (e.g., running away from the bear to safety), the brain gradually returns to its baseline, and the individual becomes regulated once again. However, experiences of complex trauma cause the brain to learn that it needs to be on hyperalert (i.e., the bear is always around)—it is constantly waiting for the next bad thing to happen. As a result, the amygdala tends to be overactive even when there is not an immediate threat. Individuals with histories of trauma are thus more likely to be put into a survival state, in turn shaping how they perceive interactions and circumstances. When something in the present moment (e.g., tone of voice, nonverbal communication, attitude, interaction, environment) is perceived as a threat because of this overactivation of the amygdala, the lid flips, and the individual's brain and body are ready to fight, run away, or freeze. Therefore, even "simple" requests or seemingly nonthreatening interactions that some may not even think twice about can be activating to those with histories of trauma.

Re-traumatization

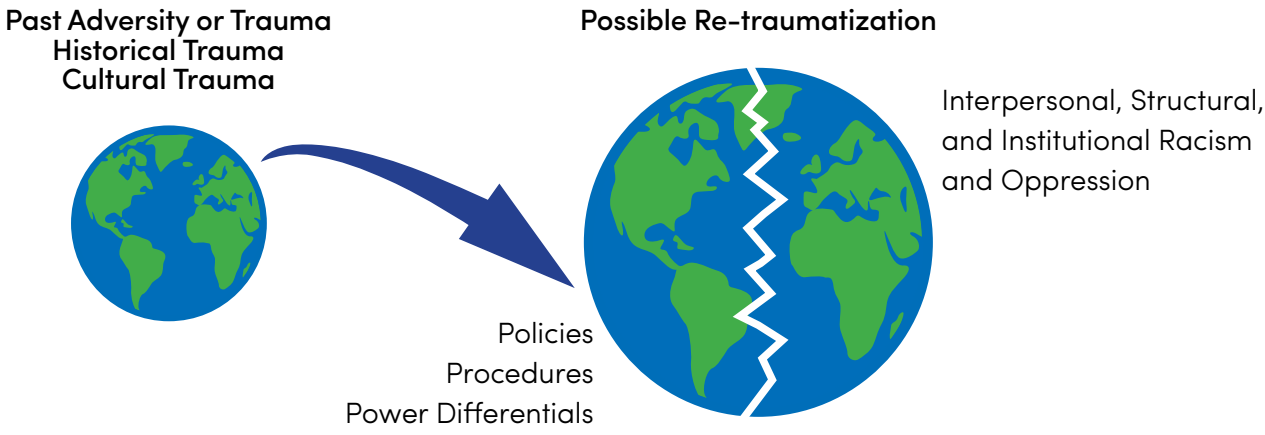
Due to the high prevalence of trauma and adversity, we know that organizations and systems can unintentionally flip the lids of or re-traumatize those receiving services and the individuals who work there (Jennings, 2009; SAMHSA, 2014a). Re-traumatization is any interaction, procedure, or even something in the physical environment that either replicates someone's trauma literally or symbolically, which then triggers the emotions and cognitions associated with the original experience (Jennings, 2009). What is experienced as re-traumatizing may sometimes be clear to us—such as recognizing someone with an abuse history may feel triggered when touched without permission, or it may not be as apparent—such as smelling the same cologne as a person's attacker. Experiences that are re-traumatizing do not need to exactly replicate the original trauma. We have learned that the way we do business (protocols, procedures) can hurt people (Jennings, 2009).

Figure 5 below illustrates system and relationship dynamics/themes that are often experienced as being re-traumatizing:

SYSTEM *(Policies, Procedures, Structural and Institutional Racism, and Oppression)*	RELATIONSHIP *(Power, Control, Subversiveness, Interpersonal Racism, and Oppression)*
HAVING TO CONTINUALLY RETELL THEIR STORY	NOT BEING SEEN/HEARD
BEING TREATED AS A NUMBER	NON-TRANSPARENCY AND VEILED TRUTHS
BEING SEEN AS A LABEL (E.G., ADDICT, SCHIZOPHRENIC)	DOES THINGS FOR RATHER THAN WITH
NO CHOICE IN SERVICE OR TREATMENT	USE OF PUNITIVE TREATMENT, COERCIVE PRACTICES, AND OPPRESSIVE LANGUAGE
NON-ACKNOWLEDGEMENT OF WORK-RELATED STRESS	RACIAL PROFILING
NO ACCESS TO SERVICES	BEING NON-COLLABORATIVE
PRACTICES WITHOUT ACCESSIBILITY CONSIDERATIONS	VICTIM BLAMING
ISOLATION OR EXCLUSION PRACTICES	NON-ACKNOWLEDGEMENT OF HISTORICAL NARRATIVES
MARGINALIZING PRACTICES	MICROAGGRESSIONS
PRACTICES WITHOUT CULTURAL CONSIDERATIONS	NON-INCLUSIVE LANGUAGE AND MESSAGING
"ISMS" AND PHOBIAS	NON-ACKNOWLEDGEMENT OF POWER DYNAMICS

Figure 5 – Trauma Dynamics/Themes

http://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/what-is-trauma-informed-care.html



RESILIENCE is the process of adapting to trauma and adversity—the ability to bounce back or return to the level of functioning prior to the trauma/adversity occurring.

POST-TRAUMATIC GROWTH [PTG] occurs when individuals are able to derive meaning from the event or circumstances and experience a positive change as a result.

Resilience and Post-Traumatic Growth

As noted in Figure 6, experiencing trauma/adversity can lead to varying levels of impairment and distress. The reaction could elicit several different outcomes: resilience, growth, and impairment. Resilience is the process of adapting to trauma and adversity—the ability to bounce back, or return to the level of functioning prior to the trauma/adversity occurring. When individuals are able to derive meaning from the event or circumstances, and experience a positive change as a result, they undergo what is called post-traumatic growth (Tedeschi & Calhoun, 2004). An example of PTG is a mother who lost her child to an accident caused by an intoxicated driver joining Mothers Against Drunk Driving in order to advocate for and support others.

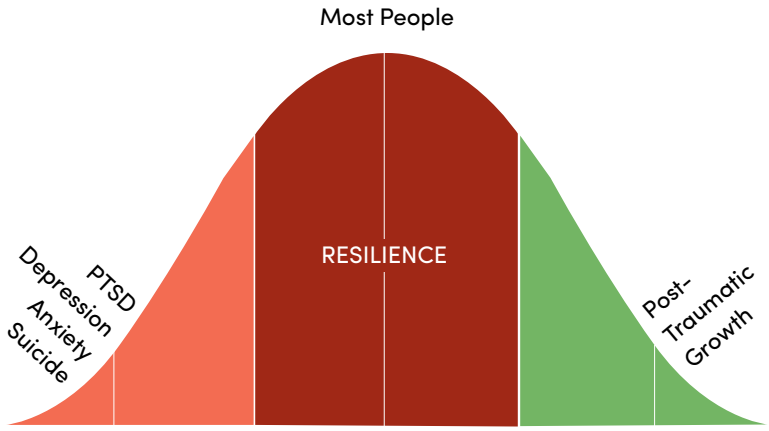


Figure 6 – Trajectories Following Trauma (adapted from Harris, 2017)

Impact of the Work: Considering the Workforce

A trauma-informed entity not only recognizes the effect of trauma on clients/patients/students/consumers, but also the impact on the workforce, based on their own and others' experiences of stress, trauma, and/or adversity. Figure 7 below describes those impacts:

IMPACT	DEFINITION
Secondary Traumatic Stress (STS)	Experience of trauma-related symptoms in a worker as a result of witnessing the trauma/adversity of another; typically quick in onset.
Vicarious Trauma (VT)	Development of negative changes in work worldview as a result of the cumulative impact of witnessing trauma/adversity over time.
Burnout	A gradual process of a staff member's experiencing feelings of hopelessness, fatigue, and being overwhelmed as a result of a lack of support, excessive workloads, and unrealistic expectations.
Compassion Fatigue (CF)	Experiencing the combination of STS, VT, and/or burnout.
Moral Injury and Moral Distress	An injurious experience that occurs when the worker engages in, fails to prevent, or witnesses acts that conflict with their values or beliefs, which can lead to feelings of moral distress, such as guilt, shame, and anger.
Decision Fatigue	Decrease in decision-making capacity after a long period of making multiple, sometimes rapid decisions.
Vicarious Resilience (VR)	Positive meaning-making and shift of the worker's experience as a result of witnessing the resilience of others.
Vicarious Post-Traumatic Growth (VPTG)	Development of positive changes and growth in worker's worldview as a result of witnessing the post-traumatic growth of others.
Compassion Resilience	Ability to maintain one's own physical, emotional, and mental well-being while compassionately doing the work with patients, families, and co-workers.
Moral Resilience	Ability to respond positively to the distress and adversity caused by an ethically complex situation.

Figure 7 – Adapted from Krause & Green (2015); Tedeschi & Calhoun (2004); National Center for PTSD (2020); Rushton (2017) and Compassion Resilience Toolkit (n.d.)

Examples to operationalize some of the concepts above are indicated in Figure 8 below. The impact of the work may look different, depending on the profession—consider how your organization/system may be impacted as you read the examples below.

SECONDARY TRAUMATIC STRESS: Shortly after interviewing a victim of physical abuse, a nurse begins to have a headache and is unable to concentrate, which results in her leaving her shift early.

VICARIOUS TRAUMA: A child-welfare worker finds herself not wanting to let her daughter out of her sight after taking the position six months prior because she feels the world is not safe for children.

BURNOUT: A supervisor of an agency that recently experienced funding cuts and many furloughs recognizes one of her employees has been coming to work late, is consistently behind in paperwork, and presents as exhausted with a depressed mood.

MORAL DISTRESS: A doctor feels increasingly powerless and hopeless that she has to turn patients away from their COVID-19 unit because there are not enough beds.

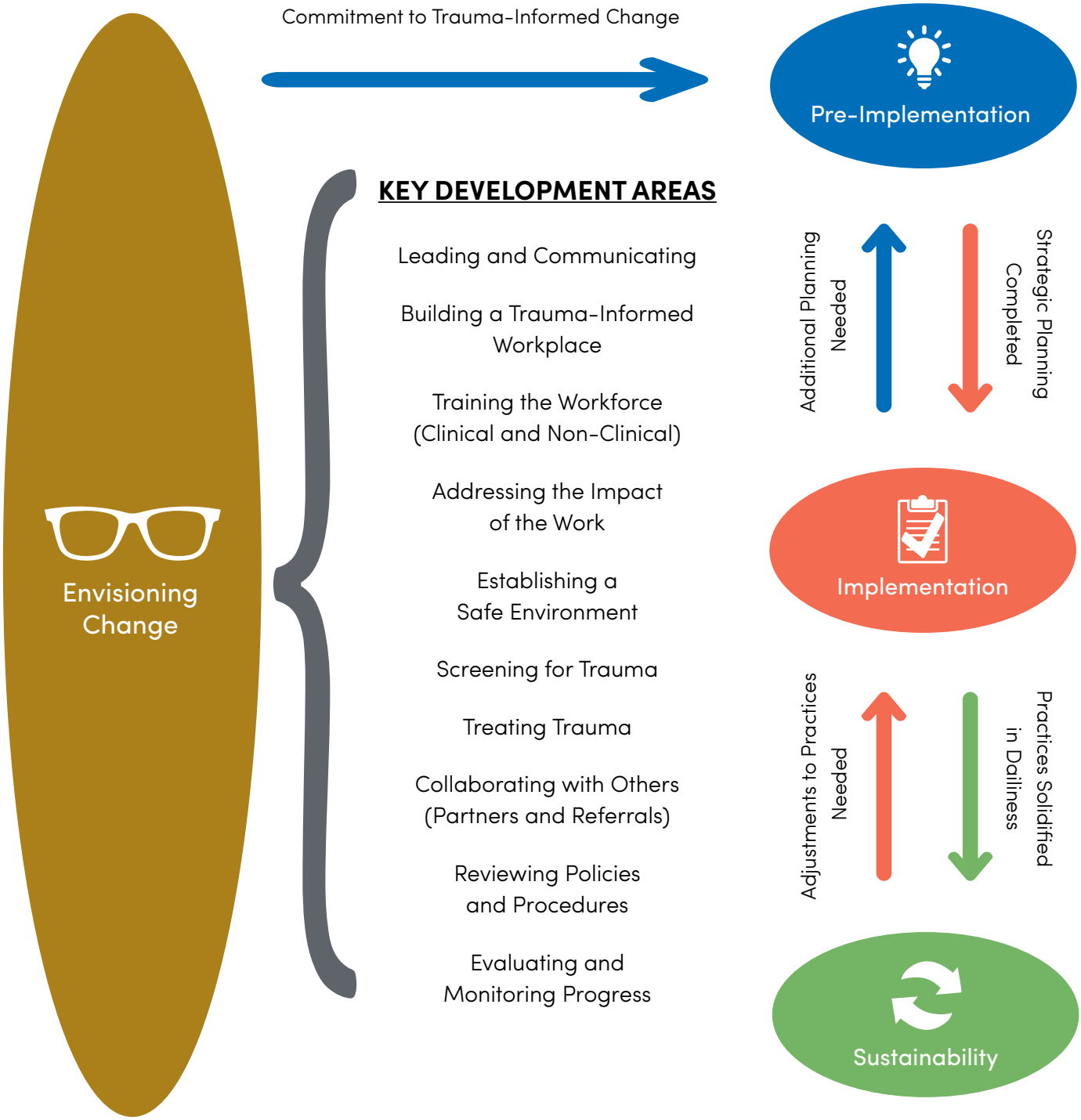
DECISION FATIGUE: After a long day of needing to make multiple decisions in high-stress situations, a police officer finds himself irritable when a family member or colleague asks him a simple question.

VICARIOUS RESILIENCE: A teacher reaffirms the reason he decided to go into education after witnessing one of his students excel in his classroom, despite the struggles she had at the beginning of the year due to family adversity.

VICARIOUS POST-TRAUMATIC GROWTH: A counselor reflects on how he has become more compassionate and self-aware over the years as a result of witnessing the growth of his clients.

Figure 8 – Examples of Possible Impacts of the Work

TRAUMA-INFORMED ORGANIZATIONAL CHANGE PROCESS



Adapting to Your System

Different systems adapt TIC according to the work they do—which may or may not involve care. For example, we have adopted the title of Trauma-Informed Educational Practices (TI-EP) in our work with schools, Trauma-Informed Medicine (TIM) in our work with health care settings, and Trauma-Informed Policing (TIP) in our work in law enforcement. It is important to note that similarly to how we worked with systems to adapt TIC to TI-EP, TIM, and TIP, the language in this manual can always be adapted to your specific system. For the sake of consistency throughout this manual, TI-EP, TIM, and TIP will be used when discussing examples related to those settings, but otherwise we will use the term "trauma-informed approach."

NOTE: *Look for the icons below throughout the manual, as they indicate real-life implementation examples from our work in organizations/systems.*

Universal

Any organization, system, or business, regardless of its role/function.

Trauma-Informed Policing (TIP)

Specific to law enforcement organizations and systems.

Trauma-Informed Educational Practices (TI-EP)

Specific to education/schools.

Trauma-Informed Medicine (TIM)

Specific to hospitals, primary care, and other health care systems.

For more details regarding how to use this manual, please read the section on Page 38.

Our Approach

Evaluation

Evaluation is a key component of the trauma-informed approach. It allows us to *take a pulse* and reassess how trauma-informed we are. Evaluating how trauma-informed an organization/system is involves looking at the culture and climate, as well as its policies and procedures, through a trauma-informed lens. Our evaluation process utilizes an organizational assessment tool that asks staff (and sometimes clients/patients/students/consumers) for their perceptions of the five guiding values and principles of a trauma-informed approach, and about specific policies/procedures within their work at their organization/system that are trauma-informed. There are multiple trauma-informed organizational assessment tools to choose from, which we will discuss later in the manual within the key development areas.

Taking a pulse refers to assessing where an organization/system currently is in the trauma-informed change process in order to make informed decisions about next steps.

Having a big-picture evaluation plan is critical for measuring the progress and overall success of trauma-informed organizational change. Part of the evaluation plan is taking a baseline, which means evaluating before any trauma-informed training or implementation steps occur. The organization/system can then use the results of the evaluation to make deliberate decisions regarding trauma-informed change—mainly what to focus energy and resources on first, based on reported strengths and areas for improvement. In addition to identifying where to start, the organization/system can also use the baseline evaluation as an anchoring point to monitor progress moving forward. As can be seen in Figure 9 below, regular monitoring of progress via evaluation of implementation steps (what is working, what needs to be tweaked, etc.) is the central component of sustaining trauma-informed organizational change. Strategies and considerations for creating an overall evaluation plan will be discussed later in the manual in the Evaluating and Monitoring Progress section.

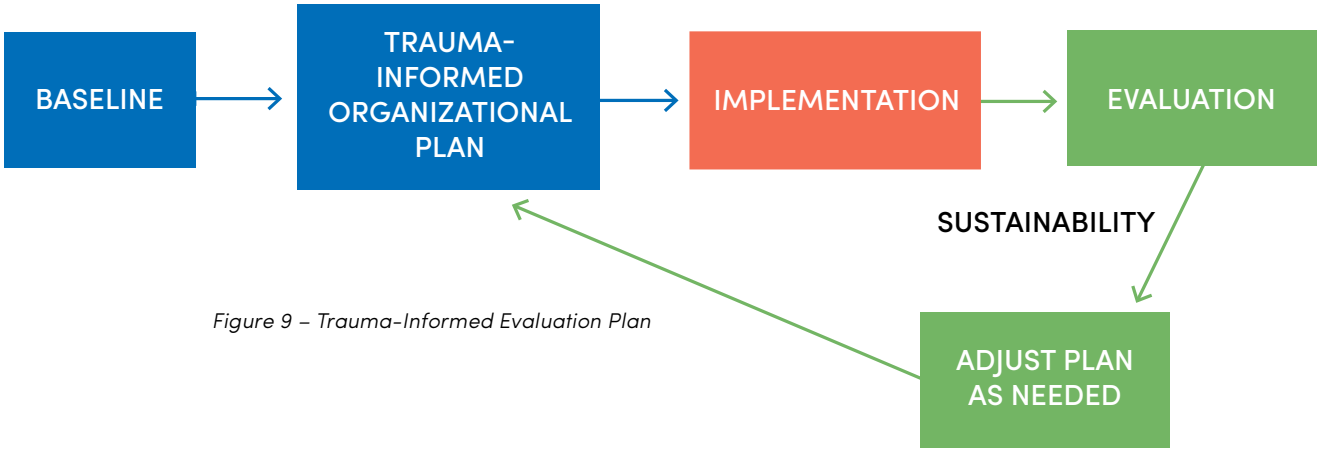


Figure 9 – Trauma-Informed Evaluation Plan

Five Guiding Values and Principles

The five guiding values and principles proposed by Harris and Fallot (2001) provide a general framework that can be used in any organization/system with everyone, including at a worker-to-client/patient/student/consumer level, a worker-to-worker level, and a leadership-to-worker level. While we strive to incorporate all five to the best of our ability, we may not be able to use all of them in every interaction. As can be seen in Figure 10, the values and principles are unique and strongly related (Hales, Kusmaul & Nochajski, 2016). This means that the values and principles can be used flexibly. For example, if we truly cannot provide any choice in a specific mandated situation, how can we at least let the individual know what to expect (trustworthiness) and/or ensure emotional safety during the process? Having a good understanding of each of the values and principles is critical for being able to be deliberate in their use.

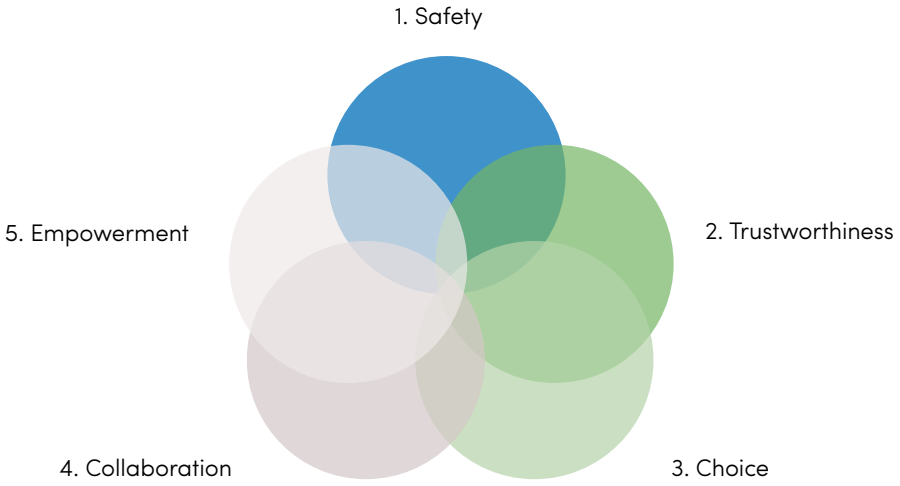


Figure 10 – The Five Guiding Values and Principles Adapted from Harris & Fallot (2001)

The five values and principles are the filter for all individuals, organizations, and systems to engage in universal precaution for re-traumatization. Only by ***intentionally*** using the values and principles of safety, trustworthiness, choice, collaboration, and empowerment in response to recognizing the impact of individual, historical, and systemic trauma on self view and worldview, is there the possibility for resilience, inclusion, equity, healing, and growth.

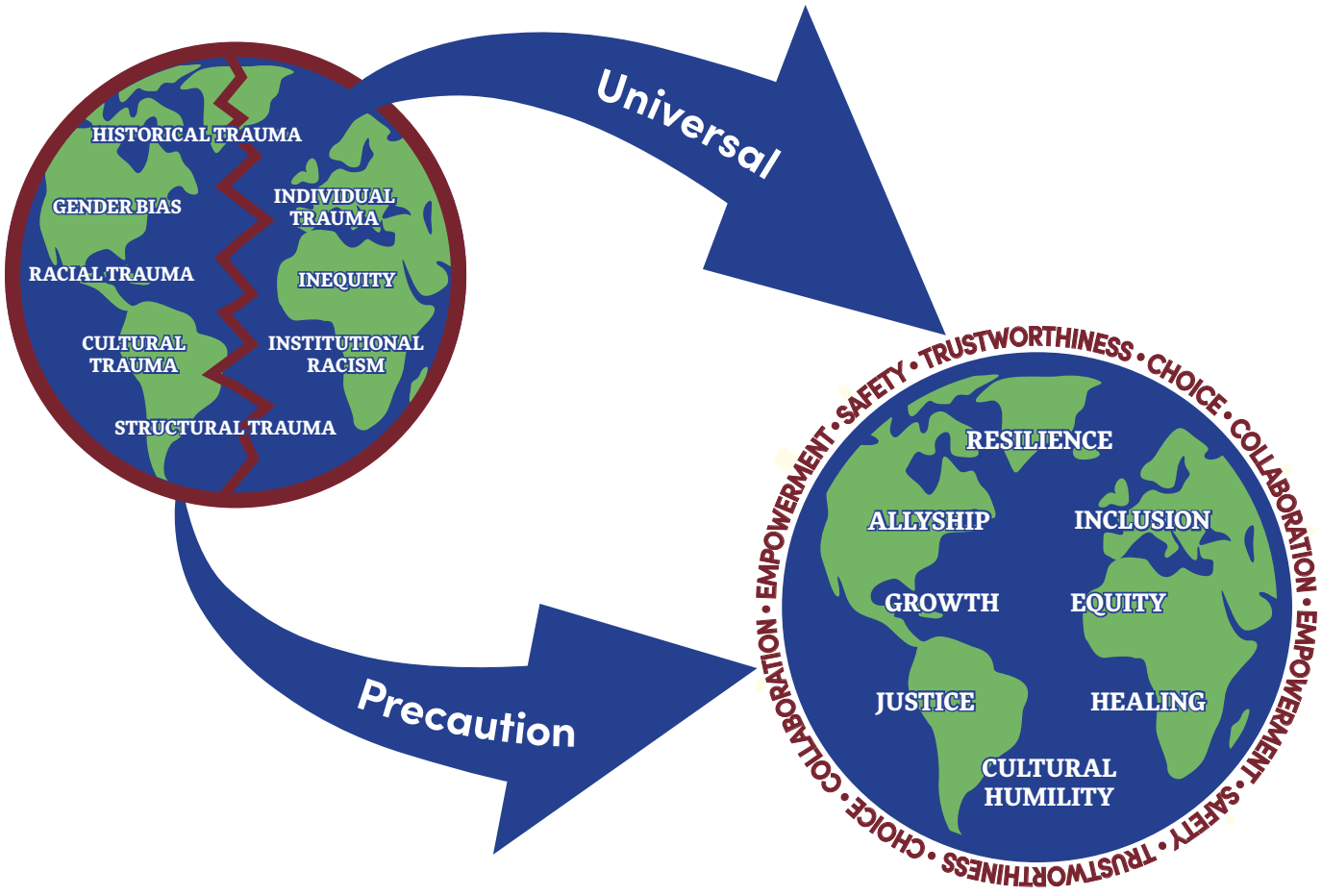


Figure 11 – Universal Precaution

The five values and principles are listed below, with descriptions and examples of what they can look like in different systems:

Safety is broken down into considerations of physical and emotional safety of all individuals in the organization/system. Physical safety involves thinking about security and the aesthetics of the building itself (appearance, lighting, photos, and artwork that represent the individuals using the space, etc.), accessibility of the building (e.g., ramps, Braille, rails, elevators, gender-neutral bathrooms) and the effect that those may have on individuals. Emotional safety can be ensured by being attentive to signs of individual discomfort and recognizing these signs in a trauma-informed way; checking in, debriefing, and providing support; openly acknowledging and witnessing inequities, marginalization and historical contexts; and ensuring interactions with everyone are welcoming, respectful and engaging (Harris & Fallot, 2001).

A supervisor regularly checks in with the workforce at the beginning and end of the day.

A teacher asks a disruptive student about what is going on prior to discussing consequences for inappropriate behavior.

A doctor asks a patient what can be done during a procedure to help the patient feel more comfortable.

A police district renovates its interview room to incorporate more comfortable seating, toys and coloring books for children, and better lighting.

Trustworthiness involves providing clear information about what will be done, by whom, when, why, and under what circumstances (including role clarity, rules/expectations, job descriptions, etc.); and ensuring that all information is available in different languages when needed, and in developmentally and culturally appropriate ways. Trustworthiness means maintaining respectful and professional boundaries, prioritizing privacy and confidentiality, and ensuring interactions and rules are consistent, with an emphasis placed on follow-through (Harris & Fallot, 2001). Trustworthiness also recognizes that individuals in marginalized groups may especially not trust providers/systems and may need more time to develop rapport and working relationships.

A worker informs a client/patient/student/consumer of his role—including what he can and cannot do within his role.

A principal sends a weekly email bulletin to teachers and staff in order keep them informed of news, changes, and upcoming events.

A hospital has a daily shift log and check-in debriefing system to ensure transparent communication and consistency between staff on different shifts.

An officer lets an individual under arrest know they will be placing their hands on them before handcuffing.

Choice involves deliberately considering how much of a voice all individuals have throughout their experience in the organization/system (care received, goals set, how to address a task, appearance of office space, vacation time, etc.), and providing everyone clear and appropriate messages about their rights and responsibilities (Harris & Fallot, 2001). Individuals and organizations understand the importance of power differentials and ways in which groups of individuals have historically had little voice or choice. Choices are provided in ways that are reflective of options regarding race, gender, and culture.

A supervisor gives a worker flextime with her schedule, as long as she meets the hours required of her.

A teacher gives a student currently struggling with working with peers a choice of working with her or independently.

A nurse provides a patient with two referral options for a cardiologist and allows him to choose which he prefers.

An officer gives a survivor of an assault the choice to take a break or slow down during the interview process.

Collaboration is the creation of an environment of doing with rather than doing to or for someone by flattening the organizational power hierarchy, giving all individuals a significant role in planning and evaluating their care/services/job, eliciting feedback from all individuals to inform organization/system-wide administration and changes, and conveying the message that individuals are the experts in their own lives (Harris & Fallot, 2001). Individuals, families, and communities are treated as the experts of their own experiences and roles—interactions and protocols create space to explore circumstances and decision-making from their own perspectives.

Administration collects and reviews anonymous suggestion-box feedback and reports the results at monthly meetings.

A social worker collaborates with the parent of a student with many absences and the student himself to create a plan for him to get to school.

A hospital has a patient advisory board that meets monthly to discuss hospital practices, policies, and feedback gathered from patients.

An officer works together with community partners to ensure a child is with a responsible adult after a parental arrest.

Empowerment pertains to recognizing and building on individual strengths/skills, highlighting supportive cultural, community and/or spiritual practices and connections, communicating a realistic sense of hope for the future, and fostering an atmosphere that allows everyone in the organization/system to feel validated and affirmed during each contact (Harris & Fallot, 2001). Policies, processes, and protocols are responsive to racial, ethnic, and cultural needs of individuals (Quiros & Berger, 2015). It is important to note that empowerment is different from cheerleading. Instead of giving someone a direct compliment or encouragement, empowerment is more about eliciting from the individual—asking him or her to come up with capacities and strengths (Krause, Green, Koury & Hales, 2017). Empowerment also includes the use of strengths-based language that is focused on solutions rather than problems.

An organization provides its workers with regular trainings and allows time for participation in continuing education to build on worker skillsets.

A school acknowledges the hard work of teachers and staff by including a staff spotlight in the monthly newsletter.

A physician assistant asks what a patient is already doing to help her succeed in reaching her goal of losing weight.

A police chief highlights a patrol officer's community engagement skills during a district meeting.

Ensuring the values and principles is a common theme that all people in an organization/system can focus on and be deliberate about by thinking, "How am I ensuring the values and principles in what I do?" regardless of whether they interact with those receiving services, staff, or both. Additionally, all of this manual's key development areas, implementation examples, and next steps are anchored in the five values and principles. Keep in mind that it is important for any action steps that are implemented in your organization to ensure the five values and principles. It is also critical that individuals who are involved in the trauma-informed organizational culture change process are in a position of *modeling the model*—meaning that the way they go about planning, implementing, and sustaining is anchored in the values and principles.

Four Levels of Trauma-Informed Care

We identify four levels to guide individuals and organizations in identifying their role(s) in responding to the presence of trauma. The levels are 1) trauma awareness, 2) trauma-informed approach, 3) trauma-sensitive practices and 4) trauma-specific treatments. Figure 12 below depicts each of the four levels:

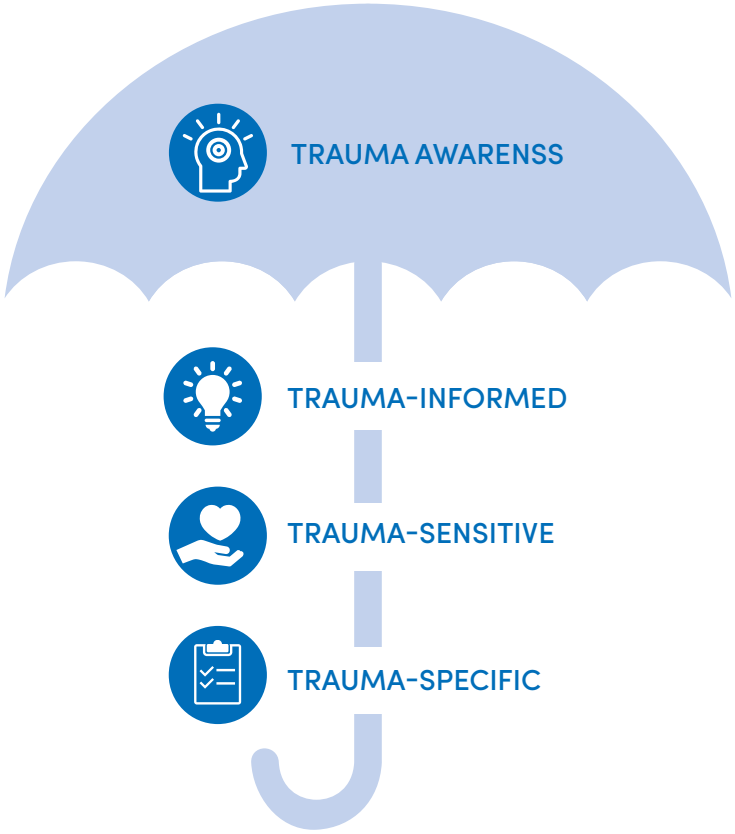


Figure 12 – Four Levels of Trauma-Informed Care

Trauma awareness occurs when individuals have knowledge and education about trauma, including what it is, the different types, and how it impacts individuals and communities. Individuals may also be aware of their clients/patients/students' trauma histories, are able to identify signs and symptoms of trauma, and respond to them with empathy and compassion.

A **Trauma-informed approach** happens when individuals, organizations, and systems use the trauma-informed values and principles with integration of DEIA considerations as the lens or filter for everything they do in order ensure universal precaution for trauma and re-traumatization. In other words, awareness of trauma is mobilized into ***intentional*** action. Being trauma-informed requires an active state of self-awareness, self-regulation, and self-reflection.

Trauma-sensitive practices are applied when individuals, organizations, and systems make specific changes to their environments, policies, protocols and procedures so they are more sensitive to the possible trauma of clients/patients/students and the workforce. The decision

to implement trauma-sensitive practices can be made through the lens of a trauma-informed approach (e.g., to create a more welcoming waiting area to specifically ensure emotional or physical safety), but they can also stand alone. For example, an organization can implement debriefing protocols in the event of a crisis or stressful incident because leaders are sensitive to the direct or vicarious impact of trauma, or create a formal protocol to universally screen for trauma based on the awareness of the prevalence of trauma in the client/patient/student population without an intentional commitment to the trauma-informed values and principles.

Trauma-specific treatments are interventions designed to treat and help people heal from their experiences of trauma. With a few exceptions, only trauma therapists who are trained and certified in a trauma-specific treatment are able to practice at this level. A list of common trauma-specific treatments available is provided on Page 96 within the Treating Trauma Key Development Area.

We now have tools to help people heal from trauma and to avoid re-traumatizing those seeking help.

A TRAUMA AWARE organization has a workforce with knowledge of the prevalence and impact of trauma on those they work with and themselves.

A **TRAUMA-INFORMED** organization turns awareness into action by engaging in universal precaution for re-traumatization through the intentional use of the five guiding values and principles as a filter for all interactions and functioning.

A **TRAUMA-SENSITIVE** organization makes changes to certain aspects of its environment, policies, procedures, and protocols to be more sensitive to the possible trauma of the individuals within it.

A **TRAUMA-SPECIFIC** organization offers evidence-based trauma treatment interventions specifically designed to treat and help individuals heal from trauma.

Figure 12A – Applying the Four Levels of a Trauma-Informed Care to Organizations

Trauma-Informed Organizational Model

The trauma-informed organizational framework provides a model for becoming a trauma-informed organization/system. The model will allow an organization/system to gain insight and direction needed during this organizational change process. Note: Many parts of your organization/system likely already reflect aspects of the trauma-informed organizational model. In order to help you identify what is already in place and how to move forward, the model consists of stages, key development areas, and domains of consideration.

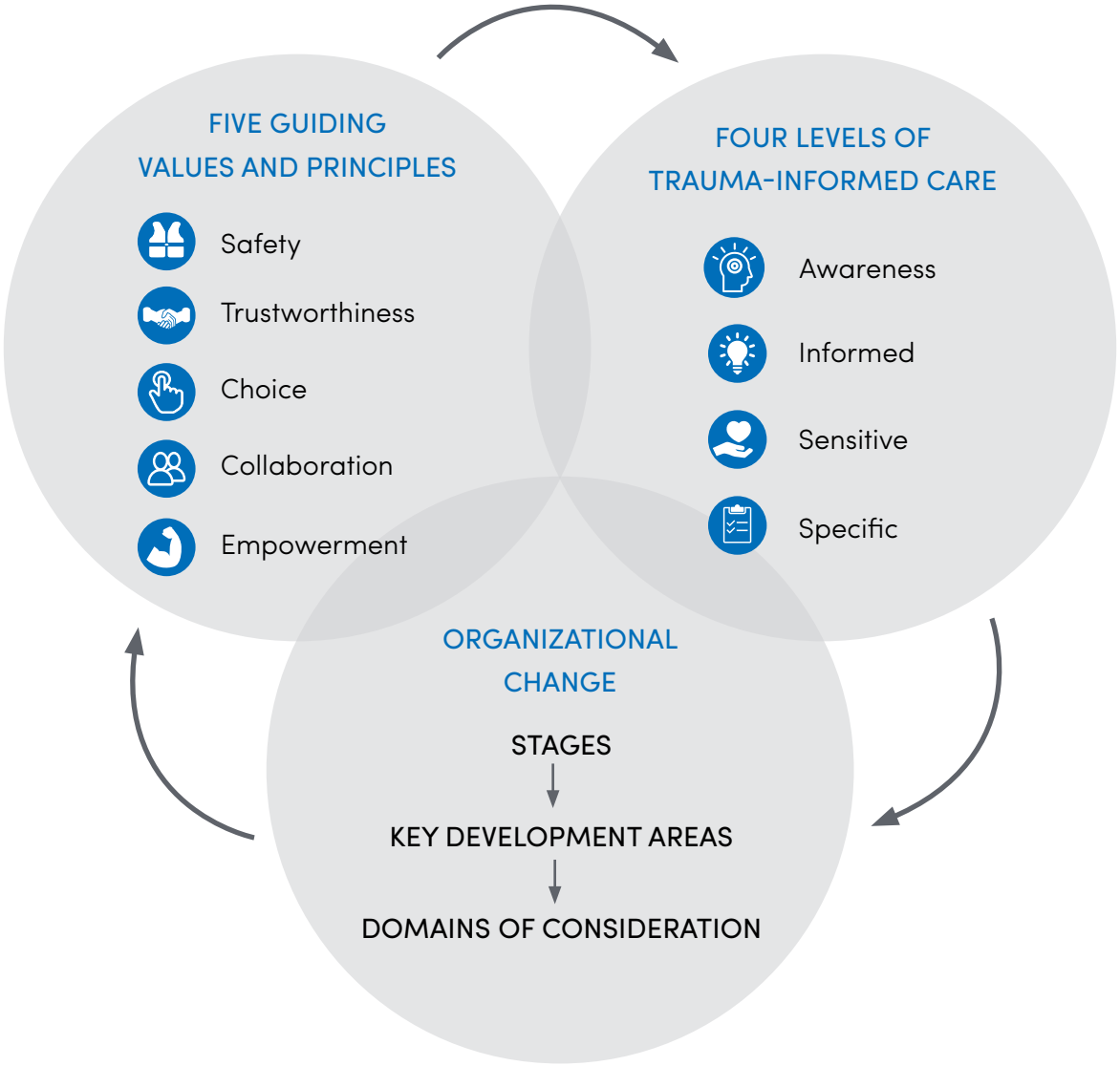


Figure 13 – Trauma-Informed Organizational Model

Envisioning Trauma-Informed Change

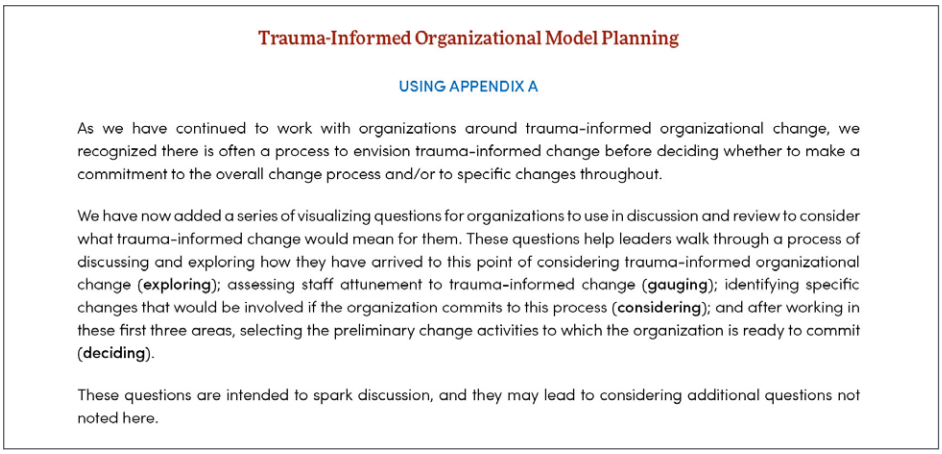
As we have continued to work with organizations around trauma-informed organizational change, we recognized there is often a process to envision trauma-informed change before deciding whether to make an overall commitment to the change process, as well as committing to the action items in each of the three stages of the trauma-informed organizational model.

We have now added a series of visualizing questions for organizations to use in discussion and review to consider what trauma-informed change would mean for them. These questions, located in **Appendix A**, help individuals walk through a process of discussing and exploring how they have arrived at this point of considering trauma-informed organizational change (Exploring); assessing staff attunement to trauma-informed change (Gauging); identifying specific changes that would be involved if the organization commits to this process and/or action step (Considering); and after working in these first three areas, selecting the preliminary change activities to which the organization is ready to commit (Deciding). We invite organizations/systems to revisit these questions throughout the change process as a way of informing their planning and action steps.

Stages of the Trauma-Informed Organizational Model

The next component of the trauma-informed organizational model is identifying the stage. The three stages of the organizational model are: **Pre-Implementation**, **Implementation,** and **Sustainability**. The things to consider, needs, and resources for trauma-informed organizational change are different, depending on which stage the organization/system is currently in. However, what we know about successful organizational change is that for it to work and be sustainable, there needs to be an acceptance that change is a flexible, ongoing, and regularly re-evaluated process (Rosenbaum et al., 2018; Tsoukas & Chia, 2002). Therefore, the three stages are dimensional and flexible.

For example, today you may find your organization/system is in the **Sustainability Stage** in one key development area, only to re-evaluate down the road and find that something new needs to be implemented—bringing that area back to the **Implementation Stage** because adjustments are required. **Figure 14** demonstrates the movement between stages, based on re-evaluation of any given key development area. Additionally, your organization/system may be in different stages, depending on which key development area is being considered (e.g., in **Pre-Implementation** for Leading and Communicating, and Sustainability for Treating Trauma).



Trauma-Informed Organizational Model Planning

USING APPENDIX A

As we have continued to work with organizations around trauma-informed organizational change, we recognized there is often a process to envision trauma-informed change before deciding whether to make a commitment to the overall change process and/or to specific changes throughout.

We have now added a series of visualizing questions for organizations to use in discussion and review to consider what trauma-informed change would mean for them. These questions help leaders walk through a process of discussing and exploring how they have arrived to this point of considering trauma-informed organizational change (**exploring**); assessing staff attunement to trauma-informed change (**gauging**); identifying specific changes that would be involved if the organization commits to this process (**considering**); and after working in these first three areas, selecting the preliminary change activities to which the organization is ready to commit (**deciding**).

These questions are intended to spark discussion, and they may lead to considering additional questions not noted here.

Appendix A

TRAUMA-INFORMED ORGANIZATIONAL CHANGE PROCESS

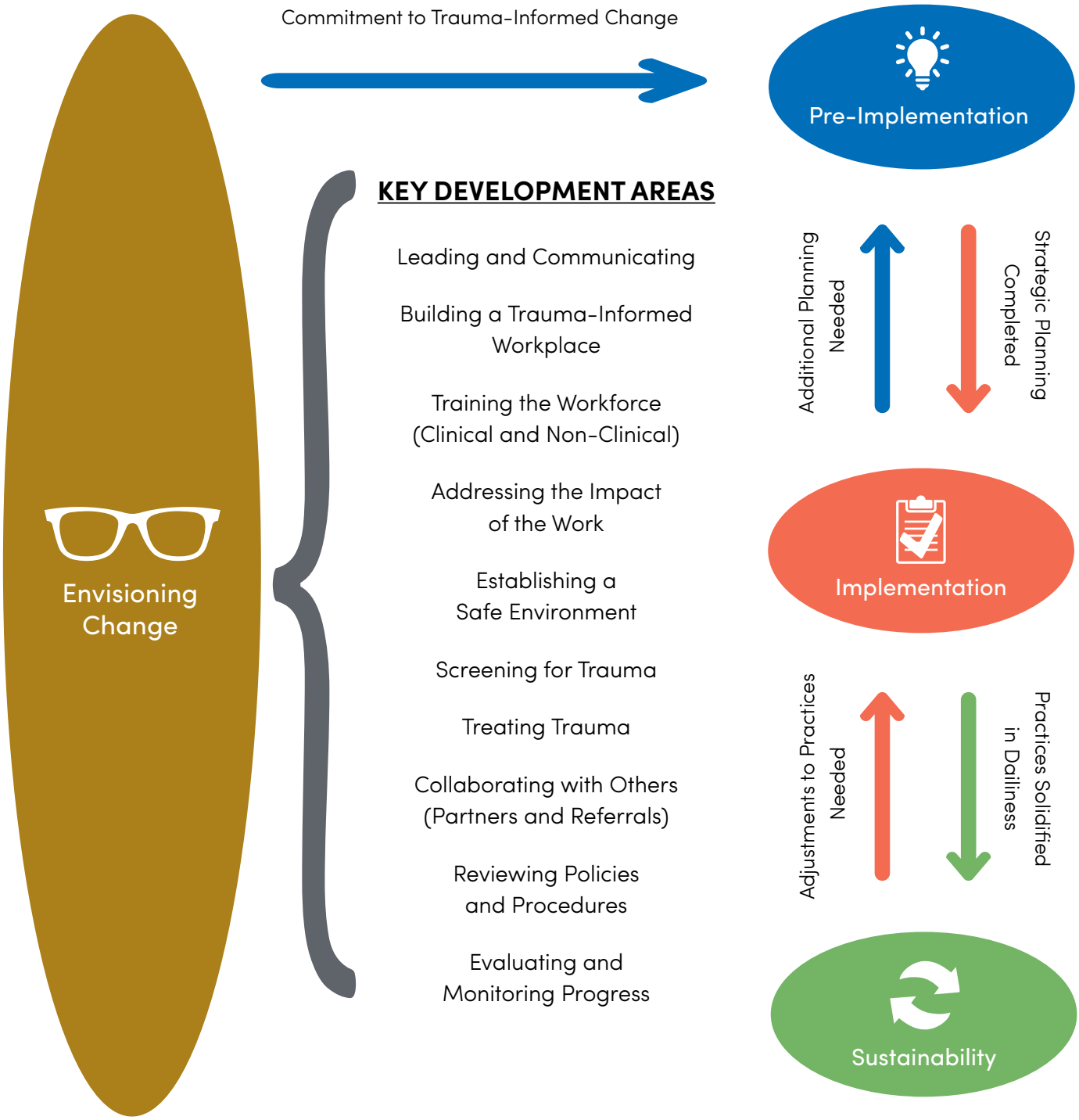


Figure 14 – Trauma-Informed Organizational Change Process

Key Development Areas

1. **Leading and Communicating** – Involves having leadership/administration buy-in, investment, and consistent messaging around trauma-informed organizational change, and the presence of a committee/team leading the change process.

2. **Building a Trauma-Informed Workplace** – Involves ensuring hiring, new-hire orientation, and other human resources practices are conducted in ways that are trauma-informed and trauma-sensitive.

3. **Training the Workforce (Clinical and Non-Clinical)** – Involves a realistic and sustainable plan for providing ongoing trauma-informed education and training to all levels of the workforce.

4. **Addressing the Impact of the Work** – Involves increasing workforce awareness of how to prevent/manage secondary traumatic stress, vicarious trauma, and compassion fatigue, as well as implementing organizational/system structures to help support workers and promote vicarious resilience/vicarious post-traumatic growth.

5. **Establishing a Safe Environment** – Involves taking a deliberate look at the environment and atmosphere of the organization/system to ensure that physical space/aesthetics and culture are trauma-informed and trauma-sensitive.

6. **Screening for Trauma** – Involves deciding whether or not screening for trauma and/or adversity is appropriate in the organization/system, and if so, what tools and follow-up structures are in place to do so.

7. **Treating Trauma** – Involves having on-site trauma-specific treatment interventions or accessible referrals in place for individuals who are seeking treatment for their trauma.

8. **Collaborating with Others (Partners and Referrals)** – Involves building on and/or creating mechanisms with partner organizations/systems to collaboratively ensure trauma-informed networks, communities, and systems.

9. **Reviewing Policies and Procedures** – Involves confirming that all policies, procedures, and protocols are written and conducted in a way that is in line with a trauma-informed and trauma-sensitive approach.

10. **Evaluating and Monitoring Progress** – Involves having mechanisms in place to evaluate and monitor trauma-informed organizational change, as well as its impact on the organization/system in relation to outcomes.

Domains of Consideration (SAMHSA, 2014a)

1. **Governance and Leadership** – Leadership supports and invests in implementing and sustaining a trauma-informed approach.

2. **Policy** – Written policies establish the trauma-informed approach as a key part of the organizational mission.

3. **Physical Environment** – Everyone experiences the setting as inviting, collaborative, and physically/emotionally safe.

4. **Engagement and Involvement** – All stakeholders in the organization have significant involvement and voices in all areas of organizational functioning.

5. **Cross-Sector Collaboration** – Collaboration with others is built on mutual understanding of trauma, and the guiding values and principles of a trauma-informed approach.

6. **Screening, Assessment, Treatment Services** – All practices/services of the organization reflect the values and principles of a trauma-informed approach.

7. **Training and Workforce Development** – Organization believes that ongoing training on trauma, a trauma-informed approach, and self-care is essential.

8. **Progress Monitoring and Quality Assurance** – Organization has ongoing assessment, tracking, and monitoring of the guiding values and principles of a trauma-informed approach.

9. **Financing** – Financial structures are in place to support resources needed for implementation and sustainability of a trauma-informed approach.

10. **Evaluation** – Evaluations of implementation and service provision reflect an understanding of trauma and a trauma-informed approach.

Key Development Areas and Domains

Within the three stages of the trauma-informed organizational model are 10 key development areas—specific aspects of organizational functioning that need to be addressed through a trauma-informed lens to best create overall trauma-informed organizational change. The key development areas are the heart of the model and this manual, as the narrative and tools will walk you through and help you plan for the details of each. The key development areas are listed and summarized on Page 36.

Each key development area has one or more domains of consideration, which are domains of organizational change that SAMHSA (2014a) infused with trauma-specific content and the values and principles of a trauma-informed approach (listed and defined previously on Page 36). These domains ensure organizational change structures within each of the key development areas—which may have multiple domains of consideration in each.

Creating and sustaining the trauma-informed organizational change process is a multifaceted process with many nuances. It is important to note here that true organizational change can take a minimum of three to five years, depending on the size and structure of the organization/system. This manual is structured in a way to help you consider each of the components discussed thus far—values and principles, level of trauma-informed approach, stage, key development area(s), and domain(s) of consideration—throughout the process in the context of a time frame that makes sense for your organization/system.

*** The following page provides you with an overview of the trauma-informed organizational model's planning outline.*

Trauma-Informed Organizational Model Planning Outline

*** Blue = SAMHSA (2014a) domains of consideration within each development area*

Figure 15 – Stages of the Trauma-Informed Organizational Model

Key Development Areas:

1. Leading and Communicating *(Governance and Leadership; Engagement and Involvement; Financing; Evaluation)*
2. Building a Trauma-Informed Workplace *(Governance and Leadership; Training and Workforce Development; Policy)*
3. Training the Workforce (Clinical and Non-Clinical) *(Training and Workforce Development)*
4. Addressing the Impact of the Work *(Training and Workforce Development; Policy)*
5. Establishing a Safe Environment *(Physical Environment)*
6. Screening for Trauma *(Screening, Assessment, Treatment Services)*
7. Treating Trauma *(Screening, Assessment, Treatment Services)*
8. Collaborating with Others (Partners and Referrals) *(Cross-Sector Collaboration; Training and Workforce Development; Engagement and Involvement)*
9. Reviewing Policies and Procedures *(Policy; Engagement and Involvement)*
10. Evaluating and Monitoring Progress *(Progress Monitoring and Quality Assurance; Evaluation)*

Getting Started

How to Use the Manual

The remainder of the manual is divided according to the 10 key development areas:

- Leading and Communicating
- Building a Trauma-Informed Workplace
- Training the Workforce (Clinical and Non-Clinical)
- Addressing the Impact of the Work
- Establishing a Safe Environment
- Screening for Trauma
- Treating Trauma
- Collaborating with Others (Partners and Referrals)
- Reviewing Policies and Procedures
- Evaluating and Monitoring Progress

The process of **Envisioning Change** takes place before the commitment to becoming a trauma-informed organization happens, as well as throughout the change process to inform action steps. Within this process, individuals within the organization or system visualize what trauma-informed organizational change means within their specific organizational/systemic context, how ready the organization/system is to begin the process, and what the change process could begin to look like.

The envisioning change section of the manual **(Appendix A)** consists of a series of reflective questions designed to help those leading the process explore how being trauma-informed matches with their organizational values and priorities, gauge how receptive the workforce will be to trauma-informed change, consider what structures and supports are already available, and decide what parts of the change process make most sense to commit to right now. This section truly recognizes the ongoing importance of thinking and talking about trauma-informed organizational change.

Within the **Pre-Implementation Stage**, the organization or system prepares for and builds the foundation for trauma-informed organizational change through creating key structures to inform the implementation and sustainability stages, as well as the process of formally planning for action within identified

priority key development areas. Prior to beginning the strategic planning process, we strongly recommend that organizations and systems take two initial action steps:

1. Ensure the leadership team (including administrators) has initial training on trauma and trauma-informed approaches.

2. Designate a workgroup or committee with diverse perspectives and representation to lead the trauma-informed change process.

Leadership investment and involvement in the trauma-informed change process, as well as having even a small group of individuals positioned to wake up thinking about leading the work, sets the stage for success and overall sustainability. Once the workgroup or committee is in place with active support of leadership, members can identify and plan for action within priority key development areas to create the trauma-informed organizational plan. The Pre-Implementation Stage sections of the manual provide initial considerations, examples of the foundational structures that are recommended to be in place prior to moving to the Implementation Stage, and tools for planning within each key development area.

Within the **Implementation Stage**, organizations and systems build on foundational structures and planning from Pre-Implementation to carry out action steps specific to their trauma-informed organizational plan. Organizations and systems may choose to work on one or various key development areas at a time, based on their priorities, resources, and capacity. While a strategic implementation plan is important, it is also equally important for those leading the change process to recognize the need to be responsive and flexible. Timelines and priorities may change because of the current realities of the organization or system. Critical components of the key development areas within the Implementation Stage are:

- Have a regularly meeting workgroup or committee that leads implementation steps.
- Message the importance of a trauma-informed approach that includes DEIA.
- Include questions on trauma, DEIA, and a trauma-informed approach in the interview process for potential new hires.
- Ensure all workers (clinical and non-clinical) receive foundational education on trauma/adversity, anti-racism, anti-oppression, re-traumatization, and trauma-informed approaches, and have opportunities for follow-up conversation.
- Promote and create structures for workforce wellness and self-care in culturally sensitive ways.
- Conduct trauma-informed walk-throughs of the organization's/system's physical environment.
- Review the organization's/system's environment for emotional safety.
- Create a formal protocol when screening and assessing for trauma.
- Offer or refer out to evidence-based, trauma-specific treatment interventions.
- Engage the community, partners, and referrals in the trauma-informed change process.
- Review and revise policies, procedures, and protocols with a trauma-informed lens.
- Incorporate a trauma-informed approach into quality improvement processes.
- Create mechanisms for ongoing evaluation of the trauma-informed change process.

The Implementation sections of the manual provide considerations, examples of implementation strategies, and tools to utilize during action steps within each key development area.

The **Sustainability Stage** is when the organization or system reaches the point where it can maintain trauma-informed culture and climate. This requires organizations/systems to integrate trauma-informed practices into their fabric—in other words, the action items within the key development areas are ongoing and are a natural part of the dailiness of organizational functioning. Sustainability is reached by establishing mechanisms to consolidate gains, and tweaking implementation of action steps informed by ongoing evaluation and monitoring progress. An important consideration for those leading the trauma-informed change process is to think about sustainability as a state that is fluid, as the key development areas may fluctuate between implementation and sustainability at any time.

Action items within the Sustainability Stage include those leading the change process reviewing considerations with each key development area, specifically focusing on the practices for maintaining the action steps in implementation and sustaining overall trauma-informed organizational change. The Sustainability sections of the manual include checklists of structures and examples within each key development area to assist in this process.

The manual is set up so you can evaluate and acknowledge where your organization/system is already, make decisions regarding where to go moving forward, and then use the tools and worksheets provided to help you get there. Each key development area section includes narrative describing the various components in each of the stages, examples from our work, and worksheets to fill out.

Our recommendations for those using this manual are as follows:

1. Read the Our Approach section starting on Page 26.

2. Use Appendix A to reflect on and discuss the envisioning change process.

3. Use Appendix B (directions on Page 42) as an initial assessment of where your organization/system is regarding each key development area.

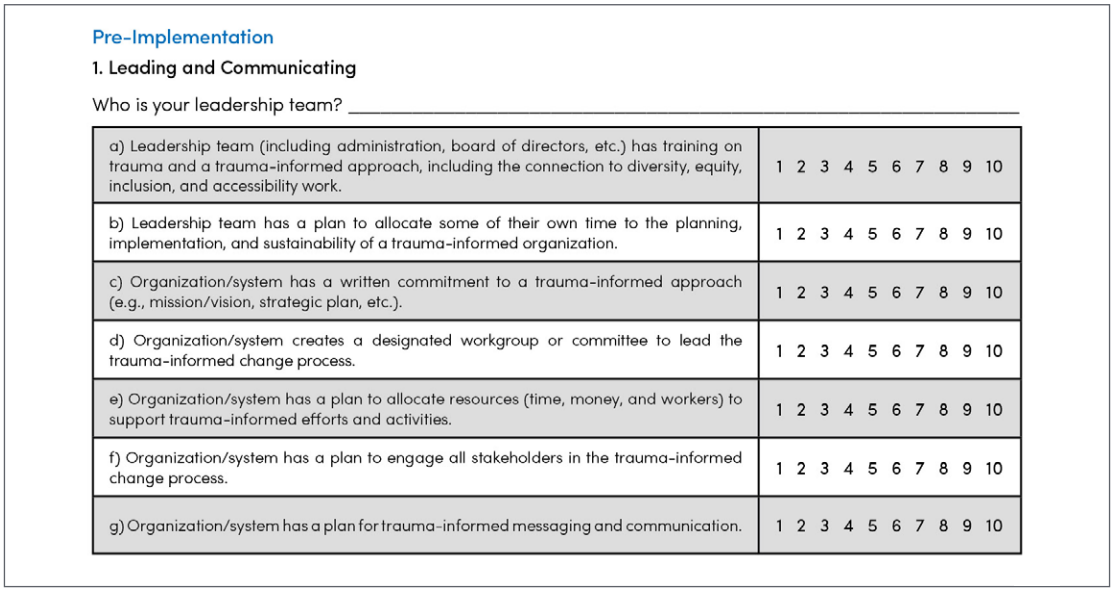
    a. *Take notice of what is already in place/what is already working, as well as what areas might make sense to focus on moving forward, based on what is possible right now.*

4. Based on your responses to Appendix B, read the section(s) of the manual that correspond to the area(s) you identified for more narrative, examples from our work, tools, and resources.

*** We recommend that those overseeing the trauma-informed change process read through the narrative of this manual in its entirety. It is critical to understand the big picture of what it takes to become a trauma-informed organization/system to make deliberate decisions on whom to involve and where to begin.*

Initial Assessment of Stages and Key Development Areas

Now that your organization/system has decided to become trauma-informed, it is important to have a true understanding of the *big picture*. Noticing what is already in place and starting with the end in mind are critical to making trauma-informed organizational change successful. The chart in Appendix B will help you take a first look by breaking down different things to consider for all 10 key development areas within each of the three implementation stages, while allowing you an opportunity to rate where your organization/system currently is for each consideration.



Pre-Implementation

1. Leading and Communicating

Who is your leadership team? _____

a) Leadership team (including administration, board of directors, etc.) has training on trauma and a trauma-informed approach, including the connection to diversity, equity, inclusion, and accessibility work.	1 2 3 4 5 6 7 8 9 10
b) Leadership team has a plan to allocate some of their own time to the planning, implementation, and sustainability of a trauma-informed organization.	1 2 3 4 5 6 7 8 9 10
c) Organization/system has a written commitment to a trauma-informed approach (e.g., mission/vision, strategic plan, etc.).	1 2 3 4 5 6 7 8 9 10
d) Organization/system creates a designated workgroup or committee to lead the trauma-informed change process.	1 2 3 4 5 6 7 8 9 10
e) Organization/system has a plan to allocate resources (time, money, and workers) to support trauma-informed efforts and activities.	1 2 3 4 5 6 7 8 9 10
f) Organization/system has a plan to engage all stakeholders in the trauma-informed change process.	1 2 3 4 5 6 7 8 9 10
g) Organization/system has a plan for trauma-informed messaging and communication.	1 2 3 4 5 6 7 8 9 10

Figure 16 – Preview of Assessment in Appendix B

The left-hand column of the chart in Appendix A lists different aspects of organizational functioning. You will see a numeric scale from 1 to 10 corresponding to each one on the right. This scale is for you to indicate where your organization/system currently is by using the following rating system:

1 = not yet started	**5 = halfway there**	**10 = ideal implementation**

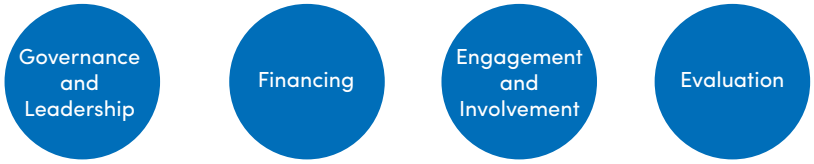
Once you complete this initial assessment, take some time to notice where your organization/system is already in relation to each area. Based on this initial look, where might it make sense to start? This chart will be further broken down and explained in detail throughout the remainder of the manual. Again, the purpose of this first look is twofold:

1. To understand the *big picture* of implementing a trauma-informed approach.

2. To get an initial sense of where your organization/system is already in each of the key development areas.

Key Development Area #1
Leading and Communicating

The Leading and Communicating Key Development Area involves inspiring leadership investment in the trauma-informed change process, creating a Trauma-Informed Workgroup or Committee to oversee the work, increasing readiness to change of all stakeholders through engagement and messaging, and creating the organization's/system's trauma-informed plan. The domains of consideration are:



Leading and Communicating Objectives:

- Understand the importance of leadership commitment and buy-in.
- Develop strategies to increase organizational/system readiness for change.
- Form a Trauma-Informed Committee that meets regularly.
- Develop strategies to evaluate the trauma-informed change process.
- Conduct a trauma-informed organizational self-assessment.
- Create a trauma-informed organizational plan.
- Elicit feedback from all individuals regarding trauma-informed implementation steps.
- Integrate a trauma-informed approach into organizational/system messaging.

Pre-Implementation Stage

Leadership Investment and Commitment

Organizational change is most effectively facilitated with leadership engagement. Without a strong commitment and investment from leadership, it will be difficult to fully address many of the key development areas in a strategic, consistent way across the organization/system. As Dr. Sandra Bloom (2008) states, a trauma-informed approach "really needs to originate with leadership. It can't be bottom-up change.... It can, but it's a lot more difficult. It's like rolling boulders uphill." Unless you are the leader in your organization/system, the first step within the **Pre-Implementation Stage** of the Leading and Communicating Key Development Area is identifying 1) who your leaders are—the CEO, executive director, board, etc., and 2) discerning if they are informed about and invested in creating trauma-informed change. True leadership commitment requires more than agreeing that a trauma-informed approach is a good idea or approving staff time to attend presentations/training.

Consider the **following signs of leadership investment** when thinking about your leadership team:

- Have a full understanding of what it means to be trauma-informed, including the connection to diversity, equity, inclusion, and accessibility work.
- Incorporate a trauma-informed approach into the organization's mission/vision.
- Integrate a trauma-informed approach into the organization's strategic plan.
- Provide resources (time, space, money) for the trauma-informed initiative.
- Allocate some time to participate in trauma-informed implementation.
- Talk about a trauma-informed approach in meetings, newsletters, performance reviews, etc.

Initial Presentation

Leadership commitment starts from having a true understanding of 1) how trauma impacts all individuals in the organization/system, 2) the importance of being trauma-informed, and 3) what it takes for an organization/system to create and sustain trauma-informed change. Many organizations strategically choose to start with initial presentations to their board and executive leadership team for this reason. The purpose of the initial presentation in this case is to increase leaders' awareness of why trauma needs to be acknowledged and how implementing a trauma-informed approach can make the organization more effective at reaching the outcomes they want—such as successful client discharges or staff satisfaction (Hales et al., 2017; Hales et al., 2018). If your leadership is not yet fully invested in trauma-informed organizational change, we recommend following a similar strategy by considering what is important to your leadership and connecting how being trauma-informed can assist or enhance what the organization does to get there.

Mission and Vision

Another successful strategy we have seen and used is deliberately connecting the values and principles of a trauma-informed approach to the organization's/system's values or mission. Staff often only have 10-15 minutes at a leadership meeting to make this initial pitch, so being able to make the argument clearly and concisely for a trauma-informed approach is important. The literature and initiatives around a trauma-informed approach continue to grow—consider what facts, statistics and information will be important, based on your audience and how much time you have.

Several teachers wishing to bring TI-EP to their school district and needing leadership engagement decide to first present to the board of education on how trauma and adversity impact learning, and how TI-EP connects with their district's core values and the restorative practices they already implement.

In order to get leadership investment, the director of nursing briefly presents to the hospital CEO and other administrators on the prevalence of trauma in patients who utilize emergency care, the potential for re-traumatization, and how TIM overlaps with and enhances patient-centered care—a core value of the hospital.

Once leaders are invested in becoming a trauma-informed organization/system, it is important that the mission and/or vision statement reflects their commitment to the trauma-informed approach, including the overlap with diversity, equity, inclusion, and accessibility. There is not one specific way to do this. For example, we have seen organizations add a deliberate section to their mission/vision about being trauma-informed in their work, incorporating the language of the five values and principles, and/or language about how they plan to respond to the prevalence of individual, historical, and/or systemic trauma. Other organizations/systems choose to create a trauma-informed vision statement that is utilized in addition to the primary mission statement. *Modeling the model* of collaboration, it is important for leadership to get input and feedback from the workforce about any changes made to the mission/vision before implementing them.

Modeling the model refers to acting in a trauma-informed manner throughout all interactions.

Strategic Plan

Lastly, leadership commitment is also seen when becoming a trauma-informed organization/system is written into the strategic plan. It is critical that leaders ensure resources—their own time, staff time, money, space—for planning, implementing, and sustaining trauma-informed change. While not all aspects of the key development areas require money to address, many of them do, depending on what resources an organization/system has available to it (e.g., access to training/trainers or changes to the physical environment). In our experience, organizations often set aside professional development or workforce training funds and apply for grant funding as a means of securing money for trauma-informed change. Even if funding for the trauma-informed initiative is limited or unavailable, it is nevertheless important to discuss what can be done in support of the key development areas. Part of incorporating the intent to become trauma-informed in an organization's/system's strategic plan is to decide what is currently possible. Remember that creating trauma-informed organizational change is a process that often takes multiple years—it is more important to overall sustainability to be strategic about what is possible, what makes sense when, and what an appropriate implementation pace is, rather than simply checking the boxes associated with each key development area.

Forming a Trauma-Informed Committee

Given the multifaceted nature of trauma-informed organizational change, leaders who champion the change process by providing direction for implementation and change are critical (Koury & Green, 2017; Shultz, 2014). Planning for and creating culture change is often too much for one or two people. Thus, it is important for your organization/system to **form a committee, workgroup, or team *prior* to moving into the Implementation Stage**. The purpose of this group may change over time—however, at minimum, it will be important for group members to oversee, plan, and manage the change process. We continue to find it is very helpful to have a team of individuals to keep the initiative active and focused.

Given the committee's purpose, all members will require the same knowledge and understanding of a trauma-informed approach as discussed in the Leadership Investment and Commitment

section. At least some members of the team need to be in roles where they can make decisions about policies and procedures; others can be in different job roles and functions. Ideally, the committee will be the most successful with diverse representation from leadership and all levels of staff, and will consider how the voices of clients/patients/students/consumers will be incorporated. Whether you choose to incorporate them as members or create a deliberate plan to elicit feedback from them throughout the change process is up to your organization/system. However, it is critical that steps are taken to address barriers of power, privilege, and fear when asking for feedback by being transparent about why feedback is being collected, how it will be used, and how constituents will hear about the results (and then following through on that plan). No matter who becomes a member of the Trauma-Informed Committee, there is a need to establish a system in which the committee can propose decisions and action steps that are informed by feedback from the rest of the organization/system.

After having an initial TI-EP presentation at the school's faculty meeting, the principal asked for volunteers from his teachers and staff to be part of the TI-EP committee with him. He also extended invitations to specific teachers and staff members whom he thought would be a good fit, based on the needs of the school.

There is no magic number of individuals who need to be included on the team. We recommend that leadership consider the size of the organization/system, and logistics of gathering groups together, based on schedules and space. A small organization may decide a team of four or five is enough, whereas a larger system like a school district or hospital system may decide to have teams in each of the buildings or locations. Additionally, committees with a lot of members can decide to divide the larger group into subcommittees, based on the goals, such as having a policy, environment, and training subcommittee.

Creating trauma-informed organizational change is a process that often takes multiple years—it is more important to overall sustainability to be strategic about what is possible, what makes sense when, and what an appropriate implementation pace is, rather than simply *checking the boxes* associated with each key development area.

The trauma-informed change process is at minimum two to three years long, especially for larger systems.

Creating the Trauma-Informed Organizational Plan

With leadership, organization/system commitment, and a Trauma-Informed Committee in place, the committee is now in a position of creating a trauma-informed organizational plan. With the goal of overall sustainability, it is important that the organizational plan is realistic and anchored in the mission/vision and overall organization's/system's strategic plan, and that it is flexible enough that adjustments can be made along the way. We also recommend that committees consider gathering some level of baseline evaluation data (see the Evaluating and Monitoring Progress Key Development Area starting on Page 116) as a means of making deliberate decisions about where the organization/system may need to focus energy and resources first.

Although there are recommendations and strategies throughout this manual for how to think about trauma-informed planning and implementation, there is no one-size-fits-all approach to becoming trauma-informed. Our recommendation is for everyone on the committee to understand what it takes by becoming familiar with the 10 key development areas in this manual, and then applying that knowledge to decide where it makes sense for your organization/system to begin. While the trauma-informed organizational plan will address all the key development areas at some point, the order in which they are addressed is flexible, based on your organization's/system's strengths, needs, and resources.

The trauma-informed change process is **at minimum two to three years long**, especially for larger systems. Organizations/systems will not address all 10 key development areas in full within the first year. In our experience, the committee can revisit the organizational plan at least annually. Mapping out the first three, six, nine, and 12 months, and then engaging in regular progress monitoring are good places to start. Once the committee decides on the priority key development areas, the appendices and other tools in the manual can be utilized to plan and implement action steps accordingly.

Planning and Discussion

The charts found in **Appendix C** and **Appendix D** can be used by the Trauma-Informed Committee to discuss, assess, and plan for the components of the Leading and Communicating Key Development Area within the Pre-Implementation Stage. The worksheets' considerations and format are similar to Appendix B that was reviewed in the Getting Started section of this manual—however, there are now follow-up questions associated with each of the considerations and some space for you to write answers to these questions. Directions for their use can be found at the beginning of each appendix.

Implementation Stage

SAMPLE LEADING AND COMMUNICATING ACTION STEPS
☐ **Train** leadership on trauma and trauma-informed approaches.
☐ **Form** a Trauma-Informed Workgroup or Committee with inclusive and diverse membership.
☐ **Reflect** commitment to trauma-informed practices in mission/vision/strategic plan.
☐ **Align** current and new initiatives with trauma-informed practices.
☐ **Allocate** resources to support trauma-informed efforts and activities.
☐ **Create** a trauma-informed organizational plan that ensures inclusive practices.
☐ **Engage** individuals and the workforce in the trauma-informed change process.
☐ **Communicate** organizational commitment to trauma-informed practices.

Leadership of the Trauma-Informed Committee

The task of the Trauma-Informed Committee during the **Implementation Stage** is to lead the trauma-informed change process. To do this, the committee needs to be active and meet regularly (e.g., having a standing meeting each month). The purpose of a regular committee meeting is to continue to plan for, adopt, and monitor action steps within the key development areas, based on the trauma-informed organizational plan that was developed in **Pre-Implementation**. During the ongoing meetings, the Trauma-Informed Committee can continue to use the guidance of this manual alongside various tools within the appendices to identify priority areas within each key development area and formulate action steps.

It is critical that the committee regularly use a portion of the meeting to reflect on both progress and challenges, and based on those conversations, to make changes to the trauma-informed organizational plan as needed. Though the overall framework of what organizations intend to follow to address the key development areas generally remains the same, the means of reaching goals may change, based on lessons learned from the process of **implementing, reflecting, and adjusting the plan as needed**. For example:

The training plan in one hospital we worked with initially included rotating small groups of staff off the floors to do follow-up activities and structured consultation after the initial trauma 101 presentation. We quickly realized with the hospital team that our original plan was not feasible or sustainable, based on staffing concerns, so the plan was modified to incorporate the use of more visuals depicting trauma-informed practices and an increase in real-time coaching and education instead.

The goal of providing short- and long-term follow-up to the original trauma 101 presentation stayed the same, but the means of how we achieved it needed to be modified, based on the feedback we received once we started implementing it. Additionally, the timing of implementing specific action steps or the order of focusing on key development areas may change because of organizational/systemic priorities changing.

Many of the organizations we had already been working with prior to the COVID-19 pandemic had outlined goals and objectives to focus on a wide range of key development areas—from training, to screening, to working on the physical environment. Almost all of those goals shifted in some way or another to focus on addressing the impact of the work as a means of supporting the workforce during a time of ongoing crisis because that was the main priority.

Establishing a means for others to provide suggestions and feedback regarding the trauma-informed change process is important for modeling the model of collaboration and for overall sustainability.

Eliciting Feedback

A second critical consideration for the Trauma-Informed Committee within the **Implementation Stage** is establishing a feedback loop with members of the workforce and clients/patients/students/consumers. Although the committee is tasked with leading the change process, it cannot make decisions for the organization/system in a vacuum. Establishing a means for others to provide suggestions and feedback regarding the trauma-informed change process is important for modeling the model of collaboration and for overall sustainability. The means used to engage and involve the workforce and clients/patients/students/consumers can vary—from having the topic as a bullet point on regular workforce meeting agendas, to creating client/patient advisory boards or student trauma-informed teams to inform the committee, to holding focus groups, to using some form of survey with all stakeholders. Regardless of the method chosen, it is key that feedback and suggestions are actively asked for (as opposed to a passive approach of telling people they can provide feedback if they wish) from diverse groups of individuals, and that there is a means for the Trauma-Informed Committee to report back out to those whose opinions were gathered.

Keeping meeting minutes and posting them in a spot where the workforce can see them, and having a member of the committee report out during a workforce meeting with opportunities for gathering feedback are two examples of how we have seen committees be transparent about incorporating feedback and decision-making.

Leadership Involvement

Lastly, it is important for executive leadership/administration to be involved with the Trauma-Informed Committee. We recommend having such representation on the committee itself—however, if that is not currently feasible, it is important to ensure that the committee is able to meet with leadership/administration regularly.

Again, as a trauma-informed approach needs to come from the top, leadership/administration needs to be fully informed of all trauma-informed efforts, activities, and changes to engage in transparent messaging across the organization/system regarding the initiative (see more about messaging in the following subsection). Having leadership/administration involvement is important to implement action steps and make changes—many of which need approval and resource investment from those in charge. Especially if not directly in the committee, we advise that leadership/administration be deliberate about defining the committee's role, empowering members to make decisions about planning and implementation, and scheduling time for discussing and approving action plans.

The director of behavioral health in one hospital system we worked in decided that, based on her current workload and wanting to empower staff members to lead the trauma-informed initiative, she was not going to be part of every committee meeting. However, she scheduled bimonthly meetings with the committee to hear suggested implementation steps and worked with committee members to gather the support and resources needed to do the work.

Trauma-Informed Messaging

Now that the organization/system has committed to becoming trauma-informed via incorporating language into the mission/vision and its strategic plan, it is important for leaders to continue to demonstrate their commitment to a trauma-informed approach by using deliberate trauma-informed messaging. First, leaders need to continue to engage in **transparent, inclusive communication about all trauma-informed efforts, activities, and changes.** To model the model of trustworthiness, all members in the organization/system need to be informed about the change process, even if they are not directly involved in the change activities themselves.

Information regarding the trauma-informed change process can be communicated by using vehicles such as newsletters, emails, posting the Trauma-Informed Committee's meeting minutes, and dedicating a few minutes at each workforce meeting for updates to be reported.

We also invite leadership to consider how communication strategies and styles model the trauma-informed values and principles of safety, trustworthiness, choice, collaboration, and empowerment in general—not only specifically in relation to the trauma-informed change process. For example, how is leadership mindful of the impact of nonverbal communication (safety), ensuring consistency or routine in the way information is delivered (trustworthiness), intentionally highlighting the options or alternatives available (choice), offering opportunities for others to give feedback on what is being communicated (collaboration), and highlighting events or information that helps build a realistic sense of hope (empowerment)?

Convey messages in inclusive, responsive ways.

Make Messaging Visible

Second, it is critical to overall investment and engagement for those in the organization/system to see that the trauma-informed approach is more than just attending training—having visuals and consistent messaging related to a trauma-informed approach will demonstrate that the organization/system is truly committed to the change process. There are various ways for this to happen. Our recommendation is to first consider what the organization's/system's overall goal for messaging is, how you already communicate information, what locations individuals often pass by or spend prolonged time in, and what has worked well in the past to convey messages in inclusive, responsive ways.

Many organizations/systems we have worked with make use of their internal or external newsletter by designating a corner or a page to something related to a trauma-informed approach—whether that be updates on implementation, recognizing staff, and/or departments engaging in any of the five trauma-informed values and principles, and/or providing snippets of trauma-informed information.

Another strategy is having leadership and/or the Trauma-Informed Committee be deliberate about sending out a few sentences or bullets each week (via email, mailbox, etc.) on specific trauma-informed strategies, such as having a trauma-informed practice (TIP) of the week. This can also include tips for self-care and wellness (see the Addressing the Impact of the Work Key Development Area).

*Having brief reading and other visual materials in common spaces can go a long way—especially when incorporated intentionally with other messaging strategies. See **Appendix E** for sample posters/visuals that we have used to message the trauma-informed values and principles as a visual reminder of consultation and coaching discussions.*

When thinking about an overall messaging strategy, many organizations/systems consider a trauma-informed theme of the month, where the focus of the newsletter, emails sent out, check-ins during workforce meetings, visual and reading materials, etc. are anchored in that theme (e.g., one of the values and principles). In our experience, having a theme helps the workforce begin speaking the same language and serves as a framework for weaving the trauma-informed approach into the organization's/system's fabric. A thematic messaging strategy allows for organizations/systems to **ensure follow-up** to messaging more easily, which is the last critical consideration. Messaging is designed to *support* the continued integration of trauma-informed practices, not take the place of real-time education and conversations.

Planning and Discussion

The charts found in **Appendix F** and **Appendix G** can be used by the Trauma-Informed Committee to discuss, assess, and plan for the components of the Leading and Communicating Key Development Area within the **Implementation Stage**. The worksheets' considerations and format are similar to Appendix B that was reviewed in the Getting Started section of this manual—however, there are now follow-up questions associated with each of the considerations and some space for you to write answers to these questions. Directions for their use can be found at the beginning of each appendix.

Sustainability Stage

Maintaining Action Steps

Sustainability within the Leading and Communicating Key Development Area is reached when the organization/system has key practices in place to maintain trauma-informed leadership, communication, and feedback-gathering from all levels of stakeholders, as well as resources to support a trauma-informed culture and climate. **The Trauma-Informed Committee can use the following checklist to ensure that the key practices are in place:**

- ☐ The Trauma-Informed Committee has a standing meeting.
- ☐ There is a schedule for intentionally revisiting the trauma-informed communication and messaging plan.
- ☐ There are adequate resources (time, money, workers) allocated to support ongoing communication and messaging.
- ☐ The leadership team has scheduled opportunities to participate in trauma-informed trainings, meetings, and activities.

Making a Commitment

The majority of the sustainability practices listed above involve scheduling—making sure that there is protected time on the calendar for the committee to meet and engage in ongoing progress monitoring of the core components in this key development area. In addition, it is important to have leadership committing to participate in trauma-informed training, meetings, and activities over time. The best way we have seen to make such scheduling happen is by designating someone on the Trauma-Informed Committee as the lead person for maintaining calendars. This individual can keep track of what is scheduled and what needs to be scheduled, and oversee reaching out to the individual(s) who need to be involved.

Additionally, in the **Sustainability Stage** of the Leading and Communicating Key Development Area, we encourage the Trauma-Informed Committee to commit to **revisiting Appendices A and B in full**, as well as any evaluation feedback, at regular intervals during its standing meeting (e.g., quarterly, or twice a year) to have a mechanism for maintaining the trauma-informed organizational plan in a way that recognizes the fluidity of sustainability.

It is important to have leadership commit to participating in trauma-informed training, meetings, and activities over time.

Key Development Area #2
Building a Trauma-Informed Workplace

The Building a Trauma-Informed Workplace Key Development Area involves hiring practices, new-hire orientation, and other human resources (HR) practices and materials related to the workforce (e.g., handbooks, policies, procedures) being developed, conducted and/or presented in ways that are trauma-informed and trauma-sensitive, including a focus on building a diverse and inclusive workplace. The domains of consideration are:

Building a Trauma-Informed Workplace Objectives:

- Recognize effective methods of increasing your organization's/system's ability to build an inclusive, trauma-informed workforce and work environment.
- Develop trauma-informed interview questions to be used in the hiring process.
- Plan for the inclusion of trauma-informed information or education in new-hire orientation.
- Interview individuals and conduct new-hire orientation in a way that models the model of being trauma-informed.
- Review all employment-related documents, policies, and processes with a trauma-informed lens.

Pre-Implementation Stage

Who is Your Workforce?

Before delving into the details of this key development area, we invite you to consider who comprises your workforce. The considerations within the Building a Trauma-Informed Workplace Key Development Area apply to all full- and part-time employee roles, and to temporary employees, volunteers, students (e.g., interns, residents), consultants, etc. As you read the following sections, be sure to have the makeup of your organization's workforce in mind, and think about how the planning and implementation steps apply to each category of workforce member.

Review of Recruitment and Hiring

The first step in the Building a Trauma-Informed Workplace Key Development Area within the **Pre-Implementation Stage** is to **create a plan for trauma-informed recruitment and hiring**. As part of the plan, the Trauma-Informed Committee needs to consider who will review current job descriptions, postings, and interview questions. How do current job descriptions accurately define roles, responsibilities, and expectations? When and how often will they be reviewed? How will the interview process demonstrate an organizational commitment to trauma-informed practices, such as by asking questions about relevant knowledge and experience, or by providing information to possible new hires?

Planning to hire a diverse, inclusive workforce that is knowledgeable about trauma and a trauma-informed approach starts with considering whom you want to recruit and the job postings themselves. Actively recruiting and hiring individuals with formal education, training, and experience in using a trauma-informed approach are important to trauma-informed organizational change (SAMHSA, 2014b). Given that organizational change requires all workforce members to have at least foundational training in trauma and a trauma-informed approach, we recommend including language about having formal education, training and/or experience in the trauma-informed approach in the *preferred* qualifications for most, if not all, job postings. For some—such as counselors or direct care staff—such knowledge may be listed as required qualifications once your organization/system is further along in the organizational change process. Depending on the setting of your organization/system, it may be important to think about actively recruiting and hiring individuals who have formal training and experience in screening, assessing and/or treating trauma (see Screening for Trauma and Treating Trauma key development areas for more details).

Additionally, trauma-informed organizations have a commitment to diversity, equity, inclusion, and accessibility. It is important for diversification to plan for and implement policies to address hiring inequities and to actively recruit various communities. It is critical for all positions to hire individuals who represent the populations your organization works with.

TRAUMA-INFORMED RECRUITMENT: A SUMMARY

- Seek formal education, training, and experience in using a trauma-informed approach.
- Seek formal training and experience in screening, assessing, and/or treating trauma.
- Create a position to be responsible for overseeing the trauma-informed change process.
- Model the model of a trauma-informed approach that includes a commitment to diversity, equity, inclusion, and accessibility by ensuring the job postings and interview questions are anchored in the five guiding values/principles.
- Have policies to address hiring inequities, and promote outreach and recruitment of diverse communities.

Having someone whose job is dedicated to coordinating, tracking, and facilitating many of these components can help ensure consistency and overall sustainability.

Consider a Trauma-Informed Coordinator Position

Another possible consideration for recruitment is creating a position to be responsible for overseeing the trauma-informed change process. This individual could be part time or full time and would minimally coordinate all trauma-informed activities. In our work with organizations, we have seen the benefit of having an internal point person for the trauma-informed change process—both as a coordinator and a trainer.

One medium-sized agency hired a full-time trauma coordinator who worked with the agency's administrators and us at ITTIC to create and modify the trauma-informed organizational plan, coordinate meetings and trainings, provide trainings and coaching, and assist in the review of some procedures and forms.

A large hospital system created a full-time director of Trauma-Informed Care position as part of its commitment to becoming more trauma-informed. This individual reports directly to the chief medical officer and is in a position of training, creating messaging, leading the committee, and supporting all other trauma-informed activities.

Trauma-informed organizational change involves many moving parts. Having someone whose job is dedicated to coordinating, tracking, and facilitating many of these components can help ensure consistency and overall sustainability. Ideally, this individual already has expertise in the trauma-informed approach and in creating trauma-informed organizational change. "Experience delivering training on trauma and a trauma-informed approach" is recommended language for preferred qualifications for this position.

Regardless of the position, it is important for the **posting to model the model of a trauma-informed approach by reflecting the five guiding values and principles**. Does the posting ensure trustworthiness by including clear, accurate, transparent job responsibilities, skills required, and expectations? Is it clear how to start the application process and whom to contact? Is it written in a way that is empowering by depicting what is expected of prospective employees rather than what is not allowed? Is it inclusive of gender, race, and ability? Does it promote equity by posting salary ranges and considering equivalent experience as comparable to formal education? Is the posting circulated to diverse communities?

A sample job description written with a trauma-informed lens can be found in **Appendix H**.

Interview Questions

Another part of the trauma-informed hiring and recruitment plan to consider in **Pre-Implementation** is incorporating interview questions on trauma, equity, and a trauma-informed approach into the interview process. To start, we recommend that the organization/system craft an opening statement used in all position interviews about the importance of a trauma-informed approach, and that it is an expectation that staff members will use a trauma-informed lens in all aspects of their work (Trauma Informed Oregon, 2014). This statement can be expanded upon by including how the organization/system operationalizes the five guiding values and principles and commits to anti-racism and anti-oppression, with follow-up questions to assess how applicants see themselves aligning with the organization's/system's trauma-informed perspective.

Some organizations we have worked with have included their trauma-informed vision statement or an opening statement as described above as something for potential applicants to review prior to the interview process. As a result, applicants have an awareness of the organization's trauma-informed approach and can better respond to the interview questions, even if they have no prior experience. The presence of a written statement also sends a message of the organization's commitment to being trauma-informed.

Depending on the position being interviewed for, the organization/system can incorporate a few or variety of questions that assess the applicant's experience working with individuals who have trauma; their knowledge of individual, racial, historical, and systemic trauma and their impact; their knowledge of and experience with the trauma-informed approach; and/or their experience with evidence-based screening tools and treatment interventions for trauma. Please see **Appendix I** for a list of sample trauma-informed interview questions.

*Many organizations we have worked with have formally incorporated in their interview process one or two questions like those listed in **Appendix I**. Others, especially those that do not have as much control over the questions, have verbally found ways to incorporate similar themes into the interview.*

Consider incorporating interview questions on trauma, equity, and a trauma-informed approach.

Focus on What You Can Control

We recognize that some organizations and systems may not have a lot of direct control over their recruitment and hiring plan. If you cannot change job descriptions, postings, or interview questions, we encourage you to focus your energy within this key development area on what you do have some control over. That is, what happens when employees are hired and begin their jobs? Time spent introducing them to the mission and vision of your organization/system, how the organization/system operationalizes trauma-informed practices, and how the particulars of their jobs fit into both can still send a similar message. Organizations/systems may choose to do this via individual or small group meetings with leaders, or through a formal new-hire orientation process.

Review of New-Hire Orientation

The next consideration for the Building a Trauma-Informed Workplace Key Development Area in the **Pre-Implementation Stage** is **planning for how foundational education on trauma (including historical and racial trauma) and a trauma-informed approach will be incorporated into new-hire orientation.** New workers will likely come to the organization/system with differing levels of knowledge and experience, so it is important to ensure that everyone has the same foundational learning to build upon when creating a trauma-informed culture. How and when this education is provided can vary, based on what the organization/system already has in place for new-hire orientation and what will be sustainable.

Some organizations/systems build in time during an in-person, new-hire orientation before workers begin their jobs, while others require that workers attend a trauma 101 presentation or watch existing online modules within the first few months of being hired.

Schools often provide a trauma 101 presentation for new teachers and staff during staff development days shortly before the school year begins, or they use time during a half-day or staff development day in the fall.

Even if formal education cannot be provided prior to workers' starting their jobs, we recommend that deliberate messaging regarding the organization's/system's commitment to being trauma-informed be included to set the tone. As previously discussed, this can be especially important for organizations and systems that are not able to engage in messaging during the recruitment and hiring processes.

One agency that we worked with did not have the means to incorporate trauma-informed education in its new-hire orientation directly. Instead, it created a 10-minute video that had a welcome message from the executive director, including the importance of a trauma-informed approach to the agency and the timeline for when new hires would receive training. In addition, various staff members described and acted out what a trauma-informed approach looks like in their programs.

It is important to remember that offering initial information or formal education during new hire-orientation is just one part of the organization's/system's overall trauma-informed training plan. Because trauma-informed learning requires a digestive process, the content included, means of delivery, and timing of the new-hire education are all dependent on what the big-picture training plan is. How to think about creating an overall training plan and other important training considerations are discussed in more detail in the Training the Workforce (Clinical and Non-Clinical) Key Development Area section of the manual.

Trauma-Informed Orientation Experience

In addition to planning to incorporate information or education, we recommend that organizations and systems plan for an overall trauma-informed orientation or onboarding experience. The Trauma-Informed Committee can consider issues such as how new hires will have formal time to meet current employees, how new hires will be trained and mentored to be successful in their roles, how there will be time for new hires to provide feedback on their observations of the workplace, and how there will be a focus on resources and information on employee wellness or self-care. Starting a new job can be stressful for anyone—it is important to have the process of becoming an employee *model the model* of the trauma-informed values and principles of safety, trustworthiness, choice, collaboration, and empowerment. The above topics can help greatly in this regard. More examples of trauma-informed hiring and orientation practices are described in the **Implementation Stage**.

Review of Human Resources (HR) Practices

The last consideration within the **Pre-Implementation Stage** is ensuring that the organization/system has a **plan for reviewing its human resources practices**. Having representation from human resources or unions on the Trauma-Informed Committee can be very useful in these discussions. If representatives from HR/unions are not formally a part of the committee, we highly recommend that the committee set up meeting time with them when working on this key development area. Together, you can create a plan for what HR and/or other employment practices need to be reviewed with a trauma-informed lens, when they will be reviewed, and by whom, and how often they will be revisited after the initial review.

Such practices will be discussed further in the **Implementation Stage**. However, examples of what the Trauma-Informed Committee can plan to review include documents such as employee handbooks, and statements of employee rights and responsibilities, as well as mechanisms such as performance reviews, internal investigation processes, benefits programs, and other wellness supports, policies pertaining to workforce conduct, and how staff members are recognized and acknowledged. One can anticipate that there may be some overlap between the review of policies and procedures, and addressing the impact of the work when reviewing human resource practices. However, it is important to have an intentional HR and employee focus to ensure the most trauma-informed experience for the workforce.

Planning and Discussion

The charts found in **Appendix J** and **Appendix K** can be used by the Trauma-Informed Committee to discuss, assess, and plan for the components of the Building a Trauma-Informed Workplace Key Development Area within the **Pre-Implementation Stage**. The worksheets' considerations and format are similar to Appendix B that was reviewed in the Getting Started section of this manual—however, there are now follow-up questions associated with each of the considerations and some space for you to write answers to these questions. Directions for their use can be found at the beginning of each appendix.

It is important to have an intentional HR and employee focus to ensure the most trauma-informed experience for the workforce.

Implementation Stage

SAMPLE BUILDING A TRAUMA-INFORMED WORKPLACE ACTION STEPS
☐ **Design** trauma-informed interview questions and job postings.
☐ **Ensure** hiring processes model values of trauma-informed practice.
☐ **Review** handbooks and other HR documents with a trauma-informed lens.
☐ **Consider** how building a diverse, inclusive workforce enhances safety and trust.
☐ **Hire** employees who are knowledgeable about trauma and trauma-informed care.
☐ **Create** explicit HR policies prohibiting harassment and discrimination.
☐ **Incorporate** trauma-informed values into performance evaluations.
☐ **Provide** performance reviews in culturally and individually responsive ways.
☐ **Include** foundational information on trauma and trauma-informed approaches in orientation.

Trauma-Informed Hiring and Orientation Practices

Within the **Implementation Stage**, the organization/system puts the job postings, interview questions, and plan for introducing trauma-informed practices to new hires into action. The organization/system also takes steps to **ensure that all aspects of the hiring and orientation process are trauma-informed**. In addition to the changes previously described, other hiring and orientation protocols and procedures are reviewed for how well they are anchored in the five guiding values and principles, and adjusted as needed (Harris & Fallot, 2001). **Figure 26** on Page 61 gives examples of how various aspects of hiring and orientation processes can be trauma-informed as a way of gauging your own practices.

Trauma-Informed Employment Practices

The second component of this key development area within the **Implementation Stage** is to **ensure that ongoing employment practices—including written documents, and policies and protocols, are also in line with the five trauma-informed values and principles** (Harris & Fallot, 2001).

Trauma-Informed Values and Principles

All documents and protocols related to HR (such as employee handbooks; employee rights, responsibilities, and conduct; job descriptions; organizational charts and staffing plans; employee performance metrics; etc.) are reviewed and revised to be more trauma-informed. Much like the job postings discussed in **Pre-Implementation**, written HR documents can build **trustworthiness** with staff by being transparent, accessible, and accurate. For example, do job descriptions accurately define roles, responsibilities and what is expected of someone in that position? Are job descriptions and protocols revised, based on changes in the organization/system and/or changes to positions as time goes on? Does the employee handbook clearly lay out what is expected of staff and what staff can expect from the organization/system (including consequences) in a way that is accessible?

Many organizations have extensive employee handbooks or other documents that explain procedures, protocols, and conduct that staff members are expected to follow while on the job. Some decide to use this review time to ensure that policies/protocols are in line with trauma-informed values and principles, and to update and streamline them to promote transparency and accessibility for staff. Others create shorter universal policies with specific sections for various roles.

How do HR policies and protocols related to scheduling, holiday and sick time, benefits, and training and development incorporate a level of employee **choice and collaboration**? HR can also promote **safety and empowerment** by being intentional about protocols and supports for the workforce. Are there explicit policies prohibiting discrimination, microaggressions, and harassment? Does HR have processes in place to address issues regarding racial or other equity-related barriers in the workplace? What policies are in place to support staff following critical incidents, including paid time off? How does HR contribute to acknowledgement of staff members through activities such as employee spotlights, celebrating staff successes, and sponsoring events and gatherings? What supports for workforce wellness are in place, such as employee assistance programs, having a calming room or space specifically for staff or benefits such as gym memberships, etc.? To what extent do benefit packages provide choices to staff members and address mental health coverage? How do staff performance metrics and plans focus on development and support?

One organization we worked with incorporated the five values and principles into their staff performance metrics. Staff members were evaluated on and had to evaluate themselves on their intentional use of safety, trustworthiness, choice, collaboration, and empowerment as part of their performance reviews. Additionally, the organization used the values and principles to guide their performance improvement plan protocol—both the written document and the way staff members were engaged in the conversation.

We recommend looking more carefully at the Addressing the Impact of the Work, and Reviewing Policies and Procedures key development areas in conjunction with considering the answers to these questions for more implementation examples and ideas.

Considering Language

Lastly, being trauma-informed includes recognizing the potential of re-traumatization by verbal and written communication. Therefore, in addition to considering the trauma-informed values and principles, review written documents for the use of **positive, inclusive, and trauma-informed language**. While trauma-informed documentation and language will be discussed in more detail in the Reviewing Policies and Procedures Key Development Area, below are some initial guidelines to consider for HR documents:

Ensure expectations are written in order to describe the desired behavior/outcome (rather than using "no," "not allowed," "cannot," etc.

Replace shame/blame language (e.g., "staff should") and absolutes (e.g., "staff must") with language regarding what is expected (e.g., "staff is expected to...")

Planning and Discussion

The charts found in **Appendix L** and **Appendix M** can be used by the Trauma-Informed Committee to discuss, assess, and plan for the components of the Building a Trauma-Informed Workplace Key Development Area within the **Implementation Stage**. The worksheets' considerations and format are similar to Appendix B that was reviewed in the Getting Started section of this manual—however, there are now follow-up questions associated with each of the considerations and some space for you to write answers to these questions. Directions for their use can be found at the beginning of each appendix.

SAFETY

- Conduct interviews and orientations in ways that are welcoming, respectful, and engaging.
- Include safety training and/or review of safety protocols in new-hire orientation.
- Establish a protocol for how current workers welcome, meet, and support new workers.
- Ask what each person prefers to be called.
- Provide an overview of the environment (e.g., emergency exits, location of bathrooms, breaks that will occur, etc.).
- Provide the opportunity to access refreshments (e.g., water, coffee) and the bathroom prior to starting an interview and/or throughout a new-hire orientation.

TRUSTWORTHINESS

- Ensure job postings are transparent about tasks, responsibilities, and expectations.
- Provide clear information on what to expect before and during the interview and orientation process.
- Be transparent about the purpose of any background checks or pre-employment tests.
- Ensure workers at the front desk are aware of who is coming in for an interview and when.
- Ask if interviewees need clarification or rewording of questions.
- Inform applicants in a timely and respectful manner if they are not selected.
- Include review of responsibilities and expectations in new-hire orientation (verbal and in writing).

CHOICE

- Provide some choice in time frames for interviews, whenever possible.
- Incorporate various ways for staff members to learn about their jobs and workplace environment.
- Inform applicants and new staff of their options in the workplace.

COLLABORATION

- Provide opportunities for feedback, and elicit opinions during the hiring and orientation process.
- Negotiate hours, salaries, and benefits in a way that is collaborative and inclusive, whenever possible.
- Be intentional about including and working with new hires.

EMPOWERMENT

- Inquire about strengths and capacities during the interview.
- Provide job training/opportunity for shadowing during the orientation process.
- Encourage and promote a culture of learning.

Figure 26 *– Sample Trauma-Informed Hiring and Orientation Practices*

Sustainability Stage

Maintaining Action Steps

Sustainability within the Building a Trauma-Informed Workplace Key Development Area is reached when the organization/system has key practices in place to promote and maintain the trauma-informed values and principles in all phases of employment. **The Trauma-Informed Committee can use the following checklist to ensure that the key practices are in place:**

- ☐ There is a schedule for regularly reviewing employee handbooks, paperwork, and HR-related policies and practices.
- ☐ There is a schedule for regularly reviewing job postings and descriptions.
- ☐ Foundational information on trauma and trauma-informed approaches is given as part of the new-hire orientation process.
- ☐ There is a method for employees to provide anonymous feedback about the emphasis on the commitment to a trauma-informed approach and equity in employment processes.
- ☐ Trauma-informed practices are incorporated into employee performance metrics.

Making the Commitment

The key practices for sustainability require a commitment to scheduling and implementing protocols. It is important to have someone on the Trauma-Informed Committee or in HR ensure that calendar time is protected for the purpose of reviewing HR-related documents and processes at the interval agreed upon. That could mean HR staff members and others involved in the review process join the committee meeting at a regular interval, or a separate time could be set up. Additionally, sustainability requires both protocols and resources to support the provision of trauma-informed information at new-hire orientation, intentionally gathering and reporting on feedback about employment processes, and a means of tracking trauma-informed practices as a valued employee performance metric—such as building it into a performance evaluation form used by all supervisors.

Additionally, in the **Sustainability Stage** of Building a Trauma-Informed Workplace, we encourage the Trauma-Informed Committee to commit to **revisiting Appendices J, K, L, and M**, as well as any feedback regarding employment processes, at regular intervals during its standing meeting (e.g., quarterly or twice a year) to allow for flexibility and ongoing progress monitoring within this key development area.

The key practices for sustainability require a commitment to scheduling and implementing protocols.

Key Development Area #3
Training the Workforce (Clinical and Non-Clinical)

The Training the Workforce (Clinical and Non-Clinical) Key Development Area involves having a realistic and sustainable plan for ongoing trauma-informed education and training for all levels of the workforce. The domain of consideration is:

Training the Workforce (Clinical and Non-Clinical) Objectives:

- Create a plan for ongoing training of the workforce on all components of a trauma-informed approach.
- Allocate resources for trauma-specific training (e.g., evidence-based interventions).
- Form an internal Champion Team that includes trainers, mentors, and/or coaches.

Pre-Implementation Stage

Planning for Trauma-Informed Training

An important component of becoming a trauma-informed organization/system is staff training. Given that a trauma-informed approach requires an organizational shift, all levels of the workforce—regardless of role—need at least foundational education on trauma and a trauma-informed approach. Asking workers to attend a one- or two-time presentation is not enough. Ensuring that there are means of both short- and long-term follow-up with the workforce receiving trauma content is also critical because learning about trauma and a trauma-informed approach is truly a digestive process (Harris & Fallot, 2001; Koury & Green, 2017). Because of this, at a minimum we require that workers have some form of in-person follow-up within 30 to 45 days of the initial presentation in our work with organizations. This allows them to continue to consider what being trauma-informed means for their roles. Sometimes organizations/systems are excited to begin the change process and offer foundational education to staff without necessarily having a plan for ongoing discussion.

In our experience, the workers can then feel frustrated about learning trauma information without having sufficient time to discuss how they are able to respond, or they begin to think about trauma-informed practices as another flash-in-the-pan initiative. Not only is it best practice to ensure ongoing trauma-informed training rather than doing a content dump, it also avoids false starts.

Therefore, we highly recommend that in the **Pre-Implementation Stage**, organizations/systems **create a training plan before providing any education**. There are many layers to think about, including:

Who: Who still needs foundational education? For example, considering how many workers have yet to receive trauma-informed education and understanding their roles are critical components of informing the training plan—both the how and what below. Additionally, the organization/system needs to consider who will deliver the foundational education and ongoing training.

Organizations/systems are invited to consider their current culture. Some may recognize the need for outside consultants to deliver at least the foundational education, based on workers responding better to an outside expert. Others know that there are key, influential members of the workforce whom others respect and listen to, based on their time in the organization/system or because of their roles.

When we work with organizations, we provide the initial education and ongoing training, consultation, and coaching. However, part of our process is to build capacity for a core group of individuals within the organization to deliver foundational education and/or be in the role of mentor or coach. We will discuss the importance of forming a team with trainers, mentors, and/or coaches in the Implementation Stage of this key development area. This is also important for financial sustainability.

Ensuring that there are means of both short- and long-term follow-up with the workforce receiving trauma content is critical.

What: What type of information is needed for the individuals you identified above? Everyone in the organization/system—from support staff to the board—needs to receive at least foundational education, and as previously discussed, it is best practice to at least have a one-time follow-up, if not ongoing follow-up discussions. However, some workforce roles can receive more in-depth or different types of training, such as leaders and supervisors having content on trauma-informed leadership and supervision, and clinical staff being trained in trauma-specific treatments. We will discuss content of training more in the **Implementation Stage** section of this key development area.

When: When will foundational education occur? As a separate time for training? In orientation or staff development days? Within the context of staff meetings? What about the ongoing training components? Additionally, consider the overall timeline for all current staff completing foundational education, when new staff will receive it, and the actual time for presenting content, depending on what is possible.

How: Given the number of staff who can do the training, when it is possible to train, and your overall resource capacity, how will the education and training be facilitated? Will it be rolled out to everyone at once, or will it be done according to role or department? Will training be offered in-person, online, or both?

Some organizations/systems choose to hire outside consultants to provide psychoeducational presentations focused on this content, while others make use of various online courses and webinars. Others use both—for example, hiring outside consultants to provide education to current workers, as well as building in online education into new-hire orientations. Generally, organizations/systems utilize their own workers to facilitate ongoing conversations, based on resources and sustainability.

The two-page worksheet found in **Appendix N** will help you begin structuring an overall training plan for your organization/system in light of these considerations. Our recommendation is to read the remainder of this key development area's section prior to printing and filling out the worksheet.

Planning and Discussion

The charts found in **Appendix O** and **Appendix P** can be used by the Trauma-Informed Committee to discuss, assess, and plan for the components of the Training the Workforce (Clinical and Non-Clinical) Key Development Area within the **Pre-Implementation Stage**. The worksheets' considerations and format are similar to Appendix B that was reviewed in the Getting Started section of this manual—however, there are now follow-up questions associated with each of the considerations and some space for you to write answers to these questions. Directions for their use can be found at the beginning of each appendix.

Given that a trauma-informed approach requires an organizational shift, all levels of the workforce—regardless of role—need at least foundational education on trauma and a trauma-informed approach.

Implementation Stage

SAMPLE TRAINING THE WORKFORCE (CLINICAL AND NON-CLINICAL) ACTION STEPS

- ☐ **Ensure** regular trauma-informed staff development for all roles.
- ☐ **Incorporate** learning and discussion around diversity, equity, inclusion, and accessibility in all training/education.
- ☐ **Form** a training/mentor team to provide ongoing education/coaching.
- ☐ **Provide** trauma-specific training for clinical staff, when possible.
- ☐ **Include** learning and application of trauma-informed approaches in supervision and meetings.

Foundation Education

The first consideration for the Training the Workforce (Clinical and Non-Clinical) Key Development Area in the **Implementation Stage** is **delivering foundational education on trauma and a trauma-informed approach**. Currently, there is no minimum standard or requirement when it comes to content for trauma-informed education and training. Experts in the field advise that workers receive education about how and why trauma is an important consideration within their organization/system, how organizational dynamics can unintentionally replicate someone's original trauma, and the key components of a trauma-informed approach (Harris & Fallot, 2001; Jennings, 2009; SAMHSA, 2014b).

We recommend that whatever education and training modality you choose, the knowledge base being built needs to incorporate information on the following:

- Individual, racial, historical, and systemic trauma.
- Adverse childhood experiences and adverse community environments.
- The impacts of trauma and adversity (especially on the brain).
- Re-traumatization and what it looks like at relational and system levels.
- An overview of the trauma-informed approach.
- The trauma-informed values and principles (including how they promote diversity, equity, inclusion, and accessibility).
- Secondary trauma, vicarious trauma, burnout, and compassion fatigue .
- Wellness, self-care, resilience, and growth.

All this information does not need to be incorporated into a single session. Even with foundational education, we recommend dosing the material over two or three sessions, when possible, to give workers time to digest the information and begin to derive meaning from it for themselves personally and in the context of their roles.

The Additional Resources section for Training the Workforce (Clinical and Non-Clinical) Key Development Area includes opportunities for online education to start your search. In addition, there is a link to a free trauma 101 PowerPoint presentation with trainer notes on the Trauma Informed Community Initiative of Western New York's website. It can provide a base for your own delivery of foundational education (it is designed to be an approximately two- to three-hour training).

Ongoing Training

Once workers receive psychoeducation on trauma and a trauma-informed approach, it is important to ensure there are **means for ongoing training and continued learning** (Harris & Fallot, 2001; SAMHSA, 2014b). Especially when workers receive initial content online, there needs to be opportunities to reflect on and process the trauma content, as well as continue to operationalize what being trauma-informed means in their specific roles. We have found that follow-up that occurs with smaller groups of workers (approximately 20 or less) and has some opportunity for workers to be together with others in similar roles (e.g., support staff) has been most beneficial in enabling people to digest the material. Certainly, workers in different roles can learn from each other and benefit from being in mixed groups—however, it has been our experience that support staff members, finance, maintenance, and other roles that have different responsibilities from direct-care staff may feel left out in initial follow-ups that do not help them operationalize the values and principles of a trauma-informed approach specifically for their roles. Additionally, clinical staff may benefit from receiving training specific to the diagnosis and treatment of trauma that would not be useful for those in non-clinical staff roles.

If your organization/system has clinical staff members, is there an opportunity to get some of them trained in trauma-specific treatment interventions such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) or Eye Movement Desensitization and Reprocessing (EMDR)? (See the Treating Trauma Key Development Area for more information on trauma-specific interventions.)

Much of the content of trauma-informed and trauma-sensitive follow-up training is like that of the initial education—impact of trauma/adversity, re-traumatization, anti-racism and anti-oppression strategies, vicarious trauma, the values and principles of a trauma-informed approach, resilience, and post-traumatic growth, etc.—however, now it looks at each of these areas in more depth. Whereas the initial education provides an overview to build a foundation, ongoing training serves the purpose of contextualizing, operationalizing, and allowing workers to apply the content to their individual roles and to the organization/system overall.

Trauma-Informed Supervision Training

Any staff roles that provide clinical or non-clinical supervision to workers can benefit from follow-up training specific to their supervisory roles in addition to the ongoing training provided to all staff. Example topics, skills, and strategies for trauma-informed supervision training include:

- Promoting workforce productivity and accountability by neutralizing re-traumatization and decreasing emotion dysregulation of workers.
- Supporting workforce wellness and compassion resilience in culturally responsive ways.
- Assessing, preventing, and responding to the negative impacts of the work (e.g., vicarious trauma).
- Discussing culture, diversity, power, and privilege in supervision.
- Encouraging the workforce's use of and reflection on trauma-informed approaches.
- Modeling their own regulation and wellness strategies.

Trauma-Informed Leadership

Similarly, executive leaders and administrators can benefit from training specific to their roles that focuses on the big picture of the organization/system and leading.

Example topics, skills, and strategies for trauma-informed leadership training include:

- Trauma-informed organizational strategic planning.
- Trauma-informed communication and messaging.
- Policy development and review.
- Leadership responses to adversity and crisis.
- Modeling their own regulation and wellness strategies.

Methods for Ongoing Training

Continued education and training can be implemented in various ways. For overall sustainability, we recommend considering providing structured time for the workforce to attend training during or before/after the workday (when possible), as well as making use of times during which workers are already together, such as workforce meetings and supervision. For example:

Many organizations we work with incorporate five to 10 minutes of content and/or discussion about trauma-informed practices as part of regular staff meeting agendas. During this time, they may show a brief video clip and encourage discussion, or engage workers in an activity to either get feedback or help them continue to see the role of trauma-informed approaches in their work.

Doing so allows for continued learning as well as further integration of a trauma-informed approach into the fabric of the organization/system—especially when done in combination with messaging strategies discussed previously in the Leading and Communicating Key Development Area.

One of the hospital systems we worked in utilized the trauma-informed value-and principle-of-the-month messaging strategy. The messaging via posters in the lobby, in elevators, and in nursing stations was accompanied by monthly meetings having a brief check-in, in which staff members shared how they saw the value/principle used, or how they used it themselves.

As well as ongoing training for all levels of the workforce specific to taking a trauma-informed approach, we advise that the organization/system consider trainings that will assist/support workers in building a trauma-informed environment. For example:

Are there opportunities for workers who interface with clients, patients, students, or consumers to attend trainings on de-escalation strategies and maintaining professional boundaries? Are there opportunities for all staff members to participate in trainings on implicit bias and microaggressions, as well as managing the negative impact of the work (e.g., vicarious trauma, burnout)?

Many school districts we have worked with have other initiatives that require training, such as restorative practices and foundations, or even have staff members who are trained in Therapeutic Crisis Intervention (TCI) or Strategies for Crisis Intervention and Prevention (SCIP). As part of their trauma-informed work, they ensure that staff attending these trainings also were asked to consider the connections with trauma-informed approaches and practices (when outside experts provide them) or integrate pieces of trauma-informed information when delivered internally. Messaging strategies are important here to help workers connect the dots.

Encouraging and providing opportunities for all levels of the workforce to engage in training and professional development specific to their roles in general is a great example of how the organization/system can anchor the trauma-informed value and principle of empowerment.

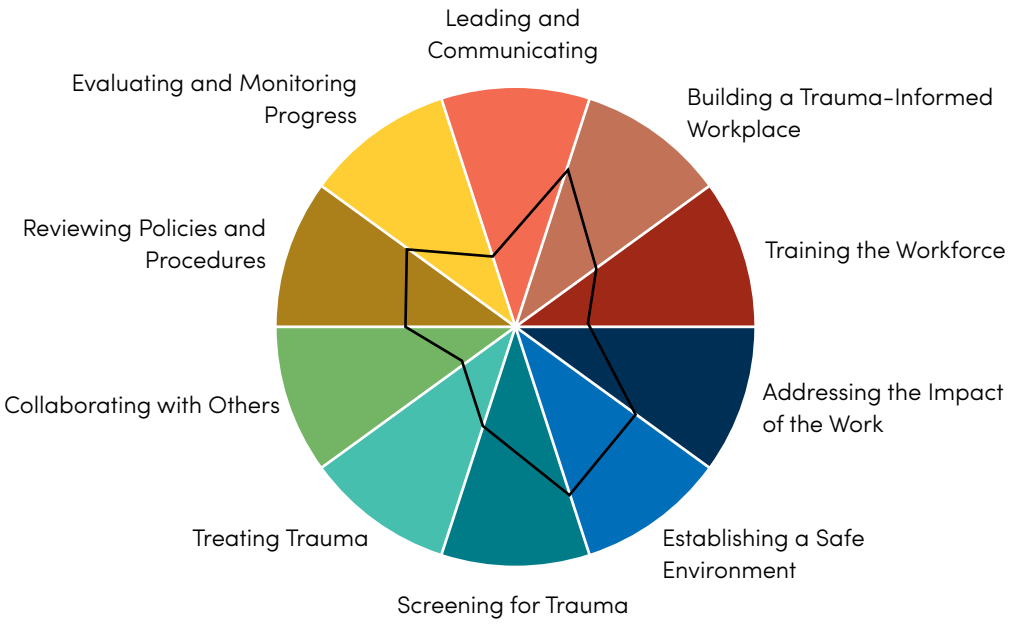


Figure 27 *- Champion Reflection of Implementation in Key Development Areas*

Champion Team Development

Forming an internal Champion Team is one of the most important ways to ensure overall sustainability of trauma-informed culture change. It is also a training model that can be considered by organizations/systems that are looking to bring in outside resources for training and do not currently have the funds for said resources to train all of their team members. While all staff members need to have education and training on a trauma-informed approach, Champions are those who think about trauma first, prioritize the trauma-informed lens in all areas of organizational functioning, and are able to assist in the development of the workforce's learning around a trauma-informed approach (Harris & Fallot, 2001; Koury & Green, 2017, SAMHSA, 2014b). These individuals are usually trained through a train-the-trainer model with a parallel process—they learn the content, skills, and resources, and learn how to deliver the content, skills, and resources to others. This is important to consider—understanding and knowing the information is one thing, but being able to deliver it is another. Trauma material is different from other types of education and requires training in order to effectively deliver the message to others.

Who is a Champion?

There are a few things to consider regarding the formation of a Champion Team. First, reflecting on what workforce roles make the most sense given the nature of your organization/system. In our experience, this has been done a few ways. Having a choice to participate in the Champion Team is important—however, that does not mean leadership cannot be strategic about recommending or reaching out to certain workers, similar to the strategies discussed in the Leading and Communicating section when considering who to be on the Trauma-Informed Oversight Committee. Members of the workforce who have been or are projected to be with the organization/system for a long period of time are good candidates, as again, the primary role of the Champion Team is to provide overall sustainability. If your organization/system already has workers who provide training, they are among those to consider. Additionally, including a variety of workforce roles and perspectives (e.g., direct-care staff, support staff, leadership) is important, as members are better able to provide real-time mentoring/coaching with their co-workers in the moment.

With that being said, it may make sense for a certain group of staff members to take on this role, based on the system. For example:

Within schools, we have witnessed the mental health teams becoming the Champions because of their ability to already push into classrooms and provide learning opportunities for others in the building.

Role of Champions

The second thing to consider is the purpose of the Champion Team. In some organizations, the initial Trauma-Informed Committee previously discussed will expand to include workers who want to be trainers and mentors, and the full team will be referred to as the Champion Team. At other times, the Trauma-Informed Committee focuses on overseeing overall implementation, while the Champion Team focuses on training and education. We suggest that your organization/system define the role and purpose of the Champion Team before recruiting workers to be a part of it.

A few organizations we have worked with have utilized an ambassador model for delivering training and education. They had their core Trauma-Informed Committee that also had the role of making decisions about content, and individuals called ambassadors with representation from all the organization's locations. The ambassadors learned the information from the core committee, and then brought the same information back to their locations—often during a staff meeting. This was a means of more efficiently providing education and training across the organization, and promoting similar conversation in a consistent manner.

Another large organization we worked with has a process of creating 12 months' worth of mini sessions each year. Champions at each of its various sites then have the option to utilize the materials—including a video or handout, as well as discussion prompts—in their staff meetings, based on what they thought was most relevant that month.

Other organizations we have worked with don't have individuals who feel comfortable getting up in front of their peers to deliver information. In these cases, we focus on mentor development. Trauma-informed mentors more informally encourage conversations to utilize a trauma-informed lens. They are trained to advocate for the use of trauma-informed values and principles, and they can encourage their peers during case review or discussions of students, patients, and clients to take a "what happened?" versus a "what's wrong with?" approach. In addition, they know where to find trauma and trauma-informed resources and can be individuals who model the model of trauma-informed practices in all that they do.

Planning and Discussion

The charts found in **Appendix Q** and **Appendix R** can be used by the Trauma-Informed Committee to discuss, assess, and plan for the components of the Training the Workforce (Clinical and Non-Clinical) Key Development Area within the **Implementation Stage**. The worksheets' considerations and format are similar to Appendix B that was reviewed in the Getting Started section of this manual—however, there are now follow-up questions associated with each of the considerations and some space for you to write answers to these questions. Directions for their use can be found at the beginning of each appendix.

Sustainability Stage

Maintaining Action Steps

Sustainability within the Training the Workforce (Clinical and Non-Clinical) Key Development Area is reached when the organization/system has key practices in place for ongoing learning and dialogue about trauma and trauma-informed practices. **The Trauma-Informed Committee can use the following checklist to ensure that the key practices are in place:**

- ☐ There is a schedule for foundational trauma-informed education and yearly refreshers for all staff.
- ☐ Discussions on trauma and application of trauma-informed approaches, including diversity, equity, inclusion, and accessibility, are built into workforce meetings regularly.
- ☐ Discussions on trauma and application of trauma-informed approaches are a part of supervision protocols.
- ☐ There are adequate resources (time, money, workers) allocated to support ongoing education and training.

The key practices for sustainability require a commitment to the training plan via ensuring time and other resources are protected for education and ongoing training. Again, the Champion Team is a key structure for success in this key development area because it can provide the training and/or facilitate discussion, and be responsible for staying up to date on the latest information and resources, and making sure the time is carved out for the purpose of training and discussion. Having trauma-informed practices be part of employee evaluations, as was previously discussed in the Building a Trauma-Informed Workplace Key Development Area, is another way to maintain the value of ongoing training and discussion.

Additionally, in the **Sustainability Stage** of the Training the Workforce (Clinical and Non-Clinical) Key Development Area, we encourage the Trauma-Informed Committee to commit to **revisiting Appendices O, P, Q, and R**, as well as any feedback regarding education and training at regular intervals during its standing meeting (e.g., quarterly or twice a year) to allow for flexibility and ongoing progress monitoring within this key development area.

Forming an internal Champion Team is one of the most important ways to ensure overall sustainability of trauma-informed culture change.

Key Development Area #4
Addressing the Impact of the Work

The Addressing the Impact of the Work Key Development Area includes increasing workforce awareness of how to prevent/manage the possible negative impacts of the work, as well as implementing organizational/system practices to help support workers and promote vicarious resilience, vicarious post-traumatic growth, and compassion resilience. The domains of consideration are:

Addressing the Impact of the Work Objectives:

- Provide education and training on the positive and negative impacts of the work (e.g., vicarious trauma, vicarious resilience).
- Provide supervision to support the well-being of the workforce.
- Create a plan for organization/system practices to promote vicarious resilience, vicarious post-traumatic growth, and compassion resilience in the workforce.
- Ensure an organizational/system culture of collaboration and empowerment.
- Build leadership capacity for self-awareness, self-reflection and self-regulation.

Pre-Implementation Stage

Considerations for Supporting the Workforce

As we previously discussed in the introductory section to the manual, having empathy while working with individuals who have histories of trauma and adversity can lead to workers' experiencing negative impacts on their health and well-being in the form of secondary traumatic stress (STS), vicarious trauma (VT), and compassion fatigue (CF). While not necessarily directly related to witnessing trauma and adversity, burnout, moral injury and moral distress, and decision fatigue are also possible impacts of the work that need to be considered. Additionally, it is important to recognize the workforce can be impacted positively in the form of vicarious resilience (VR) and vicarious post-traumatic growth (VPTG).

Emotion Regulation: The ability to influence what emotions we have, when we have them, and how we experience and express our feelings. Involves changing the intensity, duration, and/or type of emotions.

Self-Awareness: The ability to consciously focus on ourselves—recognizing our feelings, thoughts, and behaviors, and how they are impacting the present moment.

Compassionate Boundaries: The practice of proactively identifying, communicating, and reinforcing what is acceptable, and what is not acceptable to maintain our own well-being and respond compassionately to others.

Figure 28 – Skills and Practices to Build Compassion Resilience, Adapted from Brown (2015) and WISE & Rogers Behavioral Health (n.d.).

Compassion resilience (CR) is another possible impact of the work that describes individuals' ability to maintain their own physical, emotional, and mental well-being while compassionately doing their work with others (WISE & Rogers Behavioral Health, n.d.). Doing the work in a state of CR requires individuals to practice emotion regulation, self-awareness, and maintaining compassionate boundaries.

All three of these require skillsets and practices that workers may or may not already have, and therefore, this key development area invites leadership to consider ways in which skills can be learned, developed, and practiced. To truly address the impact of the work in ways that promote CR, VR, and VPTG, workers need to be in tune with what and how they are experiencing their jobs, and intentionally use strategies accordingly.

Self-care and individual wellness strategies are key in addressing the impact of the work. However, trauma-informed organizations also have the responsibility to ensure practices are in place that acknowledge the potential negative impact of the work, and support the workforce in ways to prevent and mitigate it, while striving to promote CR, VR, and VPTG. Putting policies and supports in place for the workforce is an important means of promoting safety and empowerment of the workforce, and addressing the impact of the work increases overall organizational productivity because STS, VT, burnout, and CF are associated with high staff turnover, more random sick days, low morale, and overall job dissatisfaction (Meichenbaum, n.d., Northeastern University's Institute on Urban Health Research, n.d.).

Self-care and individual wellness strategies are key in addressing the impact of the work.

Putting policies and supports in place for the workforce is an important means of promoting safety and empowerment.

Creating a Plan to Support the Workforce

Within the **Pre-Implementation Stage** of Addressing the Impact of the Work Key Development Area, the Trauma-Informed Committee's role is to create a plan for how the organization/system will support the workforce. There are a number of examples of structural and procedural supports described in the **Implementation Stage** of this key development area that can be referenced while creating the plan. However, we also encourage the committee to consider the following before selecting supports:

1 **Notice What Already Works** – Organizations/systems often have some supports in place for the workforce, such as time off, benefits, social gatherings, team meetings, wellness teams, etc. We encourage the committee to first take time to notice what is already contributing to workforce wellness before planning for additional supports. Structures and practices that already work can be built upon.

2 **Get Input and Feedback** – Critical to this process is getting information from workers about what they would like to see, what is working and what is not. The Trauma-Informed Committee may have good intentions and a solid plan, but if workers are not included, there is a risk that individuals will not use the supports put in place.

3 **Model Expectations** – While many organizations/systems are recognizing the importance of prioritizing workforce wellness, taking time during the workday to engage in self-care and regulation often requires a culture shift. Systems sometimes reward overwork while stigmatizing self-care and boundaries. Therefore, in addition to providing opportunities and supports, leaders need to message and model the expectation that staff members need to take care of themselves. Regular encouragement to engage in supports and intentional modeling of work-life balance and emotion regulation are critical to the success of a culture shift. When workers hear and see that the organization/system expects them to take care of themselves, it is more likely to happen.

4 **Acknowledge, Witness, and Connect** – We have seen organizations/systems come up with various creative and meaningful ways to support the workforce. With that being said, we ask the Trauma-Informed Committee and leaders to remember that no matter what they implement, it is essential to keep in mind the importance of acknowledging the reality of what is, witness and validate the experience of others, and prioritize connection whenever possible. We often cannot change or fix many of the personal or professional stressors that contribute to or exacerbate the negative impacts of the work. What matters most is *how* we respond.

The Role of Leadership

Leadership plays a critical role in promoting workforce wellness and resilience. The **Implementation Stage** of this key development area will provide examples of various practices and policies that leaders can help develop and put in place within their organizations/systems. However, in order for any of these strategies to be effective, leaders need to first start with themselves. Trauma-informed leaders are those who **regularly engage in their own self-awareness, self-reflection, and self-regulation**. Leaders need to notice and reflect on how they are experiencing and being impacted by their own roles—not only considering the impact of the work on their workforces. Even if they are not in the position of working with clients/patients/students/individuals directly, leaders can nevertheless be witness to and respond to the organization/system with empathy and great responsibility. Burnout and decision fatigue are especially common among leaders, who often have many competing priorities for their time and not enough resources.

To support workforce wellness and maintain trauma-informed interactions with others, leaders need to be regulated and focused on their own well-being. Using the concept of emotional contagion from Dr. Bruce Perry, a leader who is calm and steady is able to regulate workforce members who are experiencing dysregulation. In contrast, leaders who are dysregulated will dysregulate those around them (Info NMN, 2020). Developing and maintaining regulation skills require active self-awareness and reflection. Workers look to their leaders as models for how to respond to events in their everyday jobs, as well as in response to high stress and crisis. Therefore, we invite those in leadership roles to honestly consider what their own capacity is for self-awareness, reflection, and regulation. It is important to include opportunities to develop, practice, and model these skills as you plan next steps in this key development area.

Planning and Discussion

The charts found in **Appendix S** and **Appendix T** can be used by the Trauma-Informed Committee to discuss, assess, and plan for the components of the Addressing the Impact of the Work Key Development Area within the **Pre-Implementation Stage**. The considerations and format in these worksheets are similar to Appendix B that was reviewed in the Getting Started section of this manual—however, there are now follow-up questions associated with each of the considerations and some space for you to write answers to these questions. Directions for their use can be found at the beginning of each appendix.

Workers look to their leaders as models for how to respond to events in their everyday jobs as well as in response to high stress and crisis.

Implementation Stage

SAMPLE ADDRESSING THE IMPACT OF THE WORK ACTION STEPS
☐ **Ensure** training on how staff can be impacted by the work.
☐ **Prioritize** and promote workforce wellness in culturally sensitive ways.
☐ **Create** policy and practices to provide support to the workforce.
☐ **Implement** check-in and debriefing protocols that are inclusive and accessible.
☐ **Elicit** feedback from the workforce about what is working and what is needed.
☐ **Engage** workers in noticing capacity, success, and how they are managing.

Education and Training

One important component of addressing the impact of the work in the **Implementation Stage** is to **provide education and training on the various ways staff members can be impacted by the work** they do, what indicators may be present, what risk and protective factors might be in play, and how to manage work-related stress and trauma. Awareness is critical to workers' ability to identify warning signs of the negative impacts and implement strategies to help mitigate or prevent them all together.

The Professional Quality of Life Scale or PROQoL (see the Additional Resources section) is a self-assessment tool that organizations can implement during training or supervision to invite workers to consider indicators of burnout, secondary trauma, and compassion satisfaction in the last 30 days. Organizations may decide to introduce it in training and then utilize it quarterly to encourage self-awareness and reflection.

It is equally important to provide education and training opportunities that help workers identify what self-care or wellness strategies they already engage in, what currently works for them in managing work-related stress and trauma, and new tools and strategies they can try to implement—especially strategies to manage in the moment and while at work. Emotion regulation is another key protective skillset that is important to trauma-informed interactions and resilience of the workforce. Similarly, organizations/systems can consider providing general resilience trainings, as well as those that teach workers acceptance-based and mindfulness techniques as a means of coping (Meichenbaum, n.d.). Teaching and encouraging workers to notice what is working, what is going well, and what successes occurred that day (however small) will help transform VT into VR, CR, and VPTG.

Supervision

Another important form of support that is highly recommended is providing regularly scheduled and consistent supervision—some form of which (individual or group) is important for all workers, no matter what their roles are. Supervision is especially critical for workers who provide evidence-based trauma-specific treatment interventions. However, it is important for organizations/systems to recognize that supportive supervision is beneficial for non-clinical staff, too. Regardless of workers' roles, supervisors can provide a safe place and the opportunity for workers to discuss their stress reactions, stressors/concerns related to their roles and methods of coping/managing. It is important that supervision be conducted in a trauma-informed way—such as by checking in with the worker prior to getting into task-related agenda items and being culturally responsive. It is also helpful for trauma-informed supervisors to keep an eye on workload balance and indicators of emotional distress in those they supervise. The supervision category within the Additional Resources section includes various resources regarding providing supervision in a trauma-informed way.

- The action plan has space to delineate next steps for those considerations you wish to see improvement in. We recommend you identify the top 1-2 considerations in each section and think about what it would take to raise your score just *one number higher*.

1. Individual Level

The organization/system encourages, and provides time and resources for the workforce to:

Engage in self-awareness and self-check ins.	1 2 3 4 5
Seek support from supervisors, co-workers and friends/family.	1 2 3 4 5
Communicate expectations for self and others.	1 2 3 4 5
Attend training opportunities on the impact of the work and wellness.	1 2 3 4 5
Notice capacities, successes and possibilities.	1 2 3 4 5
Take breaks and time off for physical and mental health.	1 2 3 4 5
Reflect on the meaning and value of the work.	1 2 3 4 5

Appendix U

Organization/System Supports

In addition to training and supervision, there is a variety of other policies, procedures, and resources that can strategically be put in place to support the workforce and promote CR, VR, and VPTG. **Appendix U** provides a tool for leaders and the Trauma-Informed Committee to assess and consider possible supports at an individual, peer, and full organizational level within their organization that can be used in addition to the examples and narrative below to formulate action steps in the **Implementation Stage.**

Check-Ins

One common procedure that is relatively easy to implement is checking in with workers. Regular check-ins at the beginning of meetings, during quick morning huddles, and/or at other times workers already meet/gather provide opportunities for leadership to quickly get a sense of how workers are doing, what is going on that day, and what workers may need moving forward. Checking in with workers is clearly important after an incident or negative event occurs. However, it is equally important for leaders to check in with workers regardless of whether or not something has occurred that day because it helps to establish emotional safety and build trust. Check-ins do not need to require a lot of time, and staff members do not have to elaborate on personal details.

Something as simple as asking, "On a scale of 1 to 10, with 10 being today's a great day and 1 being the total opposite, where are you now, and what will it take to move one number higher?" can provide leaders with information regarding how workers are doing and an opportunity to identify other support needed from them or co-workers.

One elementary school we worked with decided to start all faculty and grade-level meetings with a check-in. The Trauma-Informed Committee utilized wellness-related check-ins, and decided to follow up with a prompt asking teachers and staff to share something that went well that week or that day (a "success story")—no matter how small—to help promote vicarious resilience.

The spiritual care department of one hospital we worked with utilized brief reflection prompts on pocket-sized strips of paper as a means of checking in with nurses and providers on unit floors. These reflections ranged from asking staff to notice what was going well today, to prompting them to take pause or to consider how they were getting from one moment to the next.

Debriefing

When incidents occur, whether that means an internal event such as the loss of a client, or an external event that has an impact on the workforce, such as a school shooting, it is critical for debriefing to occur in ways that are inclusive and accessible. We often hear workers share that they feel like documentation and discussion around how to prevent an incident like that from occurring again is all that is important to the organization/system. While certainly those conversations are necessary and useful, there is a need to provide emotional debriefing first.

Organizations/systems may have their own internal workforces to provide debriefing (e.g., on a hospital floor), or have an external resource such as Crisis Services come in to talk with staff. Getting feedback from the workforce on what debriefing needs to look like is important, as some workers may not feel safe with an outside agency representative, and others may prefer to talk with someone not related to the agency. Creating a plan for formal debriefing, with input from the workforce, also allows leadership to ask about and better address inclusivity and accessibility considerations.

One organization we worked with implemented a system whereby a few of its trauma-informed Champions volunteered to be a part of a response team, which had a formal protocol for reaching out to workers (or a whole department) when something occurred. Workers do not have to engage with the response team, but if they do, they are given the opportunity to debrief and are connected to other resources as necessary.

Regardless of who provides debriefing, it is important that it be done in a trauma-informed way, and that the individual doing the debriefing is trained on how to do so.

Policies and Procedures

Organizations/systems can also consider human resources and workforce policies. Benefits, salaries, and time off—flextime, vacation time, sick time, specific time for mental health days—all contribute positively to workforce wellness and resilience. Organizations/systems can provide employee assistance programs (EAP), and/or include other forms of mental health services for staff and their families. Also important are formal policies and procedures, such as those that address worker concerns, respond to workers who have been impacted by vicarious trauma, prohibit workplace harassment and discrimination, and evaluate staff satisfaction. You can refer to the Building a Trauma-Informed Workplace Key Development Area for more details on how human resources can support the workforce in trauma-informed ways.

While an EAP can be a tremendous support for workers and their families, organizations/systems need to consider how the resource is messaged. Workers may be hesitant to utilize an EAP out of fear that their boss or colleagues will find out, or they may not consider it at all because it was only mentioned once at orientation. One organization we worked with regularly talks about its EAP in staff meetings and during supervision meetings as a means of normalizing the impact of the work and getting support, reminding staff that it is a free resource, and clarifying confidentiality/privacy.

Emotion regulation is a key protective skillset that is important to trauma-informed interactions and resilience of the workforce.

Wellness Activities

Lastly, organizations/systems often offer activities to promote workforce wellness. It is important to ask individuals, departments, and teams what wellness looks like to them, and not assume that leaders or committees creating the supports automatically know what wellness means or requires of them. Our experience is that these activities are different from one organization to another and tend to be the supports that are most influenced by workers themselves. Examples include having wellness challenges or events, after-work social events, team-building activities, holiday and other celebration potlucks, book clubs, support sessions, pop-up staff appreciation days, healthy snacks and drinks available in break rooms, yoga and Zumba sessions, and more.

Various school districts we work with have implemented "wellness Wednesdays" or "mindful Mondays" that are organized by the school social workers, administrators, or teachers themselves as ongoing supports for teachers and staff. These days promote regulation by incorporating small self-care or wellness activities that occur either during the day or after school. Example activities include things like providing a hot chocolate bar in the winter, facilitating two- or three-minute grounding exercises, having relaxing music in the staff room, and actual support sessions.

Workers in hospitals are often unable to leave their floors or units to engage in organized wellness activities during their shifts. One hospital system implemented a mobile "resilience cart" that had self-care and wellness resources, small treats, reflection prompts, etc. on it as a means of showing appreciation and providing support.

Getting input and feedback from the workforce around wellness activities is important to ensure engagement. Wellness committees and leaders sometimes make the mistake of choosing one or two things to offer (such as yoga or a social gathering after work hours) without consulting the staff. Consequently, they are disappointed and frustrated that few staff members show up. Additionally, it is important for organizations/systems to encourage, recognize, and celebrate cultural self-care and wellness practices when offering wellness activity options.

Messaging Expectations

It is important for trauma-informed leaders to promote a culture of wellness when it is expected that workers will engage in strategies to take care of themselves. While leaders certainly cannot force workers to engage in wellness practices, they can model the model of regulation and wellness themselves, as well as actively encourage workers to take breaks, set aside time for lunch, and ensure they have manageable caseloads or workloads. Showing respect for work-life boundaries is another important aspect of modeling the model.

One leader in a large organization is very intentional about messaging the expectation that staff members need to take pause, reflect, and take care of themselves as part of the organization's goal to create a culture of wellness. Workers repeatedly hear the phrase, "We always have five minutes" from the leader and supervisors as a reminder that no matter how stressful the situation, no matter how busy anyone is, self-care, regulation, and connection are always a priority.

Culture of Collaboration and Empowerment

Our research shows that as workforce perceptions of the trauma-informed values and principles increase, staff satisfaction goes up and self-reported burnout decreases. Experiences of collaboration and empowerment specifically are often referenced in organizational strategies to promote workforce wellness and resilience while mitigating burnout and compassion fatigue. Some examples of how organizations/systems can work toward environments that promote worker empowerment and collaboration are: ensuring staff have meaningful input into organizational decision-making (especially with regard to issues that impact them), encouraging their voice and respecting opinions shared, encouraging and providing time for affinity groups and peer support, and formally recognizing and appreciating workers for their hard work and successes.

Two hospitals we worked with acknowledged their workers by having employee spotlights in their newsletters, encouraging kudos cards (which are compliments written by co-workers wanting to acknowledge each other), and by highlighting in staff meetings and on bulletin boards in break areas compliment cards written by patients.

Planning and Discussion

The charts found in **Appendix V** and **Appendix W** can be used by the Trauma-Informed Committee to discuss, assess, and plan for the components of the Addressing the Impact of the Work Key Development Area within the **Implementation Stage**. The considerations and format in these worksheets are similar to Appendix B that was reviewed in the Getting Started section of this manual—however, there are now follow-up questions associated with each of the considerations and some space for you to write answers to these questions. Directions for their use can be found at the beginning of each appendix.

Getting input and feedback from the workforce around wellness activities is important to ensure engagement.

Sustainability Stage

Maintaining Action Steps

Sustainability within the Addressing the Impact of the Work Key Development Area is reached when the organization/system has key practices and mechanisms in place to support and promote resilience of the workforce. **The Trauma-Informed Committee can use the following checklist to ensure that the key practices are in place:**

- ☐ There is a schedule for training on the impact of the work and self-care for all staff.
- ☐ There is a supervision schedule for each workforce member.
- ☐ There is a formal mechanism for the workforce to provide feedback on policies that support workforce wellness.
- ☐ There are adequate resources (time, money, workers) allocated to support workforce wellness policies and practices.

The key practices for sustainability require both a commitment to scheduling resources and maintaining a feedback loop with the workforce. Having a member of the Trauma-Informed Committee (or the training subcommittee if your organization has one) ensure training on the impact of the work and self-care is on the calendar is important to hold the organization/system accountable. Tracking supervision time or implementing supervision logs can help ensure there is protected time for supervision.

Additionally, in the **Sustainability Stage** of Addressing the Impact of the Work Key Development Area, we encourage the Trauma-Informed Committee to commit to **revisiting Appendices T, U, V, and W**, as well as any feedback regarding workforce supports at a regular interval during their standing meeting (e.g., quarterly or twice a year) to allow for flexibility and ongoing progress monitoring within this key development area.

Key Development Area #5
Establishing a Safe Environment

The Establishing a Safe Environment Key Development Area involves taking a deliberate look at the environment and atmosphere of the organization/system to ensure that both the physical space/aesthetics and culture are trauma-informed and trauma-sensitive. The domain of consideration is:

Establishing a Safe Environment Objectives:

- Define what makes a safe environment within a trauma-informed organization/system.
- Identify how your organization/system is going to or has already considered aspects of creating a safe environment.
- Schedule and conduct regular trauma-informed environment walk-throughs.
- Provide opportunities for all individuals to give feedback regarding their experiences of safety.
- Implement changes from the results of the trauma-informed environment walk-through and feedback gathered when feasible.

Pre-Implementation Stage

Planning to Assess the Environment

There are a number of considerations to keep in mind when looking at the environment of your organization/system with a trauma-informed and trauma-sensitive lens. Physical safety, or considering the physical environment of your organization's/system's building, involves thinking about security, location, accessibility, and general aesthetics. How welcoming, inviting, and inclusive is the space for all who use it? Identifying what emotional safety looks like in the organization/system is another consideration. How are interactions characterized by empathy, support and respect? How does the culture express the value of relationship, diversity, and emotion regulation?

Within the **Pre-Implementation Stage** of the Establishing a Safe Environment Key Development Area, the Trauma-Informed Committee's role is to create a plan for assessing the physical and emotional safety of the environment. Before reviewing the tool available to assist in this process, we encourage the committee to consider the following:

1 Status of Physical Space – The use of the walk-through tool will vary, depending on your organization/system. For example, if your organization is starting from the ground up (and thus does not yet have a physical space), the tool is useful in conversations with builders and stakeholders regarding designing the physical building and decorating the interior. If you are moving to a new building, it can inform decision-making when selecting a space or when making decisions about the space upon moving in. Lastly, when you have an already-established space, the walk-through tool provides a mechanism of sustainability to reassess the environment at regular intervals and collect feedback about what is working and what is not.

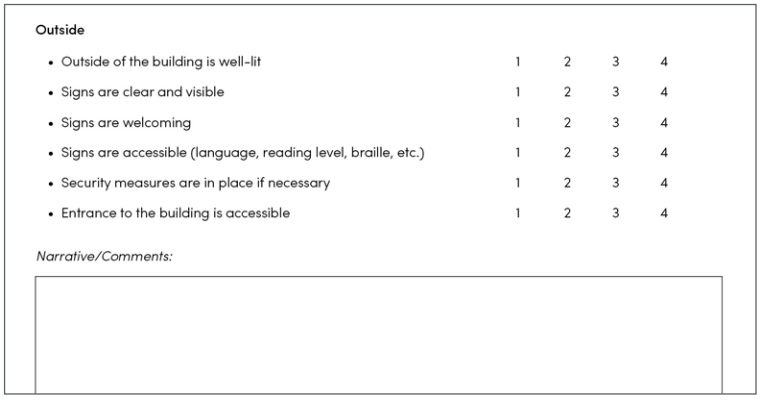
2 Notice What Has Already Been Put in Place – Organizations/systems often have already put time, energy, and resources into creating a welcoming physical space. We encourage the committee to notice what steps have already been taken, what the response was to the changes, and how the organization/system was able to make those changes. These considerations can be built upon when creating mechanisms to gather and respond to feedback about the environment.

3 Who, When, and How – Conducting the trauma-informed environment walk-through requires individuals to actually walk around the space (rather than sitting at a desk or using a computer to fill out a form). The Trauma-Informed Committee needs to consider who will be part of the walk-through, when and how often it will occur, and how the results of the walk-through will be recorded and reviewed. In addition, the subsequent action plan and changes made need to be communicated to the rest of the organization/system.

4 Get Input and Feedback – While the committee will likely take a lead role in conducting the environmental walk-through, it is critical to ensure various perspectives are included in the process. The committee can decide whether it will actually have representatives from different stakeholder groups complete the walk-through, or if it can include the voices of those offering feedback via survey or focus group about their experiences of physical and emotional safety within the organization/system. There is a difference between being safe and feeling safe, and what helps one person feel more comfortable may not be the same for someone else. A diversity of perspectives is needed in order to best address possible safety concerns.

5 Invite Important Stakeholders to the Table – If your organization/system does not own the building, or you have specific departments or staff members dedicated to addressing the physical space (e.g., maintenance, buildings and grounds, etc.), we highly encourage the committee to invite them to be part of the conversation. They do not always have to be part of the committee, but they can be invited in when specifically focusing on the environment. Providing information on trauma triggers, re-traumatization, and trauma-informed environments to important stakeholders can increase their engagement when changes are recommended. They will also be clear about parameters of what can and cannot be changed.

> Create a plan for assessing the physical and emotional safety of the environment.



Outside

- Outside of the building is well-lit 1 2 3 4
- Signs are clear and visible 1 2 3 4
- Signs are welcoming 1 2 3 4
- Signs are accessible (language, reading level, braille, etc.) 1 2 3 4
- Security measures are in place if necessary 1 2 3 4
- Entrance to the building is accessible 1 2 3 4

Narrative/Comments:

Appendix X

Adapting the Trauma-Informed Walk-Through Tool

Appendix X has a trauma-informed environment walk-through tool that can be used to assess the environment for physical and emotional safety. Our walk-through is broken into four main areas—outside, waiting areas, service/common areas, and bathrooms. You will see there is a list of considerations under each with a numeric scale to rate your location, as well as space to write a narrative and other comments that arise while completing the walk-through.

The walk-through was designed to be general enough to apply to as many organizations as possible. There may be things on the list that may not make sense given the services you provide or the type of setting you work in. For example, having plants to make rooms feel more welcoming and inviting may make sense in an outpatient agency, but may be a safety concern for an inpatient behavioral health unit. Within the **Pre-Implementation Stage**, the Trauma-Informed Committee will review the walk-through tool and make note of considerations that may need to be added/changed to better match your organization/system. The tool will then be ready to use in the **Implementation Stage** to conduct regular walk-throughs.

One Trauma-Informed Committee in an elementary school we worked with printed out the walk-through and spent part of a meeting making edits on paper to better match language and categories to their building. Committee members created an addendum to the walk-through for classroom walk-throughs. Once they finished, they put the revised walk-through questions into an online survey tool and utilized tablets as they, students, and families walked around the building to complete the walk-through.

We recommend that the committee read the rest of the narrative section of the Establishing a Safe Environment Key Development Area prior to finalizing your walk-through tool adaptations and conducting your first formal walk-through.

Planning and Discussion

The charts found in **Appendix Y** and **Appendix Z** can be used by the Trauma-Informed Committee to discuss, assess, and plan for the components of the Establishing a Safe Environment Key Development Area within the **Pre-Implementation Stage**. The worksheets' considerations and format are similar to Appendix B that was reviewed in the Getting Started section of this manual—however, there are now follow-up questions associated with each of the considerations and some space for you to write answers to these questions. Directions for their use can be found at the beginning of each appendix.

Implementation Stage

SAMPLE ESTABLISHING A SAFE ENVIRONMENT ACTION STEPS
☐ **Conduct** regular trauma-informed environment walk-throughs.
☐ **Elicit** feedback about the environment from all stakeholders.
☐ **Implement** suggested environmental changes as much as possible.
☐ **Engage** in consistent, transparent, and compassionate communication.
☐ **Provide** resources to support changes to the environment.
☐ **Encourage** open conversations about trauma, race, inequity, and oppression.

Conducting Environment Walk-Throughs

Reviewing your organization/system for potential trauma triggers in the environment is important to provide physical and emotional safety for all individuals in the building. While we cannot predict every environmental factor that may trigger an individual, the Trauma-Informed Committee can utilize its customized **Appendix X** from the **Pre-Implementation Stage** work in this key development area to continue to assess the environment and make changes as needed.

The first component of conducting a trauma-informed environment walk-through involves **looking at the physical environment**. Generally speaking, a trauma-informed and sensitive environment is one that is welcoming, friendly, and aesthetically comfortable. The following list summarizes the main areas of focus:

1 **Lighting** – Includes how well-lit the parking lot/areas around the exits to the building and bathrooms are. It also includes being mindful of how bright lighting in service/common areas can make the environment feel sterile and less comfortable. Is there a way for workers to adjust lighting to provide choice (e.g., having desk lamps and overhead lighting)?

2 **Security** – Includes noting what security measures are in place (e.g., locked doors, cameras, security personnel, etc.), being transparent about the reasons for the security measures, being mindful of the possible discomfort they may cause individuals, and considering how security personnel may present less intrusively if they are present (e.g., clothing, level of warm interaction, etc.).

3 **Accessibility** – Includes considerations of how accessible the building is to individuals with disabilities, transportation difficulties, etc., how easily accessible bathrooms are to all individuals (e.g., gender-neutral bathrooms), and ensuring that signage regarding directions is visible and able to be understood by the individuals who come to the building.

4 **Private Spaces** – Includes assessing the space for the availability of private spaces that ensure confidentiality of sensitive conversations—which may include separate rooms, screens/dividers, white-noise makers, etc. It may also include adequate spacing between seating in waiting areas and a designated space for individuals to engage in self-care practices.

5 **Décor** – Includes considering the color of walls, use of plants/aquariums, reading materials, and murals/artwork/photos that are culturally relevant and appropriate for those utilizing the space (e.g., representation of race, gender, and/or other cultural considerations, different languages, child-friendly materials, etc. as applicable).

6 Signage – Includes reviewing all signs and posted memos for the use of positive language that depicts what is expected rather than what is not allowed. For example, a sign that says "smoke-free environment" rather than "no smoking." This also includes ensuring signage is clear, accurate, and can be read by those using the building—which may mean translating into other languages or using pictures rather than words.

When thinking about addressing aspects of the physical environment, it is important to acknowledge that you may have to be creative and think outside the box about solutions. Even if it is not currently possible to make an ideal change (such as getting a completely different space), there are often smaller changes that can be effective. We encourage the Trauma-Informed Committee to use next-small-step thinking when creating the action plan. For example, if a priority consideration is currently rated as a 1 on the scale, what will it take to get to a 2?

One program we worked with was located in a basement of a building and had no natural light. Clients and staff often stated that they felt like they were in a closet. The program could not afford to change spaces to a location with windows. However, the team received a suggestion of putting up large artwork or photos of outdoor scenery to move up one point on the scale. While it did not change the fact that they were in a basement, putting up images of outdoor spaces in offices resulted in positive client feedback almost immediately.

An inpatient behavioral health unit we worked with was very limited on the décor it could have on the unit because of safety concerns. Plants, artwork, and even comfortable seating—items that can make the environment more welcoming—were not available to them. One small step they came up with instead was to replace traditional light panels with those that had a cloud overlay to help patients who were not allowed to go outside feel more comfortable. In addition, the unit felt less sterile. Another idea the unit staff considered was painting a nature scene on the wall itself rather than hanging artwork.

The second component of the trauma-informed walk-through is to look for indicators of trauma-informed workforce interactions and culture. Observing how workforce members interact with each other and clients/patients/students/consumers as part of the walk-through process can provide a window into the culture of the organization/system. Within the Establishing a Safe Environment Key Development Area, the Trauma-Informed Committee is specifically looking for indicators of emotional safety. See **Figure 29** for sample indicators.

- Individuals are verbally welcomed when they enter the space.
- Interactions demonstrate empathy, concern, and support .
- Individuals are informed about what to expect and what is expected of them.
- Staff members respond sensitively to flipped-lid reactions.
- Staff members acknowledge stress, adversity, and trauma.
- Interactions are validating and affirming.
- Staff members utilize person-first and inclusive language.
- There are opportunities for emotion regulation.
- Interactions embrace diversity, equity, inclusion, and accessibility.

Figure 29 *- Sample Emotional Safety Indicators*

With the increase in utilizing virtual platforms for connection (e.g., telehealth or holding team meetings on videoconferencing platforms), it has become more important to also consider what safety looks like in virtual spaces. While not an exhaustive list, the considerations below are important in ensuring emotional safety virtually:

1 **Connection** – Includes being present and available virtually, engaging in positive greetings, checking in with individuals before getting into business, and providing opportunities to meet one on one.

2 **Expectations** – Includes communicating expectations regularly throughout the meeting or session, setting and sharing an agenda ahead of time, orienting individuals to technology and options for participation, and providing predictable, structured routines when meeting more than one time for similar purposes.

3 **Language and Dialogue** – Includes being intentional about using language to promote inclusivity and acceptance, asking about what safety means in virtual settings, addressing concerns through one-on-one contacts whenever possible, and gathering feedback about experiences of safety in virtual spaces.

4 **Regulation** – Includes providing time and space for short regulation activities (e.g., starting and/or ending the meeting or session with a brief breathing exercise), and presenting directions and new information in small, concrete steps.

As a reminder, incorporating different perspectives when completing the trauma-informed environment walk-through is critical. When gathering feedback, the Trauma-Informed Committee needs to consider and acknowledge power dynamics. Having regular conversations as an organization about what safety means and looks like, encouraging open and frequent dialogue about discrimination, oppression, and racism, and following through in response to feedback gathered are all examples of how the committee can continue to promote emotional safety when seeking feedback. Even if suggestions cannot be incorporated, it is critical to report the results of the walk-through and any other means of gathering feedback with specific information as to what the action steps are and/or why certain changes are not possible.

Incorporating different perspectives when completing the trauma-informed environment walk-through is critical.

Planning and Discussion

The charts found in **Appendix AA** and **Appendix BB** can be used by the Trauma-Informed Committee to discuss, assess, and plan for the components of the Establishing a Safe Environment Key Development Area within the **Implementation Stage**. The worksheets' considerations and format are similar to Appendix B that was reviewed in the Getting Started section of this manual—however, there are now follow-up questions associated with each of the considerations and some space for you to write answers to these questions. Directions for their use can be found at the beginning of each appendix.

Sustainability Stage

Maintaining Action Steps

Sustainability within the Establishing a Safe Environment Key Development Area is reached when the organization/system has key practices in place to gather feedback and implement changes to the environment to promote physical and emotional safety. **The Trauma-Informed Committee can use the following checklist to ensure that the key practices are in place:**

- ☐ There is a schedule for conducting regular environment walk-throughs.
- ☐ There is a mechanism for all individuals to provide feedback on their experiences of physical and emotional safety.
- ☐ There are adequate resources (time, money, workers) allocated to the implementation of recommended changes in the physical environment.

The key practices for sustainability require a commitment to scheduling resources and maintaining a feedback loop with all stakeholders. Having a member of the Trauma-Informed Committee (or an environment subcommittee, if your organization has one) ensure the walk-through and other means of gathering feedback from stakeholders are consistently scheduled will help promote accountability. Incorporating the review of the environment as part of organization/system quality assurance or quality improvement protocols can also help ensure protected time for the walk-through process.

Additionally, in the **Sustainability Stage** of the Establishing a Safe Environment Key Development Area, we encourage the Trauma-Informed Committee to commit to **revisiting Appendices Y, Z, AA, and BB**, as well as any feedback regarding physical and emotional safety, at regular intervals during its standing meeting (e.g., quarterly or twice a year) to allow for flexibility and ongoing progress monitoring within this key development area.

It is critical for sustainability to ensure various perspectives are included in the process. A diversity of viewpoints is necessary in order to best address possible concerns.

Key Development Area #6
Screening for Trauma

The Screening for Trauma Key Development Area involves deciding whether or not screening for trauma and/or adversity is appropriate in the organization/system, and if so, ensuring a protocol for the use of screening tools and follow-up resources is in place. The domain of consideration is:

Screening for Trauma Objectives:

- Decide if it is appropriate for the organization/system to screen for trauma.
- Formalize screening for trauma into a policy/protocol that includes follow-up with the individuals screened.
- Train workers on how to screen in a trauma-informed way.

Pre-Implementation Stage

Deciding to Screen

While screening for trauma is an important component of being trauma-sensitive, it does not always make sense for every organization/system to implement universal trauma screening. Universal trauma screenings are those that are conducted with all clients/patients/students/consumers in the organization/system. Currently, there are arguments for and against the use of universal screening for trauma and adversity. Proponents of universal screening argue that not only is trauma exposure common, but unrecognized and unaddressed trauma symptoms can lead to negative treatment and health outcomes. Screening can help prevent misdiagnosis and inappropriate treatment planning. On the other hand, those against universal screening argue there is still a lack of clarity and consensus about how to interpret and utilize scores—particularly the Adverse Childhood Experiences questionnaire (Anda et al., 2020). There is also potential for re-traumatization and lack of standardization of screening training, administration, and follow-up.

It does not always make sense for every organization/system to implement universal trauma screening.

The first consideration within this key development area in **Pre-Implementation** is for your organization/system to **make a deliberate decision whether it is appropriate to universally screen for trauma.** This decision needs to be informed by the following considerations:

1 **Setting** – Given that trauma is very personal and often associated with feelings of shame, considering the setting and role of your organization/system can make screening less likely to be perceived as intrusive. Settings that focus on the promotion of health (physical and behavioral), those that generally have a long-term relationship with individuals, serve the purpose of connecting individuals to resources, and/or provide trauma-specific treatment are those that are more suited to universal screening. Trauma screening may not make sense in settings that are focused on addressing a limited set of needs/concerns (e.g., a dentist's office or other specialists).

2 **Ability to Follow Up** – Organizations and systems implementing universal screening need to ensure they have follow-up protocols for responding to the results of the screen. If the screen indicates the need for further assessment and treatment, and the organization/system does not provide them in-house, there needs to be a list of accessible and affordable referrals to providers who can provide the trauma-specific treatment in the follow-up conversation with the individuals screened. If the screen does not indicate the need for further assessment or treatment, it is still equally important to have a debriefing conversation with the individual, including the reason for the screening, what the screening indicated, and reassurance that if the individual experiences symptoms or situations like the screening, the individual can inform the worker and receive appropriate follow-up and resources.

3 **Capacity for Workforce Training** – It is critical that workers who will be involved in implementing a universal screening tool for trauma are trained on how to give the screen and have the follow-up conversations in ways that are trauma-informed, in line with anti-racist and anti-oppressive screening protocols, and appropriate, given their roles to prevent re-traumatization of the individual and the worker. As a reminder, it is the role only of individuals who provide trauma-specific assessment and treatment to ask for specific/intense details regarding someone's trauma history. While non-clinical workers who are trained can provide the screening, they need to understand their role is to provide validation and supportive responses. With that being said, it can be beneficial to have a worker who is trained in trauma assessment have follow-up conversations and do further work with individuals who need a more in-depth assessment.

4 **Use of Screening Tools** – There are multiple validated tools available to conduct trauma screenings, so Trauma-Informed Committees can ideally choose an existing tool rather than improvising or creating their own questions. The screening tool may be a self-assessment or face-to-face interview—it is important for the emotional safety of those involved and the fidelity of the tool for it to be used in the way it was designed. For example, if your organization/system is not able to spend the time needed for a face-to-face interview, review and consider only self-assessment tools rather than using an interview tool as a self-assessment. The following section will discuss selecting a screening tool.

Choosing a Screening Tool

If your organization/system decides to universally screen for trauma and/or adversity, based on the considerations discussed above, the next step is making a deliberate choice of what screening tool to use. Many governing bodies of systems of care, such as the National Child Traumatic Stress Network (NCTSN), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Office of Mental Health (OMH), have recommendations of specific tools to use. The Additional Resources section on Page 127 includes references to lists of possible available screening and assessment tools. When considering which tool is most appropriate, the Trauma-Informed Committee members need to consider which tools are already recommended for their setting, how much time is available to both do the screen and have a follow-up conversation, and what the language, literacy, and cultural considerations are for the specific population they work with.

Before selecting a tool, we recommend first checking with governing bodies that are pertinent to your organization/system for recommendations and reading the section of SAMHSA's (2014) *TIP-57* linked in the Additional Resources section of this manual.

Creating the Protocol: General Considerations

Once an organization/system decides to screen for trauma and selects the tool that makes the most sense for its setting, the goal of the Trauma-Informed Committee in **Pre-Implementation** is to plan to **create a formal screening protocol.** In the **Implementation Stage**, we will get into more detail regarding protocols for providing the trauma screening that will need to be incorporated in the final protocol. However, there are some key general considerations that we invite the committee to think about first:

Who: Who will be involved in the screening protocol? Various workers may be part of the components of the screening protocol, such as explaining the screen and its purpose, providing the screen, engaging individuals in follow-up discussions, tracking how screening information is collected and used, providing supervision/support to those doing the screen, etc.

What: What training will be provided to staff involved in the screening protocol? Training is important to ensure fidelity to the screen and to conduct each part of the protocol process through a trauma-informed lens. Specifically, this means being transparent and clear about what individuals can expect in the screening process, eliciting only the minimum information necessary for determining a history of trauma and the possible existence and extent of trauma symptoms, having a sensitive follow-up conversation anchored in choice and collaboration, and making sure the individual is grounded and feels safe before leaving.

Before selecting a tool, we recommend first checking with governing bodies that are pertinent to your organization/system for recommendations.

Training is important to ensure fidelity to the screen and to conduct each part of the protocol process through a trauma-informed lens.

When: When will the screen take place? Your organization/system may have multiple points at which the screen could occur. For example, a trauma screen may be given during the initial intake or assessment process when an individual first comes to the organization, and again on a yearly basis. Timing is important when considering the general flow of whom individuals see when they come to the organization. It is important to ensure that individuals are not given the same screen multiple times by different people (e.g., in a hospital setting, once in the emergency department, and again once admitted to the floor). An organization would also decide if a screening completed in one program will be shared with other programs within the organization on an as-needed basis (e.g., a screen completed in a counseling program and then shared with the foster care program also working with the same individual, with an appropriate release form). Depending on the tool used, it is important to also consider the appropriate frequency of rescreening. For example, giving an adult the ACE questionnaire more than once would not make sense because the individual's ACE score would not change.

How: How will the information collected from the screen be used to inform treatment? How will the information be documented? How will individuals who require further assessment and treatment be connected to workers who are able to do so, whether the organization/system has internal capacity to provide them or not? How will the Trauma-Informed Committee evaluate the overall effectiveness of the screening protocol?

We recommend that the Trauma-Informed Committee read the rest of the Screening for Trauma Key Development Area narrative prior to finalizing the plan to create a formal screening protocol.

Planning and Discussion

The charts found in **Appendix CC** and **Appendix DD** can be used by the Trauma-Informed Committee to discuss, assess, and plan for the components of the Screening for Trauma Key Development Area within the **Pre-Implementation Stage**. The worksheets' considerations and format are similar to Appendix B that was reviewed in the Getting Started section of this manual—however, there are now follow-up questions associated with each of the considerations and some space for you to write answers to these questions. Directions for their use can be found at the beginning of each appendix.

Implementation Stage

SAMPLE SCREENING FOR TRAUMA ACTION STEPS
☐ **Develop** formal protocols for screening (when, by whom, follow-up).
☐ **Use** evidence-based and age-appropriate screening tools.
☐ **Ensure** screening is provided in a trauma-informed way.
☐ **Elicit** only information necessary for determining a history and extent of symptoms.
☐ **Consider** cultural factors that may impact the screening process.

Providing the Screen

The Screening for Trauma Key Development Area requires those involved in the process to be intentional about *how* the screen is provided. The first point of contact in the screening protocol (the individual giving the screen to be filled out or conducted via interview) is responsible for **explaining the purpose of the screen and what to expect during the process**—especially if multiple workers are involved throughout the protocol. If there are language barriers, it is important to have an interpreter present to ensure the individual has a clear understanding. The organization/system also needs to consider the process for a release of information to other providers (e.g., to a provider at another organization that provides trauma-specific treatment if not available at your organization).

The screen itself needs to be **conducted in a private space.** This can be achieved by ensuring adequate spacing between seats in the waiting room, having a separate smaller room or space separated by a divider but attached to the waiting room for the purpose of completing initial paperwork, or conducting a face-to-face interview in a private room. When screening is conducted in-person or via phone interview, it is critical for **workers to stay focused on their roles**. Especially when one is not in the role of the trauma therapist, the purpose of the screen is to indicate whether the individual may need further trauma assessment and treatment—not to get specific details about someone's narrative. Maintaining boundaries and keeping the image of skipping a stone on a lake are critical. Acknowledge and validate what is shared, and then shift the focus back to the screen, to how the individual is managing, etc. **Allowing individuals choice** in setting the pace of the conversation, taking breaks if needed (especially when the screen is given with multiple others), and answering questions, when possible, are also important for neutralizing the potential of re-traumatization and keeping individuals more regulated.

Follow-Up to the Screen

No matter what the results of the screen are, a **follow-up conversation with the individual who was screened** needs to be part of the screening protocol. Again, unless this individual is in the role of the trauma therapist, it is important that conversations following the screen are supportive without eliciting or focusing on the specific details of the individual's story. In addition to answering any questions the individual may have, follow-up conversations need to include general feedback about the results of the screen and any recommended next steps. If the individual would benefit from further assessment and/or treatment, what options are available (in-house or from collaborative-partner trauma therapists)? How will the organization/system support the individual in getting connected to the option of their choice? If the screen indicates next steps are not needed, the conversation can be brief and focus on reiterating the purpose of the screen and what their results are. Lastly, **ensuring that the individual is grounded, emotionally regulated,**

and feeling safe before leaving the follow-up discussion are other important considerations—especially when the individual appears distressed. An example of how the individual facilitating the follow-up conversation can do this is by inviting the individual to do a brief breathing or grounding exercise.

Considering the Workforce

The last consideration within the Screening for Trauma Key Development Area in the **Implementation Stage** is to **decide whether to implement a tool to screen for the impact of the work in the workforce**. As previously discussed in the Addressing the Impact of the Work Key Development Area, there are a variety of self-assessment tools that can be provided for staff members to increase their awareness of indicators of secondary traumatic stress, vicarious trauma, burnout, etc. For example, organizations may consider implementing the Professional Quality of Life Scale (PROQoL; available in the Additional Resources section) with staff quarterly. This could be done anonymously as a means of proactively raising awareness, and could also be done in individual supervision or one-on-one meetings as a screening tool to identify stress reactions and put supports in place. There is no right or wrong decision. We invite you to remember what you considered previously with individuals receiving services when deciding: What will the information be used for, how is the organization/system positioned to respond and support, and how is the process conducted in a way that is trauma-informed by specifically prioritizing emotional safety, trustworthiness, and choice. In the event the organization/system does decide to administer any of these tools, it is important to explain to staff how the results will be handled. Is staff obligated to share results? Who will have access to the results, and what will they be used for?

Planning and Discussion

The charts found in **Appendix EE** and **Appendix FF** can be used by the Trauma-Informed Committee to discuss, assess, and plan for the components of the Screening for Trauma Key Development Area within the **Implementation Stage**. The worksheets' considerations and format are similar to Appendix B that was reviewed in the Getting Started section of this manual—however, there are now follow-up questions associated with each of the considerations and some space for you to write answers to these questions. Directions for their use can be found at the beginning of each appendix.

Maintaining boundaries and keeping the image of skipping a stone on a lake are critical during the screening process.

Sustainability Stage

Maintaining Action Steps

Sustainability within the Screening for Trauma Key Development Area is reached when the organization/system has key practices in place to support its screening protocol. **The Trauma-Informed Committee can use the following checklist to ensure that the key practices are in place:**

- ☐ There are written protocols for screening for trauma in the organization.
- ☐ There is a schedule for training workforce members who are providing the screening and follow-up discussions in trauma-informed ways.
- ☐ There is a formal mechanism for evaluating the effectiveness of screening protocols.
- ☐ There is a formal process for tracking data collected and ensuring its use in informing treatment/service plans.

The key practices for sustainability require a screening protocol that is regularly evaluated for effectiveness in scheduling training for workforce members participating in the screening process, and formal mechanisms for tracking the data and how it is utilized. Incorporating the review of information collected from screening and follow-up action steps as part of organization/system quality assurance or quality improvement protocols, or just general review of treatment/service plans can also help ensure that the workforce is staying committed to the overarching purpose of screening for trauma.

Additionally, in the **Sustainability Stage** of the Screening for Trauma Key Development Area, we encourage the Trauma-Informed Committee to commit to **revisiting Appendices CC, DD, EE,** and **FF**, as well as any feedback regarding the screening process at a regular interval during its standing meeting (e.g., quarterly or twice a year) to allow for flexibility and ongoing progress monitoring within this key development area.

Key Development Area #7
Treating Trauma

The Treating Trauma Key Development Area involves either having on-site trauma-specific treatment interventions available or accessible referrals to agencies that provide trauma-specific treatment for individuals who are seeking treatment for their trauma. The domain of consideration is:

Treating Trauma Objectives:

- Use trauma-specific treatment interventions when in a role of treating trauma.
- Provide clinical supervision and support to the workers who provide trauma-specific treatments.
- Ensure trauma-specific treatment interventions are accessible to individuals seeking trauma treatment—internally or through referrals to other providers.

Pre-Implementation Stage

Trauma-Specific Treatments

As previously discussed in the introduction of this manual, trauma-specific treatment refers to evidence-based interventions designed for the purpose of helping individuals heal from trauma. Evidence-based interventions are those that have been tested for fidelity and have demonstrated impact on the targeted area for improvement. If a provider knows that an individual is experiencing trauma symptoms (from a screen or other means), it is not enough to provide or refer the individual to general behavioral health services/counseling. The following interventions are common evidence-based and trauma-specific treatments:

1. Cognitive Processing Therapy (CPT)
2. Eye Movement Desensitization and Reprocessing (EMDR)
3. Parent-Child Interaction Therapy (PCIT)
4. Prolonged Exposure (PE)
5. Seeking Safety (SS)
6. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Additional trauma-specific treatments that are promising practices include interventions such as Progressive Counting (PC) and Trauma Center Trauma-Focused Yoga (TCTFY). Individuals who provide trauma-specific treatments generally go through extensive training and supervision in order to do so. They are specifically trained in how to process the individual's trauma over time in a way that is anchored in safety and healthy coping skills. Seeking Safety, however, is present-focused and can be conducted by anyone, regardless of degree, licensure, or certification. It is important to ensure individuals seeking treatment for trauma are connected to providers who are able to utilize these trauma-specific treatments with training, fidelity, and supervision.

Similar to our discussion about tool selection in the Screening for Trauma Key Development Area, we suggest that you investigate what trauma-specific treatments are recommended in your setting and check any governing bodies that are pertinent to your organization/system for recommendations. Please see the Additional Resources section on Page 127 for both trauma-specific training opportunities and directories of providers who offer many of these treatments in the United States.

Making the Decision and Creating the Plan

The key consideration within the Treating Trauma Key Development Area is making sure that individuals who need trauma-specific treatment are able to access providers who offer the treatments. Within the **Pre-Implementation Stage**, organizations/systems need to **decide how they will ensure access to trauma-specific treatment services**. This can occur in two ways:

1. Making the decision to **offer trauma-specific treatments internally** by having clinicians within your organization/system who are trained and certified in at least one trauma-specific treatment intervention. This decision requires a plan that includes training for clinicians, mechanisms for clinical supervision, and a way to monitor treatment fidelity.

2. Making the decision to **refer out to providers who offer trauma-specific treatments in the community.** This decision requires a plan that includes a formal protocol for trauma-specific treatment referrals, creating a directory of accessible trauma-specific treatment resources that are available (including supportive cultural practices) and mechanisms to ensure the directory stays up to date.

When making the decision, we invite the Trauma-Informed Committee to consider whether or not treating trauma is in line with the organization's/system's mission and vision, whether it fits within the role and setting of the organization/system, and if there are already clinicians or capacity to ensure clinicians are trained in a trauma-specific treatment. If the answer to all three of those questions is yes, it may make sense to offer trauma-specific treatments in-house. Otherwise, it likely makes sense to plan a protocol for referring out.

Our recommendation is to read the remainder of the Treating Trauma Key Development Area narrative before formalizing your plan, regardless of which decision you choose.

Planning and Discussion

The charts found in **Appendix GG** and **Appendix HH** can be used by the Trauma-Informed Committee to discuss, assess, and plan for the components of the Treating Trauma Key Development Area within the **Pre-Implementation Stage**. The worksheets' considerations and format are similar to Appendix B that was reviewed in the Getting Started section of this manual—however, there are now follow-up questions associated with each of the considerations and some space for you to write answers to these questions. Directions for their use can be found at the beginning of each appendix.

Implementation Stage

SAMPLE TREATING FOR TRAUMA ACTION STEPS
☐ **Establish** formal protocols for individuals accessing trauma-specific treatment.
☐ **Have** access to an updated directory of trauma-specific resources.
☐ **Provide** reflective supervision for workers doing trauma-specific treatment.
☐ **Incorporate** trauma-specific treatment into treatment/service plans when needed.
☐ **Consider** cultural practices that address the healing of trauma.
☐ **Monitor** fidelity to trauma-specific treatment interventions when offered internally.

Based on your answers to the considerations in the **Pre-Implementation Stage**, your organization/system can decide whether it is more appropriate to provide in-house trauma-specific treatment, or to refer to outside organizations and/or providers. You can read the section based on that decision below for more guidance in the **Implementation Stage**. However, we also recommend that you take time to read the Cultural Considerations section, regardless of your decision.

Internal Provision of Trauma-Specific Treatment

If your organization/system decides to provide trauma-specific treatment internally, the first step is ensuring your clinicians are trained in a trauma-specific treatment. Having trained clinicians can overlap with either the Building a Trauma-Informed Workplace or Training the Workforce (Clinical and Non-Clinical) key development areas. The organization/system can create job postings to hire clinicians who already have trauma-specific treatments in their toolboxes, and/or they can invest resources into sending their current clinicians to be trained. Trainings for trauma-specific treatment interventions can be costly, which may lead to concern about turnover. Some organizations/systems require clinicians to stay with the organization for a certain amount of time after they pay for the training, to help alleviate some concerns associated with possible turnover once they are trained. They also may incentivize clinicians to stay with the organization by paying for part or all of the consultation/supervision required after the formal training. Involving trained clinicians in decision-making and acknowledging their accomplishments publicly can strengthen retention of specially trained staff. Other organizations/systems choose to go the route of strictly offering Seeking Safety in-house because it is more economical, and because it can be offered both individually and in groups. Again, web resources to locate training options can be found in the Additional Resources section for the Treating Trauma Key Development Area on Page 127.

Clinical Supervision

Equally important to considering how clinicians will be trained in trauma-specific treatments is how those offering treatments will be provided with clinical supervision. Not only is this a mechanism to help ensure treatment procedure fidelity, but it is an important support to manage and prevent secondary traumatic stress, vicarious trauma and/or compassion fatigue as we discussed previously in the Addressing the Impact of the Work Key Development Area. Organizations/systems may have licensed clinicians to provide supervision in-house or require that clinicians have outside supervision. Ideally, the organization/system can

at least assist clinicians in connecting with the outside resources, as well as possibly pay for the supervision services, even if the supervisors are not direct employees. Additional resources for trauma-informed supervision can be found on Page 125 in the section for the Addressing the Impact of the Work Key Development Area.

Defining and Monitoring Fidelity

Once a trauma-specific treatment is selected, the organization/system needs to consider how it will track and monitor fidelity to the treatment. It is important that clinicians in the organization/system recognize that cherry-picking specific aspects of the trauma treatment can be harmful and ineffective, as the protocols are specifically designed to be implemented as developed, with fidelity. Organizations/systems can also benefit from defining and monitoring fidelity because it helps with treatment accountability and evaluation of outcomes, and can be an area of strength when grants are involved.

Once the treatment is selected, we recommend having someone explore what best-practice guidelines already exist to define what fidelity looks like and plan for how to keep it alive in practice. Some treatments like TF-CBT have follow-up consultation after the initial training, to provide support while clinicians begin to implement the intervention. Some interventions may provide a fidelity checklist that can be utilized; others may only have best-practice guidelines. Additionally, we invite supervisors to consider monitoring fidelity as more of a process rather than content when linked to performance reviews, where discussions focus on the extent to which fidelity is part of the conversation rather than how good fidelity is.

Examples of how fidelity can be monitored include:

- Using a fidelity checklist in individual practice.
- Using a fidelity checklist in supervision.
- Using a fidelity checklist in case review discussions.
- Asking questions about how what clinicians did or what they might do next are informed by treatment best practices.
- Incorporating to what extent a clinician brings fidelity into case discussions in performance reviews.

Referral to Trauma-Specific Treatment Providers

When organizations/systems decide to refer out for trauma-specific treatment, the main focus of the work in implementation overlaps with the Collaborating with Others (Partners and Referrals) Key Development Area. Workforce members need to know where in the community they can refer their clients/patients/students/consumers for accessible and affordable trauma-specific treatment services. We recommend **having a formal, written directory of trauma-specific services on hand** for the workforce to provide options to the individuals they work with. For more information on how to create and maintain this type of directory, please refer to the Collaborating with Others (Partners and Referrals) Key Development Area.

Your organization/system can decide whether it is more appropriate to provide in-house trauma-specific treatment, or to refer to outside organizations and/or providers.

Exploring cultural traditions and values with individuals who are seeking trauma treatment is an important component of being trauma-informed.

Cultural and Historical Considerations

Whether your organization/system provides trauma-specific treatment internally or refers out to community resources, there needs to be consideration for **cultural practices that address the healing of trauma**. Trauma-specific treatment is more effective when it is culturally responsive (SAMHSA, 2014b). Culture and historical context influence how people experience and assign meaning to trauma, how they think about systems of care that provide services and how they perceive the concerns that warrant assistance. Providers may need to put mechanisms in place for differences in communication, language, and literacy, and around distress and trauma symptoms.

Additionally, many cultures have traditional practices that can be an important part of the healing process. Exploring cultural traditions and values with individuals who are seeking trauma treatment is an important component of being trauma-informed. What supports that draw on cultural identity and healing can be part of the treatment process? Workers providing trauma-specific treatment also need to practice cultural humility and embody the trauma-informed values of collaboration and empowerment: Individuals are the experts of their own experiences and stories, and part of the treatment process is to identify capacities and strength through a cultural and historical lens. A willingness to listen and be respectfully curious in conversations around healing is important because the therapist's ideas and beliefs about healing may be different from the individual's or family's. Actively seeking workforce members—especially therapists—and referral agencies and community-based resources that represent the communities your organization/system works with is another important way to acknowledge and be present to cultural and historical considerations.

Planning and Discussion

The charts found in **Appendix II** and **Appendix JJ** can be used by the Trauma-Informed Committee to discuss, assess, and plan for the components of the Treating Trauma Key Development Area within the **Implementation Stage**. The worksheets' considerations and format are similar to Appendix B that was reviewed in the Getting Started section of this manual—however, there are now follow-up questions associated with each of the considerations and some space for you to write answers to these questions. Directions for their use can be found at the beginning of each appendix.

Sustainability Stage

Maintaining Action Steps

Sustainability within the Treating Trauma Key Development Area is reached when the organization/system has key practices in place to ensure individuals seeking trauma-specific treatment are connected to those who offer it in culturally responsive ways. **The Trauma-Informed Committee can use the following checklist to ensure that the key practices are in place:**

- ☐ There is a formal process for referring to the organization's own trauma therapists or collaborative partners for trauma-specific treatment.
- ☐ There is a clinical supervision/consultation schedule for each workforce member providing trauma-specific treatment.
- ☐ There is a formal mechanism to monitor fidelity to trauma-specific treatments.
- ☐ There are adequate resources (time, money, workers) allocated to training clinicians on trauma-specific treatments, when applicable.

The key practices for sustainability help organizations/systems stay committed to their plan for treating trauma by maintaining resources, protocols, and mechanisms for accountability. Especially in cases where organizations are providing trauma-specific treatment in-house, we recommend having someone on the Trauma-Informed Committee stay up to date on trauma-specific treatments and cultural considerations for treating trauma. Having another person or persons to keep the directory of referrals up to date is also important, especially when that is the core of the organization's/system's plan to treat trauma. Additionally, in the **Sustainability Stage** of the Treating Trauma Key Development Area, we encourage the Trauma-Informed Committee to commit to **revisiting Appendices GG, HH, II,** and **JJ**, as well as any feedback regarding the treatment or referral process at regular intervals during its standing meeting (e.g., quarterly or twice a year) to allow for flexibility and ongoing progress monitoring within this key development area.

Organizations/systems can benefit from defining and monitoring fidelity because it helps with treatment accountability and evaluation of outcomes.

Key Development Area #8 Collaborating with Others (Partners and Referrals)

The Collaborating with Others (Partners and Referrals) Key Development Area involves building on and/or creating mechanisms with partner organizations/ systems and community partners to collaboratively ensure trauma-informed networks, communities, and systems. The domains of consideration are:

Collaborating with Others (Partners and Referrals) Objectives:

- Determine at what levels (trauma-informed, trauma-sensitive, trauma-specific) others are operating in order to create a referral list.
- Promote cross-sector collaboration by identifying possibilities for awareness-building and the creation of common trauma-informed goals.
- Model the model of being trauma-informed by working with others, being reciprocal, and listening attentively.

Pre-Implementation Stage

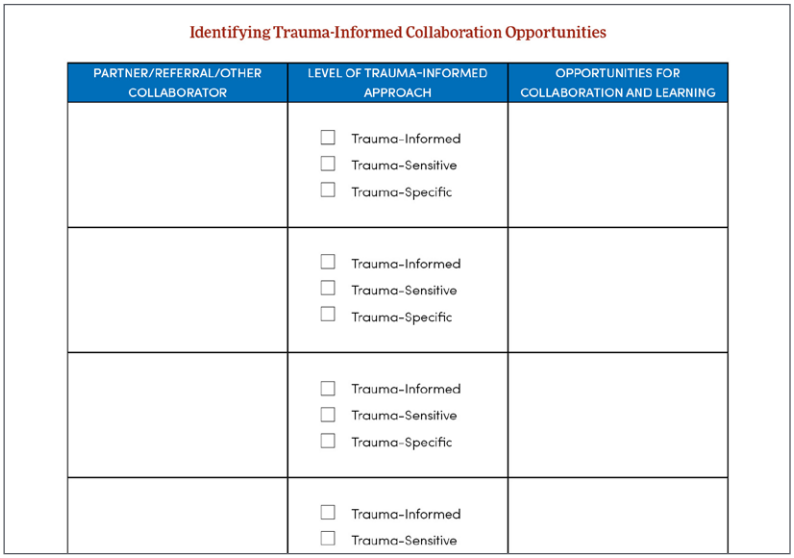
Identifying Opportunities in Collaboration

Consider those you collaborate with—whether that means partner organizations, community partners, referral locations, and/or other entities that your organization/ system regularly interfaces with. The first focus of this key development area in the **Pre-Implementation Stage** is to identify where collaborating entities are with regard to a trauma-informed approach and **consider where there may be opportunities to incorporate a trauma-informed approach together**. When thinking about other entities in relation to being trauma-informed, you will need to consider the four levels of a Trauma-Informed Care discussed previously on Page 31.

We know that individuals who have histories of trauma and adversity often have a variety of needs—which your organization/system may or may not directly address. Thus, even if your organization/system becomes trauma-informed, there is the potential that individuals will be referred to those partner organizations or collaborators. If they are not trauma-informed, the potential for re-traumatization still exists. On the other hand, there is the possibility that one or more of your partners or collaborators may be further along in the process of becoming trauma-informed. Additionally, part of being trauma-informed is recognizing the knowledge and experience of community-based organizations and partners. In both cases, identifying opportunities to share and learn from them can certainly be beneficial to your organization/system as well. At its essence, this key development area is intended to build trauma-informed networks and communities via education, advocacy, and creating collaborations based on mutual understanding of a trauma-informed approach.

The primary task within this key development area in the **Pre-Implementation Stage** is to **create a plan to maintain an up-to-date list of affordable, accessible, and culturally responsive referral sources** that workers have access to when interacting with clients/patients/students/consumers. Part of this referral list may include local resources for trauma-specific treatment, based on your decision in the Treating Trauma Key Development Area. However, even if you provide trauma-specific treatment in-house, it is still important to have such a referral list. Other resources such as mental health, medical care, housing, financial assistance, community support, etc. may be needed by individuals who have histories of trauma or when your services are at capacity. Part of the plan needs to consider who will be responsible for maintaining the referral list, how often it will be reviewed and how the organization/system will elicit feedback from those being referred in order to best ensure referral entities are as trauma-informed and trauma-sensitive as possible. We recommend that you finish reading the rest of the Collaborating with Others (Partners and Referrals) Key Development Area section before finalizing your plan.

Promote cross-sector collaboration by identifying possibilities for awareness-building and the creation of common trauma-informed goals.



Identifying Trauma-Informed Collaboration Opportunities

PARTNER/REFERRAL/OTHER COLLABORATOR	LEVEL OF TRAUMA-INFORMED APPROACH	OPPORTUNITIES FOR COLLABORATION AND LEARNING
	☐ Trauma-Informed ☐ Trauma-Sensitive ☐ Trauma-Specific	
	☐ Trauma-Informed ☐ Trauma-Sensitive ☐ Trauma-Specific	
	☐ Trauma-Informed ☐ Trauma-Sensitive ☐ Trauma-Specific	
	☐ Trauma-Informed ☐ Trauma-Sensitive	

Appendix KK

Appendix KK has a worksheet you can use to identify your partners, referral sources, and other collaborators. Once you have a list, indicate each one's level(s) of a trauma-informed approach: trauma-informed, trauma-sensitive, and/or trauma-specific. This may involve someone doing some research—making phone calls, visiting the other entity, etc. Take some time to indicate your organization's/system's relationship with each one. Where and in what ways do you already communicate? Collaborate? If an entity has already started the process of becoming trauma-informed, what can you learn from it? If not, what possibilities are there to include them in your organization's/system's trauma-informed change process? Also, consider who is missing from your list and how the organization/system can continue to build diverse collaborative relationships. We encourage the Trauma-Informed Committee to specifically consider how the organization/system collaborates and partners with community entities when brainstorming, using this worksheet—not just provider agencies and organizations. This list will be referenced again in the **Implementation Stage**.

Planning and Discussion

The charts found in **Appendix LL** and **Appendix MM** can be used by the Trauma-Informed Committee to discuss, assess, and plan for the components of the Collaborating with Others (Partners and Referrals) Key Development Area within the **Pre-Implementation Stage**. The worksheets' considerations and format are similar to Appendix B that was reviewed in the Getting Started section of this manual—however, there are now follow-up questions associated with each of the considerations and some space for you to write answers to these questions. Directions for their use can be found at the beginning of each appendix.

Part of being trauma-informed is recognizing the knowledge and experience of community-based organizations and partners.

Implementation Stage

SAMPLE COLLABORATING WITH OTHERS (PARTNERS AND REFERRALS) ACTION STEPS
☐ **Identify** trauma-informed and trauma-specific community resources.
☐ **Partner** with culturally relevant supports in the community.
☐ **Engage** partner agencies and providers in the trauma-informed initiative.
☐ **Include** community partners in the trauma-informed initiative.
☐ **Create** with partners and referrals structures for trauma-informed communication and goals.

Creating a Referral List

Based on the work done in the **Pre-Implementation Stage**, the first action consideration within the **Implementation Stage** is to **create an accurate, up-to-date referral list of agencies, organizations, and community resources that provide services that yours does not**. The process of creating a referral list involves the following considerations:

1. Doing research and calling potential referral agencies and organizations to find out what services they offer, getting more information about those services, and evaluating the degree to which they are accessible and inclusive.

2. Intentionally researching community-based organizations and other entities in the community that are relevant to the culture of individuals you work with to get more information about their supports.

3. Making personal connections with providers and community leaders at potential referral entities in order to provide a warm handoff whenever possible.

4. Gathering feedback from clients/patients/students/consumers about their experiences in referral settings, and taking the feedback into consideration when updating the referral list.

5. Continuing to be aware of which agencies and organizations are trauma-informed, trauma-sensitive, and trauma-specific by ensuring knowledge of what services and supports are provided.

6. Creating a protocol/schedule for regular review of the referral list for accuracy.

Often the Trauma-Informed Committee is responsible for the creation and maintenance of the referral list by identifying individuals to be in charge of it. However, the committee can certainly engage other members of the workforce to be in charge of keeping it updated, gathering feedback from those being referred, and/or overseeing the whole process.

Promoting Cross-Sector Collaboration

As the trauma-informed movement is still growing, there are many organizations, systems, and communities that are in varying stages of understanding and implementation of trauma-informed practices. Therefore, this key development area goes beyond having a list of referrals—it is critical that organizations/systems that are trauma-informed **actively collaborate with referral sources, partners, and other community entities to create**

a trauma-informed network/system of care. This collaboration is what operationalizes the vision of a trauma-informed service system. In the **Pre-Implementation Stage**, you already started a list of those organizations/systems/entities that your organization/system interacts with, and those that you want to collaborate with, using **Appendix KK**.

Cross-Sector Education and Mutual Learning

If you find that others are already engaging in the trauma-informed organizational change process, continue to see what you can learn from them and what opportunities there may be for collaboration. For organizations/systems and communities that have not yet begun the process of becoming trauma-informed, consider what structures are in place to promote cross-sector education, training, and mutual learning. Such structures may include inviting partners and referral sources to attend your educational presentations and trainings (and thus writing them into your overall training plan as discussed in the Training the Workforce (Clinical and Non-Clinical) Key Development Area). At the same time, you could have trainers from your trauma-informed Champion Team offer to go out to collaborative-partner or community locations to provide education and awareness. Participation in joint trainings provides additional opportunities for staff members from multiple organizations to connect and share informally.

Modeling Collaboration

While larger-scale education efforts, like the previous two mentioned, are ideal and effective, it is also important to consider additional opportunities in which your workforce interfaces with others. For example, awareness-building, education, and advocacy for trauma-informed, culturally responsive decision-making can be done within structures for communication, such as phone calls, interdisciplinary treatment team meetings, committee meetings, etc. Workers who are trained in a trauma-informed approach (especially Champions) can model the model and informally educate referral sources and partners by using the language of the guiding values and principles, reminding others to be mindful of re-traumatization and the impact of individual, historical, and systemic trauma.

Consider additional opportunities in which your workforce interfaces with others.

Additionally, the Trauma-Informed Committee can invite members from key partnerships—especially those in the community—to join committee meetings. They can be invited as formal members of the committee, such as by having former clients, family members of clients, and/or peers (those with lived experience) at the table. There can also be other mechanisms set up to regularly get partner and community feedback on what the committee is working on. Engaging with the community is critical for modeling the model of the trauma-informed value/principle of collaboration, as it allows for diverse perspectives to inform decision-making and acknowledges that people are experts of their own experiences. Collaborating in this way will create opportunities to work through

Engaging with the community is critical for modeling the model of the trauma-informed value/principle of collaboration, as it allows for diverse perspectives to inform decision-making.

differing organizational cultures and values—a positive contribution toward a trauma-informed system of care. Acknowledging and witnessing organizational and historical narratives of the larger community with your partners is important to inform your organization's/system's trauma-informed work, and help you achieve the larger goal of this key development area to form a trauma-informed community.

Formalizing Trauma-Informed Collaboration

Lastly, having formal mechanisms in place for creating common trauma-informed goals with partners and referral sources is another consideration within this key development area. One example of how we have seen organizations do this is by incorporating language about a trauma-informed approach into their memoranda of understanding (MOU) with partners—a written agreement in which both entities identify the trauma-informed approach as important to their partnership and collaboration.

For example, consider having language in an MOU that allows one organization to have access to training, meetings, etc. of the other in order to learn and grow, based on the other's trauma-informed efforts and experience.

A large county organization that provides funding and support to partner organizations requires a plan for trauma-informed development and work as part of the application for support.

Such partnerships will continue to contribute to the creation and sustainability of trauma-informed networks and communities that are informed by organizational and historical narratives.

Planning and Discussion

The charts found in **Appendix NN** and **Appendix OO** can be used by the Trauma-Informed Committee to discuss, assess, and plan for the components of the Collaborating with Others (Partners and Referrals) Key Development Area within the Implementation Stage. The worksheets' considerations and format are similar to Appendix B that was reviewed in the Getting Started section of this manual—however, there are now follow-up questions associated with each of the considerations and some space for you to write answers to these questions. Directions for their use can be found at the beginning of each appendix.

Sustainability Stage

Maintaining Action Steps

Sustainability within the Collaborating with Others (Partners and Referrals) Key Development Area is reached when the organization/system has key practices in place to promote trauma-informed collaboration and minimize the potential for re-traumatization between organizations/systems and the larger community. **The Trauma-Informed Committee can use the following checklist to ensure that the key practices are in place:**

- ☐ There is an individual responsible for ensuring an up-to-date list of affordable, accessible, culturally responsive referrals to meet needs of individuals with trauma histories.
- ☐ There are mechanisms in place to promote trauma-informed cross-sector training, communication, and collaboration with partners, referral sources, and the community.

The key practices for sustainability require ongoing commitment to both the plan to maintain the referral list and to model collaboration with other organizations and the community as a whole. Additionally, in the **Sustainability Stage** of the Collaborating with Others (Partners and Referrals) Key Development Area, we encourage the Trauma-Informed Committee to commit to **revisiting Appendices LL, MM, NN, and OO**, as well as any feedback regarding collaborative and/or referral processes, at regular intervals during its standing meeting (e.g., quarterly or twice a year) to allow for flexibility and ongoing progress monitoring within this key development area. Ensuring representation from partners, referral sources, and the community as part of this committee process is a means of sustaining the work in this key development area as well.

Key Development Area #9
Reviewing Policies and Procedures

The Reviewing Policies and Procedures Key Development Area involves confirming that all policies, procedures, protocols, and forms are written and conducted in a way that is in line with a trauma-informed and trauma-sensitive approach. The domains of consideration are:

Reviewing Policies and Procedures Objectives:

- Establish the group of individuals who will review policies/procedures.
- Create a plan for how often policies/procedures will be reviewed.
- Identify policies/procedures that are already in line with a trauma-informed approach.
- Make a deliberate decision to use the lens/filter of the three levels of a trauma-informed approach when reviewing and creating policies/procedures.
- Engage in transparent communication regarding the review process and changes.
- Invite feedback on policy/procedure review from all individuals.
- Ensure policies/procedures are easily accessible and culturally responsive to individuals they pertain to.

Pre-Implementation Stage

Setting the Stage for Trauma-Informed Policies and Procedures

Reviewing policies, procedures, protocols, and forms to ensure they are in line with a trauma-informed approach is critical to the establishment and sustainability of trauma-informed organizational change. Within the **Pre-Implementation Stage**, the task of the Trauma-Informed Committee is to **prepare for the reviewing process by creating a formal plan.**

The list below summarizes how you can begin doing so:

1 **The Reviewers:** To begin this process, your organization/system will need to decide who will be a part of the formal reviewing team. We recommend having at least two individuals directly involved in this process. Organizations/systems often have many written policies and procedures to move through, which can be a daunting task for only one individual. Additionally, one person may identify or think of something that someone else may not, so having multiple and diverse viewpoints is important.

With regard to the question of who needs to be a reviewer, it is critical to have an individual involved who has the power to make changes to policies and procedures. We also recommend considering having various roles and perspectives—meaning involving representation from at least a few different levels of the workforce and hearing the voices of clients/patients/students/consumers who reflect diversity and inclusion. It may also be necessary to bring in different reviewers, based on the policy being reviewed (e.g., HR staff to review HR policies, clinical staff to review clinical services policies). How will there be opportunities to gather/provide feedback about policy changes anonymously?

Once the specific composition of the review team has been decided, the other consideration regarding reviewers is how they will be trained to conduct the review from a trauma-informed perspective. Topics for training include re-traumatization themes, how to consider power, control, and equity in policies/procedures, using the values and principles of trauma-informed approaches, and inclusive, trauma-informed language.

2 **Timeline for Initial Review:** After deciding who will be involved, the plan needs to incorporate a timeline over which the initial review will occur. This timeline includes recruiting and training reviewers, deciding in what order policies, procedures, protocols, and forms will be reviewed, time to make revisions, how and when feedback will be elicited from those not directly at the review table, and how and when changes to policies, procedures, protocols, and forms will be communicated.

3 **How Often Reviews Will Occur:** Next, your organization/system will need to consider and plan for how often the review process will occur after the initial review. Certain documents or procedures may no longer make sense or be relevant after time, regulations may change, stakeholders change, etc. Having a formal process in place will ensure the organization/system is consistently upholding the principle of trustworthiness by being clear in expectations and providing a means of collaboration when the review process is conducted in a way that invites the voices of others.

4 **Creating New Policies and Procedures:** Another important aspect of your plan is to consider how the trauma-informed perspective will be incorporated when the organization/system creates new policies, procedures, protocols, and forms. We recommend that those in the position of creating these utilize the expertise of those who are part of the review team. Again, having a subgroup of the Trauma-Informed Committee be dedicated to policies can be helpful because then there is a formal structure to be included in the review of new policies, procedures, protocols, and forms.

5 **Accessibility:** In addition to the policies, procedures, protocols, and forms being trauma-informed, the organization/system needs to ensure that individuals have access in writing to those that apply to them—whether access is online or printed is up to you. How does the workforce already have access to your current policies and procedures? How do clients/patients/students/consumers have access to expectations, rules, and regulations pertaining to them? Is there a need

Reviewing policies, procedures, protocols, and forms to ensure they are in line with a trauma-informed approach is critical to the establishment and sustainability of trauma-informed organizational change.

to have written policies, protocols, procedures, and forms in other languages, based on the individuals within your organization/system? Does the workforce need to sift through pages and pages of policies that do not pertain directly to them, or is there a way to indicate what does pertain to them (e.g., having a section of policies that applies to everyone and then role/program-specific policies)? Again, ensuring the principle of trustworthiness via transparency of what to expect and what is expected of an individual is a critical component of this key development area.

6 **What is Already in Place:** The last consideration for the trauma-informed review plan is deliberately acknowledging the ways that current policies, procedures, protocols, and forms already have aspects of a trauma-informed, trauma-sensitive and/or trauma-specific approach. For example, what does your organization/system already have in place pertaining to safety? Are there written safety/crisis plans, and/or required annual mandatory safety training for workers? Does your organization/system have a de-escalation policy? Does the organization/system already have a written commitment to diversity, equity, inclusion, and accessibility? Are there protocols to ensure individuals are connected to trauma screening, assessment, and treatment? We encourage the Trauma-Informed Committee and/or the reviewer team to first consider what parts of policies, procedures, protocols, and forms already utilize the trauma-informed values and principles—even if the language is not intentional—in order to utilize those as examples of what is possible and build from there. This acknowledgement can also be encouraging to an organization facing a seemingly daunting organizational change process.

Once the Trauma-Informed Committee has considered and made a plan based on the five items above, you will be ready to start reviewing individual policies, procedures, protocols, and forms. This process will be discussed in more detail during the **Implementation Stage**.

Planning and Discussion

The charts found in **Appendix PP** and **Appendix QQ** can be used by the Trauma-Informed Committee to discuss, assess, and plan for the components of the Reviewing Policies and Procedures Key Development Area within the **Pre-Implementation Stage**. The worksheets' considerations and format are similar to Appendix B that was reviewed in the Getting Started section of this manual—however, there are now follow-up questions associated with each of the considerations and some space for you to write answers to these questions. Directions for their use can be found at the beginning of each appendix.

Implementation Stage

SAMPLE REVIEWING POLICIES AND PROCEDURES ACTION STEPS
☐ **Review** all policies/procedures regularly with a trauma-informed lens.
☐ **Include** the voices of various stakeholders in the review process.
☐ **Address** historical contexts and power dynamics inherent in formal policies.
☐ **Reflect** a commitment to diversity, equity, inclusion, and accessibility in policies/procedures.
☐ **Write** policies/procedures in positive language focused on the desired behavior/outcome.
☐ **Ensure** all policies/procedures are written, clear, and accessible.

Conducting Reviews with a Trauma-Informed Lens

With a plan in place for creating and reviewing policies, procedures, protocols, and forms from a trauma-informed perspective, the main task within the **Implementation Stage** is to conduct the review. The initial review from a trauma-informed perspective will likely take the longest amount of time and effort, and thus it is important to have a reasonable timeline based on the number of policies and procedures your organization/system has. As previously discussed, we recommend that you have several people to help with this initial review, given the many nuances to look for and the fact that one person may identify something that another did not consider.

*The checklist in **Appendix RR** provides a reference tool that can be used when reviewing any given policy, procedure, or form. The narrative below elaborates on what to pay attention to and look for when reviewing—we recommend that anyone participating in the review process be familiar with this narrative prior to using the tool.*

Appendix RR will assist individuals in reviewing policies, procedures, protocols, and forms, using guidance in three primary areas:

1 Potential for Re-Traumatization – Each item being reviewed needs to be considered honestly for the potential of re-traumatization of any individual within the organization/system. The re-traumatization chart on Page 20 of this manual can be referenced for common trauma dynamics/themes that often play out in service delivery, workplace environments, and interactions that will likely bring up people's trauma history, regardless of the details of what happened to them. For example, intake and assessment protocols that require individuals to answer similar questions or repeat the same information as they move through different floors/departments/workers of one organization/system will more often than not trigger those whose history includes a dynamic of being unseen or unheard.

2 Applying the Guiding Values and Principles – Especially if the potential for re-traumatization is recognized, the next step is to apply one or more of the five guiding values and principles—safety, trustworthiness, choice, collaboration, and empowerment—to reduce the risk. Using the previous example of individuals having to retell their stories, the values and principles can be applied via adjustments to the protocol. For example, the protocol can change to a triage assessment or to include a system where assessment information is transferred with the individual to better anchor emotional safety. Or the protocol can ensure that

workers are transparent about the fact that the individual may have already answered similar questions when talking to a different staff member, which could promote trustworthiness.

Additionally, the values and principles are intentionally applied in order to maintain a commitment to diversity, equity, inclusion, and accessibility within policies, procedures, protocols, and forms. For example, how do client and human resources forms provide emotional safety and choice by being inclusive of various pronouns and gender identities, and asking individuals what they prefer to be called? How do procedures and protocols foster empowerment by incorporating opportunities for cultural practices and expressions of diversity, based on the communities represented within your organization/system?

3 **Written Language** – Once the calls to action in policies, procedures, protocols, and forms are anchored in a trauma-informed approach, it is important to review the way they are written—looking specifically at the language used. Similar to the considerations already discussed in the Building a Trauma-Informed Workplace Key Development Area, in relation to reviewing the employee handbook and other human resources documents, other policies and procedures need to reflect the understanding that language used has the potential for re-traumatization, too. While the review for trauma-informed and inclusion language is not a cut-and-dried process, there are a few general guidelines to consider:

Ensure expectations describe the desired behavior/outcome rather than using "no," "not allowed," "cannot," etc. For example, reframe the statement, "Workers may not share client information with anyone without a written consent signed by the client" to "Workers may only share client information when there is a written consent signed by the client."

Review for shame/blame language (e.g., "workers should") and absolutes (e.g., "workers must"). When identified, replace with language indicating what is expected in that given situation/scenario. For example, changing the statement, "In the event of an emergency, workers should first call 9-1-1 and then notify their supervisors" to "In the event of an emergency, workers are expected to first call 9-1-1 and then notify their supervisors."

Review for any jargon, idioms, acronyms, or professional language that may limit the ability of individuals to understand the meaning—replacing these with concrete and simple language will increase overall transparency.

Review for inclusivity by ensuring that language used is person-first (e.g., "individuals who are homeless" rather than "homeless people"), is gender neutral (e.g., avoiding default language of he/his or gendering roles), and not unintentionally exclusive (e.g., using "parent/caregiver" instead of "mom/dad/birth family").

Review for potentially triggering labels, words, or phrases, such as "noncompliant," "no show," "rule of thumb," "black and white," etc.

The use of trauma-informed and inclusive language is important. However, it is also equally critical to ensure that expectations are clear after any language changes. There ultimately needs to be a balance between using trauma-informed language and clarity of expectations. For example, completely removing from a protocol absolute language or language that describes what is not allowed may leave workers unclear regarding what is expected of them, depending on revisions—thus not anchoring the principle of trustworthiness. We have learned when reviewing policies and procedures that it can be helpful to focus more on using trauma-informed language, and anchoring the values and principles in the policy narrative first, while focusing more on concrete and well-defined expectations in the procedure.

There needs to be a balance between using trauma-informed language and clarity of expectations.

Some organizations intentionally bring their legal and/or union partners in as part of the review process. They are trained on how to consider a trauma-informed lens when reviewing policies, procedures, protocols, and forms, and can then assist in the process of maintaining the balance between trauma-informed language and clear expectations. They are also helpful in letting the review team know what wording can and cannot be changed legally.

Planning and Discussion

The charts found in **Appendix SS** and **Appendix TT** can be used by the Trauma-Informed Committee to discuss, assess, and plan for the components of the Reviewing Policies and Procedures Key Development Area within the **Implementation Stage**. The worksheets' considerations and format are similar to Appendix B that was reviewed in the Getting Started section of this manual—however, there are now follow-up questions associated with each of the considerations and some space for you to write answers to these questions. Directions for their use can be found at the beginning of each appendix.

Sustainability Stage

Maintaining Action Steps

Sustainability within the Reviewing Policies and Procedures Key Development Area is reached when the organization/system has key practices in place to ensure regular review of policies, procedures, protocols, and forms, using a trauma-informed lens. **The Trauma-Informed Committee can use the following checklist to ensure that the key practices are in place:**

- ☐ There is a schedule for conducting regular trauma-informed reviews of policies and procedures.
- ☐ There are guidelines for considering trauma-informed language in developing new policies and procedures.
- ☐ There is a mechanism for all individuals to provide feedback on policy and procedure revisions.
- ☐ There is a designated, accessible place for individuals to obtain policies and procedures that pertain to them.
- ☐ There is a schedule for training workforce members to review policies and procedures for re-traumatization, equity, and inclusive, trauma-informed language.

The key practices for sustainability require a commitment to time and resources being put toward trauma-informed reviews of policies and procedures in ways that promote the gathering of feedback from various stakeholders when making revisions. Accountability can be promoted by having a key member of the Trauma-Informed Committee responsible for ensuring there is time on the calendar for review and for training reviewers. Some organizations/systems designate a subcommittee specifically for policy review that works alongside leadership or administration to create and review policies.

Additionally, in the **Sustainability Stage** of the Reviewing Policies and Procedures Key Development Area, we encourage the Trauma-Informed Committee to commit to revisiting **Appendices PP, QQ, SS, and TT,** as well as any feedback regarding policies, procedures and protocols at a regular interval during their standing meeting (e.g., quarterly or twice a year) to allow for flexibility and ongoing progress monitoring within this key development area.

It is critical to ensure policies/procedures are easily accessible and culturally responsive to individuals they pertain to.

Key Development Area #10
Evaluating and Monitoring Progress

The Evaluating and Monitoring Progress Key Development Area involves having mechanisms in place to evaluate and monitor trauma-informed organizational change, as well as its impact on the organization/system in relation to outcomes. The domains of consideration are:

Evaluating and Monitoring Progress Objectives:

- Identify organizational components to be evaluated.
- Develop strategies to evaluate the trauma-informed change process.
- Evaluate trauma-informed organizational change (culture/climate) regularly.
- Evaluate regularly the impact of a trauma-informed approach on outcome data and quality improvement.
- Revisit each of the key development areas to consolidate gains, monitor progress, and adjust implementation as needed.
- Incorporate in the evaluation the voices of all individuals in the organization/system.

Pre-Implementation Stage

Identifying What to Measure

Evaluation of how trauma-informed an organization/system is involves primarily looking at the culture and climate through a trauma-informed lens. **Organizational *culture*** has been defined as "the behavioral norms and expectations that characterize a work environment. These norms and expectations direct the way employees in a particular work environment approach their work, specify priorities, and shape the way work is done" (Glisson, 2015, p.2). In contrast, **organizational *climate*** is "created by shared perceptions of the psychological impact of employees' work environment on their own personal well-being and functioning" (Glisson, 2015, p.2). Prior to creating the evaluation plan, the Trauma-Informed Committee needs to decide what it is going to measure to inform how it will be measured. Both culture and climate are impacted when organizational change occurs—many organizations decide to measure both.

In our work with organizations/systems, we measure climate by asking the workforce its perceptions of the five values and principles of a trauma-informed approach. We measure the culture by asking about specific policies, procedures, and practices that characterize trauma-informed organizations/systems.

Outcome data is a second category of what organizations/systems may decide to measure alongside changes in culture and/or climate. We invite the committee to consider what outcome data the organization/system already collects (e.g., for individuals and staff) that you hope the trauma-informed change process will positively impact. Having a mechanism to track trends in your quality improvement data alongside trauma-informed change is an important part of the overall evaluation plan. Evaluating the impact of the trauma-informed change process on outcomes may also include the decision to evaluate additional outcomes, based on the nature of this work. We will discuss examples of such outcomes in the Implementation Stage section of this key development area.

Creating a Trauma-Informed Evaluation Plan

As previously discussed within the Our Approach section of the manual, having an evaluation plan is necessary for measuring the progress and overall success of trauma-informed organizational change. In order to do this, the organization/system needs to create an evaluation plan that both incorporates an initial baseline evaluation that ideally occurs before any formal training or implementation steps occur, as well as mechanisms for regularly evaluating and monitoring progress that promote accountability for the work.

As part of the process of creating a trauma-informed evaluation plan, we encourage the Trauma-Informed Committee to consider the following:

Tools to Evaluate: There are various trauma-informed organizational assessment tools to choose from in the Additional Resources section of the manual on Page 129—some are free, others have costs. Some are designed to be utilized as surveys, others can inform focus group questions. We recommend that your organization/system select an assessment tool that best fits your needs, based on considerations of funds, availability of personnel to collect information and evaluate data, duration of the tool, and methods to best reach the stakeholders to gather the information you need (e.g., online survey, paper-and-pencil survey, focus groups, one-on-one interviews, etc.). Ideally, you will want to use the same tool(s) consistently over time in order to compare baseline evaluation results to subsequent evaluation results as a means of truly monitoring progress.

We have had to adapt our methods of collecting data when working with various organizations and systems. While we typically collect data via an online survey, there are times when a paper-and-pencil survey, or conducting focus groups or one-on-one interviews yield better results because of accessibility considerations.

We have provided a free sample assessment tool on the following page. Our shortened Trauma-Informed Climate Scale-10 (TICS-10) is a brief, validated instrument to gather feedback from the workforce on the five guiding values and principles of TIC. Organizations have found this tool to be easy to administer, while still providing valuable information to "take a pulse" as to how the change process is being received and impacting their staff.

TRAUMA-INFORMED CLIMATE SCALE-10 (TICS-10)

The following questionnaire may be used to assess your perceptions of the agency you currently work for. The TICS-10 is a reduced version of the Trauma-Informed Climate Scale (Hales, Kusmaul, & Nochajski, 2017), based on Harris and Fallot's (2001) five values of TIC. The TICS-10 has been validated in research (Hales, Kusmaul, Sundborg, & Nochajski, 2019).

Please select the extent to which you agree or disagree with the following statements, using the following rating scale:

1 = Strongly Disagree 2 = Disagree 3 = Not Sure 4 = Agree 5 = Strongly Agree

_____ 1. When I come to work here, I feel emotionally safe.

_____ 2. If I am upset at work, I know that other staff and supervisors will understand.

_____ 3. I'm not sure whom I can trust among my co-workers, supervisors, and administrators.

_____ 4. I can trust my supervisor to be fair in dealing with all staff.

_____ 5. I feel like I have a great deal of control over my job satisfaction.

_____ 6. I don't have many choices when it comes to doing my job.

_____ 7. The leadership listens only to their favorite employees.

_____ 8. The administration here does not share decision-making with the rest of the staff.

_____ 9. This organization doesn't seem to care whether staff members get what they need to do their jobs well.

_____ 10. Staff members are not supported when they try to find new and better ways to do things.

** See **Appendix NN** for the scale and directions for scoring.

TOOLS FOR CLIENTS/PATIENTS/ STUDENTS/CONSUMERS

As the Trauma-Informed Committee considers tools for the evaluation plan, it is important to acknowledge there is still a lack of tools for collecting client/patient/student/consumer perspectives on trauma-informed change. The majority of the tools linked to in the Additional Resources section were created for workforce members and would require adaptation to be used with clients/patients/students/ consumers. As the field of trauma and trauma-informed care is rapidly changing and growing, we encourage the committee to stay informed about new resources and materials that will become available.

Time Frame for Evaluation: After selecting the focus and means for conducting the trauma-informed evaluation, the Trauma-Informed Committee needs to consider when the initial baseline evaluation will occur and how often the organization/system will conduct the evaluation process to monitor progress after the fact. From a true evaluation perspective, it is most useful to conduct the baseline evaluation prior to any implementation occurring. Having baseline evaluation data as early as possible can inform the committee's decision-making around priority areas within the trauma-informed organizational plan. We recognize that it is not always possible to have a true baseline because organizations/ systems will be in various points in the process when reading the manual. Generally speaking, organizations tend to re-evaluate at least annually as a formal mechanism to learn what impact planning and implementation steps are having.

Sharing and Using Information: Any time members of an organization/system ask for feedback, it is important that there be a deliberate system for collecting, organizing, and reporting on the results and any action steps that will be taken. How will the trauma-informed committee analyze evaluation results and use the data collected to inform implementation plans? In order to promote trustworthiness, we also recommend that leaders and the committee be transparent about the evaluation process, what it will be used for, and when and where those who are providing feedback can expect to hear a summary of the findings. We encourage the use of an informed consent form or statement, and clarifying whether data will be anonymous (no one will know the name) versus confidential (the name will be known but not shared). Additionally, depending on your stakeholders (e.g., community members), there may be a need to formally acknowledge and address historical contexts and/or inequities when collecting information. Being transparent about the purpose and any limits to confidentiality, addressing what is possible and what is not, based on feedback gathered, following through on what you say you will do, and providing mechanisms that are accessible to those whom you are collecting feedback from are ways to promote emotional safety, trustworthiness, and empowerment in the process.

Planning and Discussion

The charts found in **Appendix VV** and **Appendix WW** can be used by the Trauma-Informed Committee to discuss, assess, and plan for the components of the Evaluating and Monitoring Progress Key Development Area within the **Pre-Implementation Stage**. The worksheets' considerations and format are similar to Appendix B that was reviewed in the Getting Started section of this manual—however, there are now follow-up questions associated with each of the considerations and some space for you to write answers to these questions. Directions for their use can be found at the beginning of each appendix.

Implementation Stage

SAMPLE EVALUATING AND MONITORING PROGRESS ACTION STEPS

- ☐ **Create** mechanisms for ongoing trauma-informed evaluation.
- ☐ **Include** diverse stakeholder voices in evaluation measures.
- ☐ **Share** evaluation results and regularly respond to feedback collected.
- ☐ **Incorporate** trauma-informed practices into quality improvement processes.
- ☐ **Promote** trustworthiness and emotional safety by explaining why information is being collected, how it will be used, any parameters on anonymity/confidentiality, and by acknowledging power dynamics.

Evaluating Impact on Organizational Change

With the evaluation plan created in the **Pre-Implementation Stage**, the first consideration within the Evaluating and Monitoring Progress Key Development Area in the **Implementation Stage** is **conducting the baseline evaluation, and then subsequent evaluations as per your decided timeline**. The purpose of this formal evaluation is to monitor overall trauma-informed change through stakeholder perceptions of the five guiding values and principles of a trauma-informed approach (climate), and/or what policies and practices are in place within the organization/system (culture), depending on what the committee decides to measure. Again, we recommend that, when possible, organizations/systems use the same evaluation tool(s) as those used in the baseline so that it is possible to compare data and monitor progress over time.

Evaluating Impact on Outcome Data and Quality Improvement

As briefly mentioned in the **Pre-Implementation Stage**, another important component to consider—especially if/when grant funding is sought—is tracking how the trauma-informed change process is impacting data that your organization/system already gathers for outcome measures and/or quality improvement. Given that a trauma-informed approach is relatively new, compared to other frameworks, it is all the more important to gather data to determine if implementing it contributes to or leads to positive benefits for the workforce and clients/patients/students/consumers. Tracking changes often does not require additional work on the part of the organization/system—just someone to compare data gathered before the implementation of the trauma-informed approach to that gathered at regular intervals throughout the process (e.g., one year, two years, etc.). For example:

In our work with schools, we have looked at changes in various student outcomes already monitored, such as academic performance and disciplinary referrals, before TI-EP was implemented and throughout the change process.

With regard to quality improvement measures specifically, part of this key development area is incorporating the trauma-informed approach directly into the measures already being used.

This could be something as simple as adding a few questions regarding the five values and principles into client/patient/consumer exit surveys or yearly workforce satisfaction surveys, and using the feedback to make improvements.

Organizations/systems may decide to track new outcome data, based on the nature of the trauma-informed change process. Some examples of outcomes are: staff satisfaction, compassion fatigue, organizational commitment, and readiness to change.

Many organizations we work with decide to include the Professional Quality of Life Scale (PROQOL) to monitor compassion satisfaction and compassion fatigue over time as an outcome to compare with trauma-informed change.

Being a trauma-informed organization requires an active commitment to diversity, equity, inclusion, and accessibility. Therefore, we encourage the Trauma-Informed Committee to assess how well the organization/system collects, tracks, and uses data on different demographics (e.g., race, gender, culture, age), social determinants of health, accessibility, and equity of services provided to inform goals and better understand needs of individuals in order to address them.

Planning and Discussion

The charts found in **Appendix XX** and **Appendix YY** can be used by the Trauma-Informed Committee to discuss, assess, and plan for the components of the Evaluating and Monitoring Progress Key Development Area within the **Implementation Stage**. The considerations and format in these worksheets are similar to Appendix B that was reviewed in the Getting Started section of this manual—however, there are now follow-up questions associated with each of the considerations and some space for you to write answers to these questions. Directions for their use can be found at the beginning of each appendix.

Given that a trauma-informed approach is relatively new, compared to other frameworks, it is all the more important to gather data to determine if implementation contributes to or leads to positive benefits for the workforce and clients/patients/students/consumers.

Sustainability Stage

Maintaining Action Steps

Sustainability within the Evaluating and Monitoring Progress Key Development Area is reached when the organization/system has key practices in place to engage in ongoing evaluation and progress monitoring of the trauma-informed change process. **The Trauma-Informed Committee can use the following checklist to ensure that the key practices are in place:**

- ☐ There is a schedule for conducting regular trauma-informed evaluation.
- ☐ There is a protocol for the collection, analysis, and reporting of trauma-informed evaluation data that also addresses power, privilege, and historical and racial trauma.
- ☐ Trauma-informed practices are integrated into performance evaluations (see the Building a Trauma-Informed Workplace Key Development Area), quality assurance/ improvement measures, etc.
- ☐ The Trauma-Informed Committee dedicates a portion of its regular meetings to monitoring progress in the key development areas.

The key practices for sustainability require a commitment to time and resources being put toward evaluation and progress monitoring efforts. Accountability can be promoted by having a key member of the Trauma-Informed Committee designated to ensure the implementation of the trauma-informed evaluation schedule, and that the committee is dedicating time to monitoring progress during its regular meetings.

Additionally, in the **Sustainability Stage** of the Evaluating and Monitoring Progress Key Development Area, we encourage the Trauma-Informed Committee to commit to **revisiting Appendices VV, WW, XX, and YY**, as well as any feedback regarding the evaluation processes, at regular intervals during its standing meeting (e.g., quarterly or twice a year) to allow for flexibility and ongoing progress monitoring within this key development area.

Remember that the commitment to monitoring progress in all 10 key development areas within the **Sustainability Stage** is also a means of sustainability specifically for the Evaluating and Monitoring Progress Key Development Area. The boundary between the **Implementation** and **Sustainability** stages is fluid—as the considerations for each development area are reviewed, the implementation plan may need to be tweaked, re-implemented, and reassessed. This re-evaluation process anchored in progress monitoring and evaluation with the goal of further integration into the organization/system is the essence of sustainability.

As part of the process of revisiting each of the appendices associated with the 10 key development areas, we advise the Trauma-Informed Committee to utilize the worksheets in **Appendix ZZ** in order to create action steps to improve the level of implementation within that identified area. Directions for its use can be found at the beginning of the appendix.

Additional Resources

Leading and Communicating

Leadership Investment and Organizational Readiness

- Center for Health Care Strategies – Key Ingredients for Successful Trauma-Informed Care Implementation

http://www.chcs.org/media/ATC_whitepaper_040616.pdf

- Center for Health Care Strategies – Laying the Groundwork for Trauma-Informed Care

https://www.chcs.org/media/Laying-the-Groundwork-for-TIC_012418.pdf

- Community Connections (Harris & Fallot) – Creating Cultures of Trauma-Informed Care

https://www.theannainstitute.org/CCTICSELFASSPP.pdf

- Substance Abuse and Mental Health Services Administration – Concept of Trauma and Guidance for a Trauma-Informed Approach

https://store.samhsa.gov/system/files/sma14-4884.pdf

- Substance Abuse and Mental Health Services Administration – TIP-57 (Part 2, Chapter 1 p159-171)

https://store.samhsa.gov/system/files/sma14-4816.pdf

- Trauma-Informed Care Implementation Resource Center – Lead and Communicate about Becoming Trauma-Informed

https://www.traumainformedcare.chcs.org/lead-and-communicate-about-becoming-trauma-informed/

- Trauma Informed Oregon – Hosting a Meeting Using Principles of Trauma-Informed Care

https://traumainformedoregon.org/resource/hosting-meeting-using-principles-trauma-informed-care/

- Trauma Informed Oregon – Workforce Questions Related to Trauma-Informed Care

https://traumainformedoregon.org/resource/workforce-questions-related-trauma-informed-care/

Forming a Trauma-Informed Committee, Workgroup or Team

- Trauma Informed Oregon – Workgroup Meeting Guidelines

https://traumainformedoregon.org/resource/trauma-informed-care-workgroup-meeting-guidelines/

Trauma-Informed Messaging

- Trauma Informed Oregon – Sample Trauma-Informed Care Newsletters

https://traumainformedoregon.org/resource/sample-trauma-informed-care-newsletters/

Baseline Evaluation

- See the resources under the Evaluating and Monitoring Progress section.

Building a Trauma-Informed Workplace

Interview Questions

- National Council for Behavioral Health – Trauma-Informed Care Interview Questions

https://www.nationalcouncildocs.net/wp-content/uploads/2018/07/TIPCI-Interview-Questions.pdf

- Trauma Informed Oregon – Human Resources Practices to Support Trauma-Informed Care in Your Organization

https://traumainformedoregon.org/resource/human-resources-practices-support-tic/

New Hire Orientation

- Institute on Trauma and Trauma-Informed Care – Basics for All Staff: Online Modules

http://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/online-modules.html

- National Child Traumatic Stress Network (NCTSN) - Learning Center

https://learn.nctsn.org/

- Wisconsin Department of Public Instruction – Trauma-Sensitive Schools Learning Modules

https://dpi.wi.gov/sspw/mental-health/trauma/modules

Trauma-Informed Hiring and Orientation Protocols

- Missouri Department of Mental Health – Policy Guidance for Trauma-Informed Human Resources Practices

https://dmh.mo.gov/media/pdf/policy-guidance-trauma-informed-human-resources-practices

- Trauma Informed Oregon – Human Resources Practices to Support Trauma-Informed Care in Your Organization

https://traumainformedoregon.org/resource/human-resources-practices-support-tic/

Training the Workforce (Clinical and Non-Clinical)

Foundational Education

- Institute on Trauma and Trauma-Informed Care – Basics for All Staff: Online Modules

http://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/online-modules.html

- National Child Traumatic Stress Network (NCTSN) - Learning Center

https://learn.nctsn.org/

- Wisconsin Department of Public Instruction – Trauma-Sensitive Schools Learning Modules

https://dpi.wi.gov/sspw/mental-health/trauma/modules

Addressing the Impact of the Work

Training

- Lipsky & Burk - Trauma Stewardship (book)

https://www.amazon.com/Trauma-Stewardship-Everyday-Caring-Others/dp/157675944X

- Office for Victims of Crime – The Vicarious Trauma Toolkit

https://vtt.ovc.ojp.gov/

- UB School of Social Work – Self-Care Starter Kit

http://socialwork.buffalo.edu/resources/self-care-starter-kit.html

- WISE & Rogers Behavioral Health - The Compassion Resilience Toolkit

https://compassionresiliencetoolkit.org/

Supervision

- Hudnall Stamm - Professional Quality of Life Scale (ProQOL)

https://proqol.org/proqol-measure

- Institute on Trauma and Trauma-Informed Care – Trauma-Informed Supervision: A Practical Framework

https://ubswce.ce21.com/item/traumainformed-supervision-practical-framework-111168

- National Child Traumatic Stress Network – Using the STS Core Competencies in Trauma-Informed Supervision

https://www.nctsn.org/resources/using-secondary-traumatic-stress-core-competencies-trauma-informed-supervision

- Network180 & SAMHSA – Trauma-Informed Care Clinical Supervision Scenarios Training Video

https://www.youtube.com/watch?v=bJe5fFnwNdA&app=desktop

- Treisman – Trauma-Informed Supervision (Therapeutic/frontline context)

http://www.safehandsthinkingminds.co.uk/wp-content/uploads/2016/03/trauma-informed-supervision.pdf

Organization/System Supports

- Center for Health Care Strategies, Inc. – Strategies for Encouraging Staff Wellness

https://www.chcs.org/resource/strategies-encouraging-staff-wellness-trauma-informed-organizations/

- Northeastern University - Vicarious Trauma-Organizational Readiness Guide for Victim Services

https://vtt.ovc.ojp.gov/ojpasset/Documents/OS_VT-ORG_Victim_Services-508.pdf

- Office for Victims of Crime – The Vicarious Trauma Toolkit

https://vtt.ovc.ojp.gov/

- WISE & Rogers Behavioral Health - The Compassion Resilience Toolkit

https://compassionresiliencetoolkit.org/

Establishing a Safe Environment

Completing a Program Walk-Through

- National Center on Domestic Violence, Trauma & Mental Health – Tips for Creating a Welcoming Environment

http://nationalcenterdvtraumamh.org/wp-content/uploads/2012/01/Tipsheet_Welcoming-Environment_NCDVTMH_Aug2011.pdf

- Trauma Informed Oregon – Agency Environmental Components for Trauma-Informed Care

https://traumainformedoregon.org/resource/agency-components-trauma-informed-care/

Screening for Trauma

General Screening Considerations

- Boyle & Delos Reyes – Trauma-Informed Care: Screening & Assessment (PowerPoint Slides)

https://case.edu/socialwork/centerforebp/sites/case.edu.centerforebp/files/2021-03/2015-0422_TICVideoconference.pdf

- Substance Abuse and Mental Health Services Administration – TIP-57 (Part 1, Chapter 4 p159-171)

https://store.samhsa.gov/system/files/sma14-4816.pdf

Picking a Tool

- ACEs Connection – Different Types of ACE Surveys

https://www.pacesconnection.com/g/Canadian-ACEs-and-TI-Network/blog/ace-surveys-different-types-of

- American Psychiatric Association – Online Assessment Measures (Disorder-Specific Severity Measures, Severity of Posttraumatic Stress Symptoms Adult & Child Age 11-17)

https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures

- Center for Youth Wellness – ACEQ & User Guide

https://centerforyouthwellness.org/cyw-aceq/

- Children F.I.R.S.T. – Child and Adolescent Trauma Measures: A Review

https://ncwwi.org/files/Evidence_Based_and_Trauma-Informed_Practice/Child-and-Adolescent-Trauma-Measures_A-Review-with-Measures.pdf

- National Child Traumatic Stress Network (NCTSN) – Screening and Assessment

https://www.nctsn.org/treatments-and-practices/screening-and-assessment

Treating Trauma

Access to Trauma-Specific Interventions

- Cognitive Processing Therapy – CPT Provider Roster

https://cptforptsd.com/cpt-provider-roster/

- EMDR International Association – Find An EMDR Therapist

https://www.emdria.org/find-an-emdr-therapist/

- Seeking Safety Training, Resources and Provider List

https://www.treatment-innovations.org/seeking-safety.html

- Trauma-Focused Cognitive Behavioral Therapy Certified Therapists

https://tfcbt.org/members/

- Trauma Informed Community Initiative of WNY – Directory of Trauma-Specific Treatment Providers

https://ticiwny.org/directory/

Collaborating with Others (Partners and Referrals)General Screening Considerations

Learning from Others and Building Partnerships

- Center for Health Care Strategies – Trauma-Informed Care in Action Profiles

https://www.chcs.org/resource/trauma-informed-care-in-action-profile-series/

- Oral et al. (2016) – Communities Embracing Trauma-Informed Care

https://www.nature.com/articles/pr2015197#trauma-informed-care

https://www.nature.com/articles/pr2015197/tables/1

- National Council for Behavioral Health – Domain 6: Building Community Partnerships

https://www.nationalcouncildocs.net/trauma-informed-care-learning-community/resources/domain-6-building-community-partnerships

- National Council for Behavioral Health – Lessons Learned: Adoption of Trauma-Informed Care

https://www.nationalcouncildocs.net/wp-content/uploads/2014/01/Lessons-Learned-2012-LC-FINAL.pdf

- United Way et al. (2018) – Trauma-Informed Philanthropy

https://www.unitedforimpact.org/wp-content/uploads/2018/08/FINAL_TraumaGUIDE-single.pdf

Reviewing Policies and Procedures

Tools/Guides for Reviewing

- Anna Institute – Re-traumatization With Chart (PowerPoint)

http://theannainstitute.org/presentations.html

- Community Connections (Harris & Fallot) – Creating Cultures of Trauma-Informed Care

https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

- Substance Abuse and Mental Health Services Administration – TIP-57 (p162-163, 166)
https://store.samhsa.gov/system/files/sma14-4816.pdf

- Trauma Informed Oregon – Guide to Reviewing Existing Policies
http://traumainformedoregon.org/wp-content/uploads/2016/01/Guide-to-Reviewing-Existing-Policies.pdf

Evaluating and Monitoring Progress

- Coordinated Care Services, Inc. – Trauma Responsive Understanding Self-Assessment Tools
https://www.ccsi.org/Pages/TRUST

- National Center on Family Homelessness – Trauma-Informed Organizational Self-Assessment (section 1)
https://www.air.org/sites/default/files/downloads/report/Trauma-Informed_Organizational_Toolkit_0.pdf

- National Council for Behavioral Health – Sustainability Guide
https://www.nationalcouncildocs.net/wp-content/uploads/2014/01/TIC-Sustainability-Guide.pdf

- Southwest Michigan Children's Trauma Assessment Center – Trauma Informed Change Instrument
https://traumainformedoregon.org/wp-content/uploads/2014/10/Trauma-Informed-System-Change-Instrument-Organizational-Change-Self-Evaluation.pdf

- Trauma Informed Care Project – Agency Self-Assessment
https://traumatransformed.org/documents/tia_orchard.pdf

- Trauma Informed Oregon – Standards of Practice
https://traumainformedoregon.org/resource/standards-practice-trauma-informed-care/

- Trauma Informed Oregon – Standards of Practice (Education)
https://traumainformedoregon.org/resource/education-standards-practice-trauma-informed-care/

- Trauma Informed Oregon – Standards of Practice (Healthcare)
https://traumainformedoregon.org/resource/healthcare-standards-practice-trauma-informed-care/

- Traumatic Stress Institute – Attitudes Related to Trauma-Informed Care (ARTIC) Scale
http://traumaticstressinstitute.org/artic-scale/

Appendices

Trauma-Informed Organizational Model Planning

USING APPENDIX A

As we have continued to work with organizations around trauma-informed organizational change, we recognized there is often a process to envision trauma-informed change before deciding whether to make a commitment to the overall change process and/or to specific changes throughout.

We have now added a series of visualizing questions for organizations to use in discussion and review to consider what trauma-informed change would mean for them. These questions help leaders walk through a process of discussing and exploring how they have arrived to this point of considering trauma-informed organizational change (**exploring**); assessing staff attunement to trauma-informed change (**gauging**); identifying specific changes that would be involved if the organization commits to this process (**considering**); and after working in these first three areas, selecting the preliminary change activities to which the organization is ready to commit (**deciding**).

These questions are intended to spark discussion, and they may lead to considering additional questions not noted here.

Exploring

- What led us to consider trauma-informed implementation?
- What is it about being trauma-informed that is important?
- How does the organization already value/promote safety, trustworthiness, choice, collaboration and/or empowerment?
- What about trauma-informed implementation matches with our priorities and other initiatives?
- How will individuals (e.g., clients, patients, students) benefit from trauma-informed change?
- How will the workforce benefit from trauma-informed change?

Gauging

- Who in the organization is already aware of trauma-informed care?
- Who in the organization is already invested in trauma-informed change?
- Who in the organization still needs to become invested in trauma-informed change?
- What organizational practices are already trauma-informed?
- What is happening in the organization/community right now?

Considering

- How does the organization/staff traditionally react to change?
- What has worked well when implementing changes previously? What hasn't worked well?
- Do staff have time to formally learn about trauma-informed practices? How would time become available to formally learn about T-I practices?
- Does the organization have capacity to provide resources (time, money, personnel) to trauma-informed change processes?
- When is the best time to start planning the trauma-informed change process?

Deciding

- Based on our answers to the above questions, what part(s) of trauma-informed change make sense for us to commit to right now?

Trauma-Informed Organizational Model Planning

USING APPENDIX B

Purpose: The charts in Appendix B will help you take a first look at all 10 key development areas within each of the three implementation stages. The purpose of these charts is to provide an opportunity for leaders and Champions of the trauma-informed change process to rate where your organization/system currently is for each consideration, so that you can notice what is already in place and be able to start the trauma-informed change process with the "end in mind."

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see a numeric scale from 1 to 10 that corresponds to each consideration.

- Please use the following rating system to indicate where you feel your organization/system currently is for each:

1 = not yet started	5 = halfway there	10 = ideal implementation

Once completed, take time to reflect on your responses and what they may indicate regarding where it might make sense to start the trauma-informed change process. The appendices following this one will assist you in taking a closer look at the different key development areas once you decide which one(s) makes sense to focus on—both by inviting you to re-scale the considerations, as well as answer follow-up questions.

Pre-Implementation

1. Leading and Communicating

Who is your leadership team? _____

a) Leadership team (including administration, board of directors, etc.) has training on trauma and a trauma-informed approach, including the connection to diversity, equity, inclusion, and accessibility work.	1 2 3 4 5 6 7 8 9 10
b) Leadership team has a plan to allocate some of their own time to the planning, implementation, and sustainability of a trauma-informed organization.	1 2 3 4 5 6 7 8 9 10
c) Organization/system has a written commitment to a trauma-informed approach (e.g., mission/vision, strategic plan, etc.).	1 2 3 4 5 6 7 8 9 10
d) Organization/system creates a designated workgroup or committee to lead the trauma-informed change process.	1 2 3 4 5 6 7 8 9 10
e) Organization/system has a plan to allocate resources (time, money, and workers) to support trauma-informed efforts and activities.	1 2 3 4 5 6 7 8 9 10
f) Organization/system has a plan to engage all stakeholders in the trauma-informed change process.	1 2 3 4 5 6 7 8 9 10
g) Organization/system has a plan for trauma-informed messaging and communication.	1 2 3 4 5 6 7 8 9 10

Pre-Implementation

2. Building a Trauma-Informed Workplace

a) Organization/system has a plan for recruiting individuals who are knowledgeable about trauma and a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
b) Organization/system has a plan for the new hire orientation process to include foundational information on trauma/adversity, anti-racism, anti-oppression, re-traumatization and introduce the trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
c) Organization/system has a plan for hiring practices that are inclusive of all (gender, race, ability).	1 2 3 4 5 6 7 8 9 10
d) Organization/system has a plan for reviewing their employee handbook, employee rights/responsibilities, job descriptions, etc. with a trauma-informed lens.	1 2 3 4 5 6 7 8 9 10

Pre-Implementation

3. Training the Workforce (Clinical and Non-Clinical)

a) Organization/system has a plan to ensure all workers—clinical and non-clinical—receive foundation "trauma 101" education that covers trauma/adversity, anti-racism, anti-oppression, re-traumatization, and an introduction to a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
b) Organization/system has a plan for on-going follow-up training and discussions on trauma and the application of a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
c) Organization/system has a plan for role-specific, trauma-informed training (e.g., clinicians, supervisors, etc.).	1 2 3 4 5 6 7 8 9 10
d) Organization/system considers the development of internal trainers, mentors and/or coaches as part of the trauma-informed training plan.	1 2 3 4 5 6 7 8 9 10

Pre-Implementation

4. Addressing the Impact of the Work

a) Organization/system has a plan to ensure all workers—clinical and non-clinical—receive training on possible impacts of the work (e.g., secondary trauma, vicarious trauma, burnout, compassion fatigue, vicarious resilience, vicarious post-traumatic growth, compassion resilience).	1 2 3 4 5 6 7 8 9 10
b) Organization/system has a plan for structures/policies to support workforce health and wellness in culturally responsive ways.	1 2 3 4 5 6 7 8 9 10
c) Organization/system has a plan to create trauma-informed supervision protocols.	1 2 3 4 5 6 7 8 9 10
d) Organization/system has a plan to create trauma-informed crisis/incident debriefing protocols.	1 2 3 4 5 6 7 8 9 10

Pre-Implementation

5. Establishing a Safe Environment

a) Organization/system has a plan to regularly assess the environment for physical and emotional safety.	1 2 3 4 5 6 7 8 9 10
b) Organization/system adapts the trauma-informed walk-through tool to match their own environment.	1 2 3 4 5 6 7 8 9 10

Scaling: 1 = not yet started 5 = half-way there 10 = ideal

Pre-Implementation

6. Screening for Trauma

a) Organization/system reviews specific tools to screen and assess for trauma.	1 2 3 4 5 6 7 8 9 10
b) Organization/system has a plan to create protocols for screening and assessment of trauma.	1 2 3 4 5 6 7 8 9 10

Pre-Implementation

7. Treating Trauma

a) Organization/system has a plan to offer or refer out to evidence-based, trauma-specific treatment interventions (e.g., EMDR, CPT, Seeking Safety, TF-CBT).	1 2 3 4 5 6 7 8 9 10
b) Organization/system has a plan to develop supervision/consultation protocols for workers who provide trauma-specific treatment.	1 2 3 4 5 6 7 8 9 10

Pre-Implementation

8. Collaborating with Others (Partners and Referrals)

a) Organization/system identifies opportunities to collaborate with partners, referrals and/or other community entities in the trauma-informed change process.	1 2 3 4 5 6 7 8 9 10
b) Organization/system has a plan to maintain an up-to-date list of affordable, accessible referral sources for the needs of individuals with trauma histories.	1 2 3 4 5 6 7 8 9 10

Pre-Implementation

9. Reviewing Policies and Procedures

a) Organization/system has a plan for the regular review of policies and procedures with a trauma-informed lens.	1 2 3 4 5 6 7 8 9 10
b) Organization/system has a plan for the individuals reviewing policies and procedures to be trained on re-traumatization themes, trauma-informed language and diversity, equity, inclusion and accessibility considerations.	1 2 3 4 5 6 7 8 9 10
c) Organization/system identifies policies/procedures that already have aspects of being trauma-informed, trauma-sensitive, and trauma-specific.	1 2 3 4 5 6 7 8 9 10

Pre-Implementation

10. Evaluating and Monitoring Progress

a) Organization/system reviews existing trauma-informed evaluation tools.	1 2 3 4 5 6 7 8 9 10
b) Organization/system has an evaluation plan to elicit feedback and monitor progress of the trauma-informed change process.	1 2 3 4 5 6 7 8 9 10

Scaling: 1 = not yet started 5 = half-way there 10 = ideal

Implementation

1. Leading and Communicating

Who is your leadership team? _____

a) Leadership team allocates some of their own time to the implementation and sustainability of a trauma-informed organization.	1 2 3 4 5 6 7 8 9 10
b) Organization/system's designated trauma-informed workgroup or committee meets regularly to plan and implement action steps.	1 2 3 4 5 6 7 8 9 10
c) Organization/system has resources (time, money, and workers) available to support trauma-informed efforts and activities.	1 2 3 4 5 6 7 8 9 10
d) Organization/system actively engages all individuals in the trauma-informed change process.	1 2 3 4 5 6 7 8 9 10
e) Organization/system regularly communicates about the trauma-informed change process and messages the importance of a trauma-informed approach with connections to diversity, equity, inclusion and accessibility (e.g., newsletter, e-mail, staff meetings, posters, etc.)	1 2 3 4 5 6 7 8 9 10

Implementation

2. Building a Trauma-Informed Workplace

a) Organization/system actively hires individuals who are knowledgeable about trauma and a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
b) Organization/system incorporates questions on trauma and a trauma-informed approach into the interview process.	1 2 3 4 5 6 7 8 9 10
c) Organization/system's hiring practices are inclusive of all (gender, race, ability).	1 2 3 4 5 6 7 8 9 10
d) Organization/system's hiring and orientation processes reflect the values/principles of a trauma-informed approach (safety, trustworthiness, choice, collaboration, empowerment).	1 2 3 4 5 6 7 8 9 10
e) Organization/system's orientation process includes staff receiving foundational information on trauma/adversity, anti-racism, anti-oppression, re-traumatization and introduce the trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
f) Organization/system reviews their employee handbook, employee rights/responsibilities, job descriptions, etc. with a trauma-informed lens.	1 2 3 4 5 6 7 8 9 10
g) Organization/system provides new employees their job expectations, rights, and responsibilities in writing.	1 2 3 4 5 6 7 8 9 10

Scaling: 1 = not yet started 5 = half-way there 10 = ideal

Implementation

3. Training the Workforce (Clinical and Non-Clinical)

a) All workers—clinical and non-clinical—receive foundation "trauma 101" education that covers trauma/adversity, anti-racism, anti-oppression, re-traumatization, and an introduction to a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
b) Organization/system offers on-going follow-up training and discussions on trauma and the application of a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
c) Clinical workers are trained in evidence-based, trauma-specific treatment interventions (e.g., EMDR, CPT, Seeking Safety, TF-CBT) when possible.	1 2 3 4 5 6 7 8 9 10
d) All workers receive basic training on the maintenance of personal and professional boundaries.	1 2 3 4 5 6 7 8 9 10
e) All workers receive training on supporting, managing, and responding to reactivity (e.g., de-escalation).	1 2 3 4 5 6 7 8 9 10
f) Supervision includes the learning and application of a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
g) Workforce meetings include the learning and application of a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
h) Organization/system has internal trauma-informed trainers, mentors and/or coaches.	1 2 3 4 5 6 7 8 9 10

Implementation

4. Addressing the Impact of the Work

a) All workers—clinical and non-clinical—receive training on the possible impacts of the work (e.g., secondary trauma, vicarious trauma, burnout, compassion fatigue, vicarious resilience, vicarious post-traumatic growth, compassion resilience).	1 2 3 4 5 6 7 8 9 10
b) Workers receive regularly scheduled, trauma-informed supervision.	1 2 3 4 5 6 7 8 9 10
c) Supervision allows opportunities for workers to explore their own stress reactions, self-care, and wellness.	1 2 3 4 5 6 7 8 9 10
d) Leadership actively encourages and promotes workforce wellness and self-care in culturally responsive ways.	1 2 3 4 5 6 7 8 9 10
e) Leadership regularly checks in with the workforce and each other.	1 2 3 4 5 6 7 8 9 10
f) Organization/system debriefs after a crisis/incident.	1 2 3 4 5 6 7 8 9 10
g) Organization/system implements structures/policies to support workforce health and wellness in culturally responsive ways.	1 2 3 4 5 6 7 8 9 10

Scaling: 1 = not yet started 5 = half-way there 10 = ideal

Implementation

5. Establishing a Safe Environment

a) Organization/system regularly conducts trauma-informed walk-throughs to identify strengths and areas for improvement.	1 2 3 4 5 6 7 8 9 10
b) Organization/system elicits feedback about the safety of the environment from all individuals.	1 2 3 4 5 6 7 8 9 10
c) Areas outside the organization/system, common areas and bathrooms are well-lit.	1 2 3 4 5 6 7 8 9 10
d) Workers monitor who enters and exits the building.	1 2 3 4 5 6 7 8 9 10
e) Organization/system is welcoming and aesthetically comfortable (e.g., color of walls, presence of artwork/photos, plants, etc.)	1 2 3 4 5 6 7 8 9 10
f) Signs use positive, welcoming language and state the desired or "prosocial" behavior.	1 2 3 4 5 6 7 8 9 10
g) Organization/system has a designated "safe space" for workers to practice self-care	1 2 3 4 5 6 7 8 9 10
h) Organization/system's environment is culturally responsive (e.g., languages, décor that represent individuals using the space).	1 2 3 4 5 6 7 8 9 10
i) Common areas, service areas, bathrooms and bedrooms are inclusive, and consider privacy and accessibility.	1 2 3 4 5 6 7 8 9 10
j) Leadership and workers ensure individuals feel welcomed, respected, included, and supported in all interactions.	1 2 3 4 5 6 7 8 9 10
k) Leadership and workers maintain consistent, open, and compassionate communication.	1 2 3 4 5 6 7 8 9 10
l) Organization/system anchors emotional safety by conveying the message that everyone's voice is valued, and that feedback is important and welcomed.	1 2 3 4 5 6 7 8 9 10

Implementation

6. Screening for Trauma

a) Organization/system uses specific tools when screening and assessing for trauma.	1 2 3 4 5 6 7 8 9 10
b) Identified workers are trained in trauma screening and conducting appropriate follow-up discussions with individuals.	1 2 3 4 5 6 7 8 9 10
c) Workers conducting screening and/or assessment are trained in trauma-informed, anti-racist and anti-oppressive protocols.	1 2 3 4 5 6 7 8 9 10
d) Organization/system screens for trauma only once and shares results across settings with informed consent to avoid re-traumatization from re-screening.	1 2 3 4 5 6 7 8 9 10
e) Organization/system has a protocol for all screening results, including an updated list of referrals if trauma assessment and/or treatment is not offered on-site.	1 2 3 4 5 6 7 8 9 10

Scaling: 1 = not yet started 5 = half-way there 10 = ideal

Implementation

7. Treating Trauma

a) Organization/system offers or refers out to evidence-based, trauma-specific treatment interventions (e.g., EMDR, CPT, Seeking Safety, TF-CBT).	1 2 3 4 5 6 7 8 9 10
b) Organization/system has some form of supervision or consultation available to workers who provide trauma-specific treatment.	1 2 3 4 5 6 7 8 9 10
c) Organization/system monitors fidelity to and/or inclusion of evidence-based, trauma-specific treatments in service plans.	1 2 3 4 5 6 7 8 9 10
d) Organization/system considers cultural practices that address the healing of trauma in service plans.	1 2 3 4 5 6 7 8 9 10

Implementation

8. Collaborating with Others (Partners and Referrals)

a) Organization/system has an up-to-date list of affordable, accessible referral sources for the needs of individuals with trauma histories.	1 2 3 4 5 6 7 8 9 10
b) Organization/system works together with partners, referrals, and other community entities to create a trauma-informed network/community.	1 2 3 4 5 6 7 8 9 10
c) Organization/system has mechanisms in place to promote cross-sector training on trauma and a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
d) Organization/system has a method of communication in place with other entities working with the same individuals for making trauma-informed decisions.	1 2 3 4 5 6 7 8 9 10
e) Discharge/transitions from services is thoughtful, gradual and includes referrals to trauma-informed and community-based resources.	1 2 3 4 5 6 7 8 9 10
f) Organization/system has mechanisms to acknowledge and witness organizational, historical trauma narratives of collaborative partners and communities.	1 2 3 4 5 6 7 8 9 10

Scaling: 1 = not yet started 5 = half-way there 10 = ideal

Implementation

9. Reviewing Policies and Procedures

a) Organization/system regularly reviews and revises policies and procedures with a trauma-informed lens.	1 2 3 4 5 6 7 8 9 10
b) Policies and procedures are clear, consistent, visible, and accessible to those they pertain to.	1 2 3 4 5 6 7 8 9 10
c) Policies and procedures are anchored in the values/principles of a trauma-informed approach: safety, trustworthiness, choice, collaboration, and empowerment.	1 2 3 4 5 6 7 8 9 10
d) Policies and procedures reflect a commitment to diversity, equity, inclusion, and accessibility.	1 2 3 4 5 6 7 8 9 10
e) Policies and procedures are written in positive language that depicts the desires or "prosocial" behavior.	1 2 3 4 5 6 7 8 9 10
f) Organization/system has a de-escalation policy to minimize the potential for re-traumatization.	1 2 3 4 5 6 7 8 9 10
g) Written safety/crisis plans are incorporated into treatment, service, or work plans.	1 2 3 4 5 6 7 8 9 10
h) Individual rights, responsibilities and expectations are clear and easily accessible to those they pertain to.	1 2 3 4 5 6 7 8 9 10

Implementation

10. Evaluating and Monitoring Progress

a) Organization/system has mechanisms in place for on-going evaluation of a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
b) Organization/system incorporates a trauma-informed approach into its quality improvement processes.	1 2 3 4 5 6 7 8 9 10
c) Leadership receives regular updates on trauma-informed progress and evaluation measures.	1 2 3 4 5 6 7 8 9 10
d) Evaluation measures include the perspective of all individuals within the organization/system.	1 2 3 4 5 6 7 8 9 10
e) Organization/system is transparent in sharing evaluation data and regularly responds to feedback/evaluation.	1 2 3 4 5 6 7 8 9 10

Scaling: 1 = not yet started 5 = half-way there 10 = ideal

Sustainability

Sustainability is the ability to be maintained at a certain rate or level. Sustaining trauma-informed organizational culture change requires two things:

1) The action items in each key development area are on-going and are part of the dailiness of organizational functioning; and

2) Are informed by on-going evaluation and monitoring progress.

This section of Appendix B invites you to review considerations for each key development area, focusing on the practices for maintaining the action steps in implementation and sustaining overall trauma-informed organizational change.

1. Leading and Communicating

☐ The trauma-informed committee has a standing meeting.

☐ There is a schedule for intentionally revisiting the trauma-informed communication and messaging plan.

☐ There are adequate resources (time, money, workers) allocated to support on-going communication and messaging.

☐ The leadership team has scheduled opportunities to participate in trauma-informed trainings, meetings, and activities.

2. Building a Trauma-Informed Workplace

☐ There is a schedule for regularly reviewing employee handbooks, paperwork and HR-related policies and practices.

☐ There is a schedule for regularly reviewing job postings and descriptions.

☐ Foundational information on trauma and trauma-informed approaches is given as part of the new hire orientation process.

☐ There is a method for employees to provide anonymous feedback about the emphasis on trauma-informed and equity in employment processes.

☐ Trauma-informed practices are incorporated into employee performance metrics.

3. Training the Workforce (Clinical and Non-Clinical)

☐ There is a schedule for foundational trauma-informed education and yearly refreshers for all staff.

☐ Discussions on trauma and application of trauma-informed approaches, including diversity, equity, inclusion, and accessibility, are built into workforce meetings regularly.

☐ Discussions on trauma and application of trauma-informed approaches are a part of supervision protocols.

☐ There are adequate resources (time, money, workers) allocated to support ongoing education and training.

4. Addressing the Impact of the Work

☐ There is a schedule for training on the impact of the work and self-care for all staff.

☐ There is a supervision schedule for each workforce member.

☐ There is a formal mechanism for the workforce to provide feedback on policies that support workforce wellness.

☐ There are adequate resources (time, money, workers) allocated to support workforce wellness policies and practices.

5. Establishing a Safe Environment

☐ There is a schedule for conducting regular environment walk-throughs.

☐ There is a mechanism for all individuals to provide feedback on their experiences of physical and emotional safety.

☐ There are adequate resources (time, money, workers) allocated to the implementation of recommended changes in the physical environment.

6. Screening for Trauma

☐ There are written protocols for screening for trauma in the organization.

☐ There is schedule for training workforce members who are providing the screening and follow-up discussions in trauma-informed ways.

☐ There is a formal mechanism for evaluating the effectiveness of screening protocols.

☐ There is a formal process for tracking data collected and ensuring its use in informing treatment/service plans.

7. Treating Trauma

☐ There is a formal process for referring to organization's own trauma therapists or collaborative partners for trauma-specific treatment.

☐ There is a clinical supervision/consultation schedule for each workforce member providing trauma-specific treatment.

☐ There is a formal mechanism to monitor fidelity to trauma-specific treatments.

☐ There are adequate resources (time, money, workers) allocated to training clinicians on trauma-specific treatments when applicable.

8. Collaborating with Others (Partners and Referrals)

☐ There is an individual responsible for ensuring an up-to-date list of affordable, accessible, culturally responsive referrals to meet needs of individuals with trauma histories.

☐ There are mechanisms in place to promote trauma-informed cross-sector training, communication, and collaboration with partners, referral sources, and the community.

9. Reviewing Policies and Procedures

☐ There is a schedule for conducting regular trauma-informed reviews of policies and procedures.

☐ There are guidelines for considering trauma-informed language in developing new policies and procedures.

☐ There is a mechanism for all individuals to provide feedback on policy and procedure revisions.

☐ There is a designated, visible place for individuals to access policies and procedures that pertain to them.

☐ There is schedule for training workforce members reviewing policies and procedures on re-traumatization, equity and inclusive, trauma-informed language.

10. Evaluating and Monitoring Progress

☐ There is a schedule for conducting regular trauma-informed evaluation.

☐ There is a protocol for the collection, analysis, and reporting of trauma-informed evaluation data that also addresses power, privilege and historical and racial trauma.

☐ Trauma-informed practices are integrated into performance evaluations, quality assurance/improvement measures, etc.

☐ The trauma-informed committee dedicates a portion of its regular meetings to monitoring progress in the key development areas.

Adapted References

Fallot, R. D., & Harris, M. (2009). *Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol*. Retrieved from https://www.healthcare.uiowa.edu/icmh/documents/CCTICSelf-AssessmentandPlanningProtocol0709.pdf

Menschner, C., & Maul, A. (2016). *Key ingredients for successful trauma-informed care implementation.* Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

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Trauma Informed Oregon (2017). *The Roadmap to trauma informed care.* Retrieved from http://traumainformedoregon.org/roadmap-trauma-informed-care/

Trauma-Informed Organizational Model Planning

USING APPENDIX C

Purpose: The chart in Appendix C will invite you to re-visit the Leading and Communicating Key Development Area within the **Pre-Implementation Stage**. The purpose of this chart is to provide an opportunity to rate where your organization/system currently is for each consideration, so that you can notice what is already in place and begin to consider what aspects of this key development area to focus on for action planning.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see a numeric scale from 1 to 10 that corresponds to each consideration.

- Please use the following rating system to indicate where you feel your organization/system currently is for each:

1 = not yet started	5 = halfway there	10 = ideal implementation

** Note: **This appendix can be used alongside Appendix D**, which will ask you to write responses to follow-up questions for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Pre-Implementation

1. Leading and Communicating

Who is your leadership team? _____

a) Leadership team (including administration, board of directors, etc.) has training on trauma and a trauma-informed approach, including the connection to diversity, equity, inclusion, and accessibility work.	1 2 3 4 5 6 7 8 9 10
b) Leadership team has a plan to allocate some of their own time to the planning, implementation, and sustainability of a trauma-informed organization.	1 2 3 4 5 6 7 8 9 10
c) Organization/system has a written commitment to a trauma-informed approach (e.g., mission/vision, strategic plan, etc.).	1 2 3 4 5 6 7 8 9 10
d) Organization/system creates a designated workgroup or committee to lead the trauma-informed change process.	1 2 3 4 5 6 7 8 9 10
e) Organization/system has a plan to allocate resources (time, money, and workers) to support trauma-informed efforts and activities.	1 2 3 4 5 6 7 8 9 10
f) Organization/system has a plan to engage all stakeholders in the trauma-informed change process.	1 2 3 4 5 6 7 8 9 10
g) Organization/system has a plan for trauma-informed messaging and communication.	1 2 3 4 5 6 7 8 9 10

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

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Trauma-Informed Organizational Model Planning

APPENDIX D

Purpose: The chart in Appendix D will invite you to re-visit the Leading and Communicating Key Development Area within the **Pre-Implementation Stage**. The purpose of this chart is to provide an opportunity to respond to specific follow-up questions for each consideration.

The questions are designed so that you can both notice what is already in place and begin thinking about specific action items that may be needed within this key development area as you move forward.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see follow-up questions regarding that consideration with space to write short responses.

** **Note:** **This appendix can be used alongside Appendix C**, which will ask you to rate where your organization/system is on a scale from 1-10 for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Pre-Implementation

1. Leading and Communicating

Who is your leadership team? _____

a) Leadership team (including administration, board of directors, etc.) has training on trauma and a trauma-informed approach, including the connection to diversity, equity, inclusion, and accessibility work.	What was it/what is the plan? How will it be sustained?
b) Leadership team has a plan to allocate some of their own time to the planning, implementation, and sustainability of a trauma-informed organization.	What is the plan?
c) Organization/system has a written commitment to a trauma-informed approach (e.g., mission/vision, strategic plan, etc.).	What is the statement?
d) Organization/system creates a designated workgroup or committee to lead the trauma-informed change process.	Who is on it? What is their trauma-informed knowledge?
e) Organization/system has a plan to allocate resources (time, money, and workers) to support trauma-informed efforts and activities.	What is the plan? What are the resources needed?
f) Organization/system has a plan to engage all stakeholders in the trauma-informed change process.	What is the plan? Who will you engage?
g) Organization/system has a plan for trauma-informed messaging and communication.	What is the plan?

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

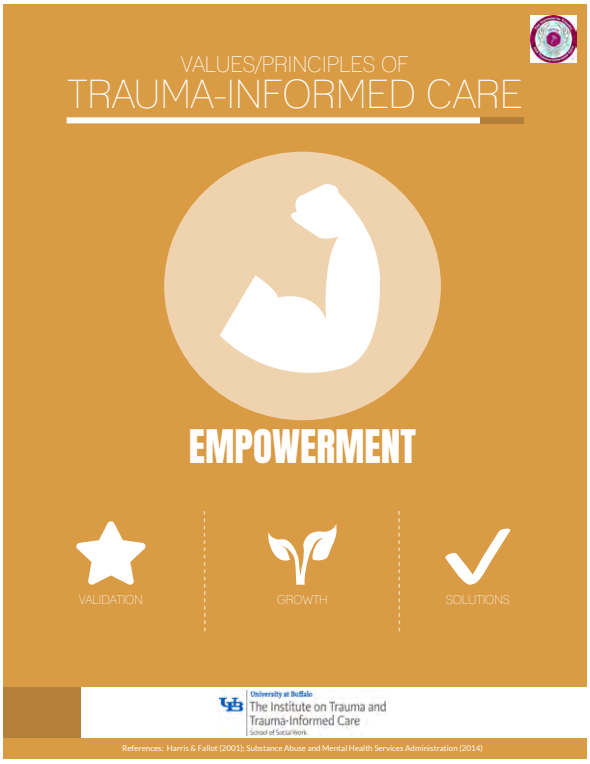
Substance Abuse and Mental Health Services Administration (2014). Concept of trauma and guidance for a trauma-informed approach. Retrieved from https://store.samhsa.gov/system/files/sma14-4884.pdf

Trauma Informed Oregon (2015). Standards of practice for trauma informed care. Retrieved from http://traumainformedoregon.org/wp-content/uploads/2016/07/Guidelines-and-Standards-of-Practice-for-Trauma-Informed-Care-07-16.pdf

Trauma Informed Oregon (2017). The Roadmap to trauma informed care. Retrieved from http://traumainformedoregon.org/roadmap-trauma-informed-care/

Sample Trauma-Informed Messaging Posters

APPENDIX E



Trauma-Informed Organizational Model Planning

USING APPENDIX F

Purpose: The chart in Appendix F will invite you to re-visit the Leading and Communicating Key Development Area within the **Implementation Stage**. The purpose of this chart is to provide an opportunity to rate where your organization/system currently is for each consideration, so that you can notice what is already in place and begin to consider what aspects of this key development area to focus on for action planning.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see a numeric scale from 1 to 10 that corresponds to each consideration.

- Please use the following rating system to indicate where you feel your organization/system currently is for each:

1 = not yet started	5 = halfway there	10 = ideal implementation

** Note: **This appendix can be used alongside Appendix G**, which will ask you to write responses to follow-up questions for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Implementation

1. Leading and Communicating

Who is your leadership team? _____

a) Leadership team allocates some of their own time to the implementation and sustainability of a trauma-informed organization.	1 2 3 4 5 6 7 8 9 10
b) Organization/system's designated trauma-informed workgroup or committee meets regularly to plan and implement action steps.	1 2 3 4 5 6 7 8 9 10
c) Organization/system has resources (time, money, and workers) available to support trauma-informed efforts and activities.	1 2 3 4 5 6 7 8 9 10
d) Organization/system actively engages all individuals in the trauma-informed change process.	1 2 3 4 5 6 7 8 9 10
e) Organization/system regularly communicates about the trauma-informed change process and messages the importance of a trauma-informed approach with connections to diversity, equity, inclusion and accessibility (e.g., newsletter, e-mail, staff meetings, posters, etc.)	1 2 3 4 5 6 7 8 9 10

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

Substance Abuse and Mental Health Services Administration (2014). Concept of trauma and guidance for a trauma-informed approach. Retrieved from https://store.samhsa.gov/system/files/sma14-4884.pdf

Trauma Informed Oregon (2015). Standards of practice for trauma informed care. Retrieved from http://traumainformedoregon.org/wp-content/uploads/2016/07/Guidelines-and-Standards-of-Practice-for-Trauma-Informed-Care-07-16.pdf

Trauma Informed Oregon (2017). The Roadmap to trauma informed care. Retrieved from http://traumainformedoregon.org/roadmap-trauma-informed-care/

Trauma-Informed Organizational Model Planning

USING APPENDIX G

Purpose: The chart in Appendix G will invite you to re-visit the Leading and Communicating Key Development Area within the **Implementation Stage**. The purpose of this chart is to provide an opportunity to respond to specific follow-up questions for each consideration.

The questions are designed so that you can both notice what is already in place and begin thinking about specific action items that may be needed within this key development area as you move forward.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see follow-up questions regarding that consideration with space to write short responses.

**** Note: This appendix can be used alongside Appendix F**, which will ask you to rate where your organization/system is on a scale from 1-10 for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Implementation

1. Leading and Communicating

Who is your leadership team? _____

a) Leadership team allocates some of their own time to the implementation and sustainability of a trauma-informed organization.	What are they allocating time to?
b) Organization/system's designated trauma-informed workgroup or committee meets regularly to plan and implement action steps.	How often do they meet?
c) Organization/system has resources (time, money, and workers) available to support trauma-informed efforts and activities.	What are they?
d) Organization/system actively engages all individuals in the trauma-informed change process.	What are the strategies for engagement? How are diversity, equity, inclusion and accessibility ensured in engagement?
e) Organization/system regularly communicates about the trauma-informed change process and messages the importance of a trauma-informed approach with connections to diversity, equity, inclusion and accessibility (e.g., newsletter, e-mail, staff meetings, posters, etc.)	What are the communication/messaging strategies?

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

Substance Abuse and Mental Health Services Administration (2014). Concept of trauma and guidance for a trauma-informed approach. Retrieved from https://store.samhsa.gov/system/files/sma14-4884.pdf

Trauma Informed Oregon (2015). Standards of practice for trauma informed care. Retrieved from http://traumainformedoregon.org/wp-content/uploads/2016/07/Guidelines-and-Standards-of-Practice-for-Trauma-Informed-Care-07-16.pdf

Trauma Informed Oregon (2017). The Roadmap to trauma informed care. Retrieved from http://traumainformedoregon.org/roadmap-trauma-informed-care/

APPENDIX H

Example Trauma-Informed Job Posting

Hope's Summit Health Centers of Greater New York

Thank you for your interest in joining the Hope's Summit team as a Care Manager. Interviews are scheduled by the hiring manager for applicants whose qualifications best meet the needs of the department and the health center. The preferred method of application is to email your cover letter and resume to our Hiring Manager, Grace Heally, at GHeally@HopesSummit.org

Company Description:

Hope's Summit is a Federally-Qualified Community Health Center located in the vibrant, resilient Riverdale neighborhood. For over 50 years, Hope's Summit has served as a trusted partner in supporting diverse community members to develop and maintain overall health and wellness. We strive to guide our health system according to the values of integrity, trust, collaboration, respect, and empowerment.

Hope's Summit strives to ensure that all staff understand the effects of psychological trauma and that all programming and services are offered through the lens of sensitivity to trauma and resilience. Policies, programs, and our spaces are developed with the goal of helping everyone feel physically and emotionally safe. We firmly believe that healing from psychological trauma is possible and have trained our clinical staff in trauma-informed practices known to be effective in aiding in the healing process.

Care Manager Job Description:

Care Managers provide integrated trauma-informed, patient-centered care in a primary care setting with the possibility of working at more than one location, including the school-based health center. Care Managers operate in collaboration with Hope's Summit's team of physicians, nurse practitioners, behavioral health and dental providers, pharmacists, nurses, medical assistants, and administrative staff. Local community members seeking our services span a variety of backgrounds and experiences, and it is expected that Care Managers demonstrate cultural humility and are able to recognize and mobilize cultural and individual strengths to facilitate healing.

Quality of life is important for both the patients we serve as well as the providers and staff we employ. This position allows for flexibility in work environment, with two community-based sites and one full-service school-based site. Staff meditation rooms available on-site. Generous benefits include: health insurance; 2 weeks vacation; paid sick leave; personal and holiday time; fitness/wellness reimbursement; and up to $500 annually for continuing education units, malpractice coverage, and/or license renewal fees.

Day-to-Day Expectations Include:

- Develop rapport and trust with patients while offering supportive counseling and crisis intervention
- Assist patients in coping with life's daily tasks to build resilience and promote psychological safety
- Conduct comprehensive assessments with sensitivity to prevent re-traumatization
- Work respectfully and collaboratively with patients to maximize community and social engagement
- Provide referrals to trauma-informed community partners to facilitate patients meeting their needs/goals

Occasional Expectations Include:

- Engage incross-team collaboration in trauma-informed case consultation meetings (1-2times/month); attend staff trainings on concepts of trauma-informed,person-centered care and other professional development programming (1 time/month)

Required Qualifications:

- Proven skills fostering collaborative relationships with people who have experiencedadversity
- Ability to respectfully engage with patients of diverse backgrounds
- Willingness and ability to actively engage in ongoing trainings and education on topics including trauma-informed care, health equity, patient-centered care, etc.
- Ability to engage in cross-team collaboration and contribute to creating a safe, supportive work culture

Preferred Qualifications:

- Experience working with marginalized and vulnerable populations in a trauma-informed manner
- Knowledge and/or experience with trauma-informed organizational change
- Awareness of social determinants of health, psychological trauma and its impacts, adverse childhood and community experiences, as well as historical, intergenerational, and cultural trauma

Sample Trauma-Informed Interview Questions

APPENDIX I

The following are sample questions that can be used when interviewing potential candidates for any position. Please note a couple of things:

1. The questions and the language used can be edited and adapted to your organization/system.
    a. Words that are italicized and in brackets indicate the interviewer can insert the relevant word based on the interview.
2. This is a collection of sample questions rather than a script—the purpose of this list is to provide examples of how an interviewer can inquire about different aspects of a trauma-informed approach, including diversity, equity, inclusion and accessibility.

- Please talk about what it means to be trauma-informed in your work. How do you see diversity, equity, inclusion and accessibility fitting into that?
- Do you have experience working for an organization or system that implemented aspects of a trauma-informed approach?
- How will you use a trauma-informed approach in your role here as a [position]?
- Give us an example of how you have used the value/principle of [value/principle] in your work.
- Give us an example of how you promoted diversity, equity, inclusion and/or accessibility in your work.
- Please talk about your understanding of how individual/historical/systemic trauma and inequities may interface with the population we work with.
- Please describe your understanding of evidence-based interventions or treatments that are available to the population we work with. How familiar are you with these?
- What strategies do you already use in order to address the potential for vicarious trauma, secondary traumatic stress, burnout and compassion fatigue? What organizational strategies or supports have you found helpful in the past?

- While all the values/principles of a trauma-informed approach are important, which one resonates with you the most? Tell us more.

- If you observe an unethical situation between a co-worker and a [client/patient/student/consumer], explain how you would use the value/principle of trustworthiness in order to address the situation.

- Tell us about a time when a colleague or an individual was not accepting of another's diversity—what was the situation and how did you respond?

- When thinking about a trauma-informed approach, what are your thoughts about the role of the *[client/patient/student/consumer]* in the work we do here?

- When thinking about a trauma-informed approach, what thoughts do you have about addressing inequities, discrimination and oppression in the work we do here?

- What characteristics or behaviors might be indicators to you that someone has experienced trauma?

- Please explain what self-care or wellness means to you. What strategies do you already use that work?

- What advice would you give to a colleague who is considering working with individuals who may have experienced trauma? With individuals who have different backgrounds or abilities?

- What aspects of the trauma-informed approach would you like to know more about?

- How do you address personal biases, challenge stereotypes and promote inclusion?

- Tell us about a time that you used a trauma-informed approach in a difficult interaction with a co-worker or *[client/patient/student/consumer]*.

- Tell us about a time when you changed your approach or style to work more effectively with an individual with a different background.

- Do you have experience screening individuals for trauma or adversity? If so, what screening tools did you use?

- Tell us about your understanding of resilience and post-traumatic growth. What thoughts do you have with regard to promoting resilience and post-traumatic growth with those we work with? In the workforce?

Trauma-Informed Organizational Model Planning

USING APPENDIX J

Purpose: The chart in Appendix J will invite you to re-visit the Building a Trauma-Informed Workplace Key Development Area within the **Pre-Implementation Stage**. The purpose of this chart is to provide an opportunity to rate where your organization/system currently is for each consideration, so that you can notice what is already in place and begin to consider what aspects of this key development area to focus on for action planning.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see a numeric scale from 1 to 10 that corresponds to each consideration.

- Please use the following rating system to indicate where you feel your organization/system currently is for each:

1 = not yet started	5 = halfway there	10 = ideal implementation

** Note: **This appendix can be used alongside Appendix K**, which will ask you to write responses to follow-up questions for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Pre-Implementation

2. Building a Trauma-Informed Workplace

a) Organization/system has a plan for recruiting individuals who are knowledgeable about trauma and a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
b) Organization/system has a plan for the new hire orientation process to include foundational information on trauma/adversity, anti-racism, anti-oppression, re-traumatization and introduce the trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
c) Organization/system has a plan for hiring practices that are inclusive of all (gender, race, ability).	1 2 3 4 5 6 7 8 9 10
d) Organization/system has a plan for reviewing their employee handbook, employee rights/responsibilities, job descriptions, etc. with a trauma-informed lens.	1 2 3 4 5 6 7 8 9 10

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

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Trauma Informed Oregon (2017). The Roadmap to trauma informed care. Retrieved from http://traumainformedoregon.org/roadmap-trauma-informed-care/

Trauma-Informed Organizational Model Planning

USING APPENDIX K

Purpose: The chart in Appendix K will invite you to re-visit the Building a Trauma-Informed Workplace Key Development Area within the **Pre-Implementation Stage**. The purpose of this chart is to provide an opportunity to respond to specific follow-up questions for each consideration.

The questions are designed so that you can both notice what is already in place and begin thinking about specific action items that may be needed within this key development area as you move forward.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see follow-up questions regarding that consideration with space to write short responses.

** **Note:** **This appendix can be used alongside Appendix J**, which will ask you to rate where your organization/system is on a scale from 1-10 for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Pre-Implementation

2. Building a Trauma-Informed Workplace

a) Organization/system has a plan for recruiting individuals who are knowledgeable about trauma and a trauma-informed approach.	What is the plan? Who/what roles need to be recruited?
b) Organization/system has a plan for the new hire orientation process to include foundational information on trauma/adversity, anti-racism, anti-oppression, re-traumatization and introduce the trauma-informed approach.	What is the plan?
c) Organization/system has a plan for hiring practices that are inclusive of all (gender, race, ability).	What is the plan? How will inclusivity be promoted?
d) Organization/system has a plan for reviewing their employee handbook, employee rights/responsibilities, job descriptions, etc. with a trauma-informed lens.	What is the plan? Who will be involved?

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

Substance Abuse and Mental Health Services Administration (2014). Concept of trauma and guidance for a trauma-informed approach. Retrieved from https://store.samhsa.gov/system/files/sma14-4884.pdf

Trauma Informed Oregon (2015). Standards of practice for trauma informed care. Retrieved from http://traumainformedoregon.org/wp-content/uploads/2016/07/Guidelines-and-Standards-of-Practice-for-Trauma-Informed-Care-07-16.pdf

Trauma Informed Oregon (2017). The Roadmap to trauma informed care. Retrieved from http://traumainformedoregon.org/roadmap-trauma-informed-care/

Trauma-Informed Organizational Model Planning

USING APPENDIX L

Purpose: The chart in Appendix L will invite you to re-visit the Building a Trauma-Informed Workplace Key Development Area within the Implementation Stage. The purpose of this chart is to provide an opportunity to rate where your organization/system currently is for each consideration, so that you can notice what is already in place and begin to consider what aspects of this key development area to focus on for action planning.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see a numeric scale from 1 to 10 that corresponds to each consideration.

- Please use the following rating system to indicate where you feel your organization/system currently is for each:

1 = not yet started	5 = halfway there	10 = ideal implementation

** Note: **This appendix can be used alongside Appendix M**, which will ask you to write responses to follow-up questions for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Implementation

2. Building a Trauma-Informed Workplace

a) Organization/system has a plan for recruiting individuals who are knowledgeable about trauma and a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
b) Organization/system incorporates questions on trauma and a trauma-informed approach into the interview process.	1 2 3 4 5 6 7 8 9 10
c) Organization/system has a plan for hiring practices that are inclusive of all (gender, race, ability).	1 2 3 4 5 6 7 8 9 10
d) Organization/system's hiring and orientation processes reflect the values/principles of a trauma-informed approach (safety, trustworthiness, choice, collaboration, empowerment).	1 2 3 4 5 6 7 8 9 10
e) Organization/system's orientation process includes staff receiving foundational information on trauma/adversity, anti-racism, anti-oppression, re-traumatization and introduce the trauma-informed approach.	1 2 3 4 5 6 7 8 9 10

f) Organization/system reviews their employee handbook, employee rights/ responsibilities, job descriptions, etc. with a trauma-informed lens.	1 2 3 4 5 6 7 8 9 10
g) Organization/system provides new employees their job expectations, rights, and responsibilities in writing.	1 2 3 4 5 6 7 8 9 10

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

Substance Abuse and Mental Health Services Administration (2014). Concept of trauma and guidance for a trauma-informed approach. Retrieved from https://store.samhsa.gov/system/files/sma14-4884.pdf

Trauma Informed Oregon (2015). Standards of practice for trauma informed care. Retrieved from http://traumainformedoregon.org/wp-content/uploads/2016/07/Guidelines-and-Standards-of-Practice-for-Trauma-Informed-Care-07-16.pdf

Trauma Informed Oregon (2017). The Roadmap to trauma informed care. Retrieved from http://traumainformedoregon.org/roadmap-trauma-informed-care/

Trauma-Informed Organizational Model Planning

USING APPENDIX M

Purpose: The chart in Appendix M will invite you to re-visit the Building a Trauma-Informed Workplace Key Development Area within the Implementation Stage. The purpose of this chart is to provide an opportunity to respond to specific follow-up questions for each consideration.

The questions are designed so that you can both notice what is already in place and begin thinking about specific action items that may be needed within this key development area as you move forward.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see follow-up questions regarding that consideration with space to write short responses.

** **Note:** **This appendix can be used alongside Appendix L**, which will ask you to rate where your organization/system is on a scale from 1-10 for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Implementation

2. Building a Trauma-Informed Workplace

a) Organization/system actively hires individuals who are knowledgeable about trauma and a trauma-informed approach.	Who is your hiring team? What is your hiring process? How will you incorporate peer voice?
b) Organization/system incorporates questions on trauma and a trauma-informed approach into the interview process.	What questions are included?
c) Organization/system's hiring practices are inclusive of all (gender, race, ability).	How are the practices inclusive?
d) Organization/system's hiring and orientation processes reflect the values/principles of a trauma-informed approach (safety, trustworthiness, choice, collaboration, empowerment).	How are the values and principles reflected?
e) Organization/system's orientation process includes staff receiving foundational information on trauma/adversity, anti-racism, anti-oppression, re-traumatization and introduce the trauma-informed approach.	What is the information? When is it provided?

f) Organization/system reviews their employee handbook, employee rights/responsibilities, job descriptions, etc. with a trauma-informed lens.	Who does the reviewing? What is the process?
g) Organization/system provides new employees their job expectations, rights, and responsibilities in writing.	How/when are they provided? How is this practice accessible?

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

Substance Abuse and Mental Health Services Administration (2014). Concept of trauma and guidance for a trauma-informed approach. Retrieved from https://store.samhsa.gov/system/files/sma14-4884.pdf

Trauma Informed Oregon (2015). Standards of practice for trauma informed care. Retrieved from http://traumainformedoregon.org/wp-content/uploads/2016/07/Guidelines-and-Standards-of-Practice-for-Trauma-Informed-Care-07-16.pdf

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Developing a Training Plan Worksheet

USING APPENDIX N

Purpose: Appendix S will help you begin structuring an overall training plan for your organization/ system by considering overall capacity, who to train when, who will provide the training, via what modality (in-person or online), etc. The chart is broken down into two sections—the initial presentation and short/long-term follow-up.

Directions:

1. Use the left column to indicate the different departments and/or roles that will need to be trained—remember, all members of the workforce have at least foundation training in a trauma-informed organization/system.

2. Use the second column to consider the timeframe for each department and/or role. How long of a period of time is possible for the training (e.g., 45 minutes; 2 hours)? When will the initial presentation be completed by? What times where individuals are gathered already are possible to use for training—especially follow-up?

3. Check the boxes in the third column to indicate whether in-person, online or both modalities of training will be used for each department and/or role.

4. Use the final column to consider other details related to the training, such as:

   - Who will deliver the training and/or what online modules will be used?
   - What content/trainings make sense for that specific department and/or role as follow-up?

   For example, perhaps your organization/system would like clinicians trained in a trauma-specific treatment intervention. Or, supervisors/management may need to be trained in trauma-informed supervision, etc.

NOTE: You may need more or less boxes than provided—feel free to make multiple copies of the charts to have enough space to account for your organization/system's workforce.

1. Initial Presentation

DEPARTMENT/ROLE	TIMEFRAME	MODALITY	DETAILS
	How long do you have: **Completed by:**	☐ In-person ☐ Online ☐ Both	**Who will deliver/what online trainings will be used:**
	How long do you have: **Completed by:**	☐ In-person ☐ Online ☐ Both	**Who will deliver/what online trainings will be used:**
	How long do you have: **Completed by:**	☐ In-person ☐ Online ☐ Both	**Who will deliver/what online trainings will be used:**
	How long do you have: **Completed by:**	☐ In-person ☐ Online ☐ Both	**Who will deliver/what online trainings will be used:**
	How long do you have: **Completed by:**	☐ In-person ☐ Online ☐ Both	**Who will deliver/what online trainings will be used:**
	How long do you have: **Completed by:**	☐ In-person ☐ Online ☐ Both	**Who will deliver/what online trainings will be used:**

2. Short-Term/Long-Term Follow-Ups

DEPARTMENT/ROLE	TIMEFRAME	MODALITY	DETAILS
	How long do you have: **Completed by:**	☐ In-person ☐ Online ☐ Both	**Who will deliver/what online trainings will be used:**
	How long do you have: **Completed by:**	☐ In-person ☐ Online ☐ Both	**Who will deliver/what online trainings will be used:**
	How long do you have: **Completed by:**	☐ In-person ☐ Online ☐ Both	**Who will deliver/what online trainings will be used:**
	How long do you have: **Completed by:**	☐ In-person ☐ Online ☐ Both	**Who will deliver/what online trainings will be used:**
	How long do you have: **Completed by:**	☐ In-person ☐ Online ☐ Both	**Who will deliver/what online trainings will be used:**
	How long do you have: **Completed by:**	☐ In-person ☐ Online ☐ Both	**Who will deliver/what online trainings will be used:**

Trauma-Informed Organizational Model Planning

USING APPENDIX O

Purpose: The chart in Appendix O will invite you to re-visit the Training the Workforce (Clinical and Non-Clinical) Key Development Area within the **Pre-Implementation Stage**. The purpose of this chart is to provide an opportunity to rate where your organization/system currently is for each consideration, so that you can notice what is already in place and begin to consider what aspects of this key development area to focus on for action planning.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see a numeric scale from 1 to 10 that corresponds to each consideration.

- Please use the following rating system to indicate where you feel your organization/system currently is for each:

1 = not yet started	5 = halfway there	10 = ideal implementation

** Note: **This appendix can be used alongside Appendix P**, which will ask you to write responses to follow-up questions for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Pre-Implementation

3. Training the Workforce (Clinical and Non-Clinical)

a) Organization/system has a plan to ensure all workers—clinical and non-clinical—receive foundation "trauma 101" education that covers trauma/adversity, anti-racism, anti-oppression, re-traumatization, and an introduction to a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
b) Organization/system has a plan for on-going follow-up training and discussions on trauma and the application of a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
c) Organization/system has a plan for role-specific, trauma-informed training (e.g., clinicians, supervisors, etc.).	1 2 3 4 5 6 7 8 9 10
d) Organization/system considers the development of internal trainers, mentors and/or coaches as part of the trauma-informed training plan.	1 2 3 4 5 6 7 8 9 10

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

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Trauma-Informed Organizational Model Planning

USING APPENDIX P

Purpose: The chart in Appendix P will invite you to re-visit the Training the Workforce (Clinical and Non-Clinical) Key Development Area within the **Pre-Implementation Stage**. The purpose of this chart is to provide an opportunity to respond to specific follow-up questions for each consideration.

The questions are designed so that you can both notice what is already in place and begin thinking about specific action items that may be needed within this key development area as you move forward.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see follow-up questions regarding that consideration with space to write short responses.

** **Note:** **This appendix can be used alongside Appendix O**, which will ask you to rate where your organization/system is on a scale from 1-10 for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Pre-Implementation

3. Training the Workforce (Clinical and Non-Clinical)

a) Organization/system has a plan to ensure all workers—clinical and non-clinical—receive foundation "trauma 101" education that covers trauma/adversity, anti-racism, anti-oppression, re-traumatization, and an introduction to a trauma-informed approach.	What is the plan? What content will be included in the education?
b) Organization/system has a plan for on-going follow-up training and discussions on trauma and the application of a trauma-informed approach.	What is the plan?
c) Organization/system has a plan for role-specific, trauma-informed training (e.g., clinicians, supervisors, etc.).	What is the plan? What roles will be included?
d) Organization/system considers the development of internal trainers, mentors and/or coaches as part of the trauma-informed training plan.	Who will be internal trainers, mentors and/or coaches?

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

Substance Abuse and Mental Health Services Administration (2014). Concept of trauma and guidance for a trauma-informed approach. Retrieved from https://store.samhsa.gov/system/files/sma14-4884.pdf

Trauma Informed Oregon (2015). Standards of practice for trauma informed care. Retrieved from http://traumainformedoregon.org/wp-content/uploads/2016/07/Guidelines-and-Standards-of-Practice-for-Trauma-Informed-Care-07-16.pdf

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Trauma-Informed Organizational Model Planning

USING APPENDIX Q

Purpose: The chart in Appendix Q will invite you to re-visit the Training the Workforce (Clinical and Non-Clinical) Key Development Area within the Implementation Stage. The purpose of this chart is to provide an opportunity to rate where your organization/system currently is for each consideration, so that you can notice what is already in place and begin to consider what aspects of this key development area to focus on for action planning.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see a numeric scale from 1 to 10 that corresponds to each consideration.

- Please use the following rating system to indicate where you feel your organization/system currently is for each:

1 = not yet started	5 = halfway there	10 = ideal implementation

** Note: **This appendix can be used alongside Appendix R**, which will ask you to write responses to follow-up questions for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Implementation

3. Training the Workforce (Clinical and Non-Clinical)

a) All workers—clinical and non-clinical—receive foundation "trauma 101" education that covers trauma/adversity, anti-racism, anti-oppression, re-traumatization, and an introduction to a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
b) Organization/system offers on-going follow-up training and discussions on trauma and the application of a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
c) Clinical workers are trained in evidence-based, trauma-specific treatment interventions (e.g., EMDR, CPT, Seeking Safety, TF-CBT) when possible.	1 2 3 4 5 6 7 8 9 10
d) All workers receive basic training on the maintenance of personal and professional boundaries.	1 2 3 4 5 6 7 8 9 10
e) All workers receive training on supporting, managing, and responding to reactivity (e.g., de-escalation).	1 2 3 4 5 6 7 8 9 10

f) Supervision includes the learning and application of a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
g) Workforce meetings include the learning and application of a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
h) Organization/system has internal trauma-informed trainers, mentors and/or coaches.	1 2 3 4 5 6 7 8 9 10

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

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Trauma-Informed Organizational Model Planning

USING APPENDIX R

Purpose: The chart in Appendix R will invite you to re-visit the Training the Workforce (Clinical and Non-Clinical) Key Development Area within the Implementation Stage. The purpose of this chart is to provide an opportunity to respond to specific follow-up questions for each consideration.

The questions are designed so that you can both notice what is already in place and begin thinking about specific action items that may be needed within this key development area as you move forward.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see follow-up questions regarding that consideration with space to write short responses.

** **Note:** **This appendix can be used alongside Appendix Q**, which will ask you to rate where your organization/system is on a scale from 1-10 for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Implementation

3. Training the Workforce (Clinical and Non-Clinical)

a) All workers—clinical and non-clinical—receive foundation "trauma 101" education that covers trauma/adversity, anti-racism, anti-oppression, re-traumatization, and an introduction to a trauma-informed approach.	What is the training? When does it occur?
b) Organization/system offers on-going follow-up training and discussions on trauma and the application of a trauma-informed approach.	What is the follow-up? When does it occur?
c) Clinical workers are trained in evidence-based, trauma-specific treatment interventions (e.g., EMDR, CPT, Seeking Safety, TF-CBT) when possible.	What treatment interventions?
d) All workers receive basic training on the maintenance of personal and professional boundaries.	What is the training? When does it occur?

e) All workers receive training on supporting, managing, and responding to reactivity (e.g., de-escalation).	What is the training? When does it occur?
f) Supervision includes the learning and application of a trauma-informed approach.	How is it included?
g) Workforce meetings include the learning and application of a trauma-informed approach.	How is it included?
h) Organization/system has internal trauma-informed trainers, mentors and/or coaches	Who are the trainers, mentors, and/or coaches? How are they trained?

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

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Trauma-Informed Organizational Model Planning

USING APPENDIX S

Purpose: The chart in Appendix S will invite you to re-visit the Addressing the Impact of the Work Key Development Area within the **Pre-Implementation Stage**. The purpose of this chart is to provide an opportunity to rate where your organization/system currently is for each consideration, so that you can notice what is already in place and begin to consider what aspects of this key development area to focus on for action planning.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see a numeric scale from 1 to 10 that corresponds to each consideration.

- Please use the following rating system to indicate where you feel your organization/system currently is for each:

1 = not yet started	5 = halfway there	10 = ideal implementation

** Note: **This appendix can be used alongside Appendix T**, which will ask you to write responses to follow-up questions for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Pre-Implementation

4. Addressing the Impact of the Work

a) Organization/system has a plan to ensure all workers—clinical and non-clinical—receive training on possible impacts of the work (e.g., secondary trauma, vicarious trauma, burnout, compassion fatigue, vicarious resilience, vicarious post-traumatic growth, compassion resilience).	1 2 3 4 5 6 7 8 9 10
b) Organization/system has a plan for structures/policies to support workforce health and wellness in culturally responsive ways.	1 2 3 4 5 6 7 8 9 10
c) Organization/system has a plan to create trauma-informed supervision protocols.	1 2 3 4 5 6 7 8 9 10
d) Organization/system has a plan to create trauma-informed crisis/incident debriefing protocols.	1 2 3 4 5 6 7 8 9 10

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

Substance Abuse and Mental Health Services Administration (2014). Concept of trauma and guidance for a trauma-informed approach. Retrieved from https://store.samhsa.gov/system/files/sma14-4884.pdf

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Trauma-Informed Organizational Model Planning

USING APPENDIX T

Purpose: The chart in Appendix T will invite you to re-visit the Addressing the Impact of the Work Key Development Area within the **Pre-Implementation Stage**. The purpose of this chart is to provide an opportunity to respond to specific follow-up questions for each consideration.

The questions are designed so that you can both notice what is already in place and begin thinking about specific action items that may be needed within this key development area as you move forward.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see follow-up questions regarding that consideration with space to write short responses.

**** Note: This appendix can be used alongside Appendix S**, wwhich will ask you to rate where your organization/system is on a scale from 1-10 for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Pre-Implementation

4. Addressing the Impact of the Work

a) Organization/system has a plan to ensure all workers—clinical and non-clinical—receive training on possible impacts of the work (e.g., secondary trauma, vicarious trauma, burnout, compassion fatigue, vicarious resilience, vicarious post-traumatic growth, compassion resilience).	What is the plan? What training will be included?
b) Organization/system has a plan for structures/policies to support workforce health and wellness in culturally responsive ways.	What is the plan? Who will be involved?
c) Organization/system has a plan to create trauma-informed supervision protocols.	What is the plan? Who will be involved?
d) Organization/system has a plan to create trauma-informed crisis/incident debriefing protocols.	What is the plan? Who will be involved?

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

Substance Abuse and Mental Health Services Administration (2014). Concept of trauma and guidance for a trauma-informed approach. Retrieved from https://store.samhsa.gov/system/files/sma14-4884.pdf

Trauma Informed Oregon (2015). Standards of practice for trauma informed care. Retrieved from http://traumainformedoregon.org/wp-content/uploads/2016/07/Guidelines-and-Standards-of-Practice-for-Trauma-Informed-Care-07-16.pdf

Trauma Informed Oregon (2017). The Roadmap to trauma informed care. Retrieved from http://traumainformedoregon.org/roadmap-trauma-informed-care/

Organizational/System Supports to Address the Impact of the Work

APPENDIX U

Purpose: Appendix U can be used as a tool to assess and consider possible supports to respond to possible impacts of the work and promote workforce wellness/resilience at an individual, peer and full organizational level. After moving through the full tool, there will be space to write additional comments and indicate possible next steps.

Directions: For each area of the tool, there are different considerations listed to respond to possible impacts of the work and promote workforce wellness/resilience. On the right, you will see a numeric scale from 1 to 5 that corresponds to each consideration.

1 = strongly disagree 2 = disagree 3 = neutral 4 = agree 5 = strongly agree

- Each level of the tool also has space for narrative/comments to elaborate about the specifics—this can be used to indicate both what is in place and working well, as well as what you would like to see happen that could be incorporated into the action plan.
- The action plan has space to delineate next steps for those considerations you wish to see improvement in. We recommend you identify the top 1-2 considerations in each section and think about what it would take to raise your score just *one number higher*.

1. Individual Level

The organization/system encourages, and provides time and resources for the workforce to:

Engage in self-awareness and self-check ins.	1 2 3 4 5
Seek support from supervisors, co-workers and friends/family.	1 2 3 4 5
Communicate expectations for self and others.	1 2 3 4 5
Attend training opportunities on the impact of the work and wellness.	1 2 3 4 5
Notice capacities, successes and possibilities.	1 2 3 4 5
Take breaks and time off for physical and mental health.	1 2 3 4 5
Reflect on the meaning and value of the work.	1 2 3 4 5

Practice culturally sensitive self-care and wellness strategies.	1 2 3 4 5
Engage in regulating and self-soothing activities (e.g., mindfulness, meditation, walking, stretching, etc.)	1 2 3 4 5

Narrative/Comments:

2. Peer/Co-Worker Level

The organization/system encourages, and provides time and resources for the workforce to:

Check in regularly with each other.	1 2 3 4 5
Create and use a buddy system.	1 2 3 4 5
Utilize peer supervision or consultation teams.	1 2 3 4 5
Develop informal times to connect (e.g., lunch, gatherings, etc.).	1 2 3 4 5
Join peers around a common purpose or value.	1 2 3 4 5
Create space for affinity groups and peer support.	1 2 3 4 5
Reflect on the meaning and value of the work.	1 2 3 4 5

Narrative/Comments:

1 = strongly disagree 2 = disagree 3 = neutral 4 = agree 5 = strongly agree

3. Organization/System Level

The organization/system models, and provides time and resources for:

On-going, culturally-specific supervision (individual/group).	1 2 3 4 5
Regular team meetings with opportunities to check-in/connect.	1 2 3 4 5
Balancing and limiting caseloads/workloads.	1 2 3 4 5
Acknowledgment of work-related stress and possible impacts of the work.	1 2 3 4 5
An Employee Assistance Program (EAP), or other form of available mental health services for the workforce.	1 2 3 4 5
Creation and implementation of check-in and debriefing protocols.	1 2 3 4 5
Creation and implementation of a formal policy/procedure to address workforce concerns.	1 2 3 4 5
A space to practice culturally sensitive self-care and wellness strategies.	1 2 3 4 5
Recognition and appreciation of the workforce.	1 2 3 4 5
Evaluation of staff satisfaction.	1 2 3 4 5
Messaging of self-care and wellness expectations (e.g., "take 10," regulation breaks).	1 2 3 4 5
Participation in agency or community building activities.	1 2 3 4 5
Eliciting feedback from the workforce around what is working and what is needed for support.	1 2 3 4 5
A psychologically healthy and safe workplace with a no-tolerance policy for violence, harassment, discrimination and racism.	1 2 3 4 5
A workplace environment where diversity, inclusion and accessibility are welcomed, respected and valued.	1 2 3 4 5
Training to develop skills for self-awareness, emotion regulation and compassionate boundaries.	1 2 3 4 5
Respect of the differentiation between work and non-work hours.	1 2 3 4 5

Narrative/Comments:

1 = strongly disagree 2 = disagree 3 = neutral 4 = agree 5 = strongly agree

Action Plan

RECOMMENDATION(S)	NEXT STEPS (INCLUDE TIMEFRAME, PERSONS RESPONSIBLE)
Individual Level:	
Peer/Co-Worker Level:	
Organization/System Level:	

References

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Wise & Rogers Behavioral Health. (n.d.). *Compassion resilience toolkit.* https://compassionresiliencetoolkit.org/

Trauma-Informed Organizational Model Planning

USING APPENDIX V

Purpose: The chart in Appendix V will invite you to re-visit the Addressing the Impact of the Work Key Development Area within the Implementation Stage. The purpose of this chart is to provide an opportunity to rate where your organization/system currently is for each consideration, so that you can notice what is already in place and begin to consider what aspects of this key development area to focus on for action planning.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see a numeric scale from 1 to 10 that corresponds to each consideration.

- Please use the following rating system to indicate where you feel your organization/system currently is for each:

1 = not yet started	5 = halfway there	10 = ideal implementation

** Note: **This appendix can be used alongside Appendix W**, which will ask you to write responses to follow-up questions for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Implementation

4. Addressing the Impact of the Work

a) All workers—clinical and non-clinical—receive training on the possible impacts of the work (e.g., secondary trauma, vicarious trauma, burnout, compassion fatigue, vicarious resilience, vicarious post-traumatic growth, compassion resilience).	1 2 3 4 5 6 7 8 9 10
b) Workers receive regularly scheduled, trauma-informed supervision.	1 2 3 4 5 6 7 8 9 10
c) Supervision allows opportunities for workers to explore their own stress reactions, self-care, and wellness.	1 2 3 4 5 6 7 8 9 10
d) Leadership actively encourages and promotes workforce wellness and self-care in culturally responsive ways.	1 2 3 4 5 6 7 8 9 10
e) Leadership regularly checks in with the workforce and each other.	1 2 3 4 5 6 7 8 9 10

f) Organization/system debriefs after a crisis/incident.	1 2 3 4 5 6 7 8 9 10
g) Organization/system implements structures/policies to support workforce health and wellness in culturally responsive ways.	1 2 3 4 5 6 7 8 9 10

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

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Trauma-Informed Organizational Model Planning

USING APPENDIX W

Purpose: The chart in Appendix W will invite you to re-visit the Addressing the Impact of the Work Key Development Area within the Implementation Stage. The purpose of this chart is to provide an opportunity to respond to specific follow-up questions for each consideration.

The questions are designed so that you can both notice what is already in place and begin thinking about specific action items that may be needed within this key development area as you move forward.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see follow-up questions regarding that consideration with space to write short responses.

** **Note:** **This appendix can be used alongside Appendix V**, which will ask you to rate where your organization/system is on a scale from 1-10 for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Implementation

4. Addressing the Impact of the Work

a) All workers—clinical and non-clinical—receive training on the possible impacts of the work (e.g., secondary trauma, vicarious trauma, burnout, compassion fatigue, vicarious resilience, vicarious post-traumatic growth, compassion resilience).	What is the training? When does it occur?
b) Workers receive regularly scheduled, trauma-informed supervision.	How often? How are supervisors trained in trauma-informed supervision?
c) Supervision allows opportunities for workers to explore their own stress reactions, self-care, and wellness.	How is this done?
d) Leadership actively encourages and promotes workforce wellness and self-care in culturally responsive ways.	How is this done? Are staff encouraged to take time off for personal reasons?

e) Leadership regularly checks in with the workforce and each other.	Who is leadership? How is this done? How is there communication between leadership and staff, and vice versa?
f) Organization/system debriefs after a crisis/incident.	What is the process? Who does the debriefing? How are they trained to debrief in a trauma-informed way?
g) Organization/system implements structures/policies to support workforce health and wellness in culturally responsive ways.	What are the structures/policies? How often are they reviewed?

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

Substance Abuse and Mental Health Services Administration (2014). Concept of trauma and guidance for a trauma-informed approach. Retrieved from https://store.samhsa.gov/system/files/sma14-4884.pdf

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Trauma-Informed Organizational Model Planning

USING APPENDIX X

Purpose: Appendix X will assist in assessing the physical and emotional environment of your organization/system. Our walk-through is broken into five main areas—outside, waiting areas, service/common areas, bathrooms, and workforce interactions and culture.

In order to most effectively use this walk-through, we advise:

- A small group of individuals actually walks around the space (starting from outside) rather than sitting at a desk to fill it out. Try to use the lens of an individual coming to your space for the very first time.
- Consider how you will incorporate client/patient/student/consumer voices in your review of the physical and emotional environment. Some members of organizations invite a peer worker or a client to walk around with them and to discuss the different aspects of the walk-through. Others develop surveys or suggestion cards in order to elicit this feedback.
- Complete the walk-through in full and make note of considerations that may need to be added/changed to better match your organization/system. It was designed to be general enough to apply to many organizations as possible—there may be things on the list that may or may not make sense for yours.

Directions: For each area of the walk-through, there are different prompts that are bulleted for you to consider as you are walking and observing. On the right, you will see a numeric scale from 1 to 4 that corresponds to each prompt.

- Please use the following rating system to indicate where you feel your organization/system currently is for each:

1 = needs improvement	2 = average	3 = good	4 = ideal

- Each area also has space for narrative/comments to elaborate about the specifics—this can be used to indicate both what is ideal (i.e. great artwork in the waiting room), as well as what specific aspects may need improvement (i.e. the light in the parking lot isn't working).
- The last page of the walk-through has a space for action planning in each of the four main areas. Select one or two of your lowest numbers in each area and consider what it would take to raise your score just *one number higher*.

Outside

• Outside of the building is well-lit	1	2	3	4
• Signs are clear and visible	1	2	3	4
• Signs are welcoming	1	2	3	4
• Signs are accessible (language, reading level, braille, etc.)	1	2	3	4
• Security measures are in place if necessary	1	2	3	4
• Entrance to the building is accessible	1	2	3	4

Narrative/Comments:

Waiting Area

- Area is clean, free of odor 1 2 3 4
- Area is accessible 1 2 3 4
- Staff monitor who comes in and out 1 2 3 4
- Adequate spacing between seats 1 2 3 4
- Area is welcoming and comfortable:
  - Diverse and inclusive artwork/photos 1 2 3 4
  - Plants 1 2 3 4
  - Magazines/reading material 1 2 3 4
  - Soothing colors on walls 1 2 3 4
  - Choice in lighting available 1 2 3 4
  - Child-friendly area, as appropriate 1 2 3 4
- Emergency protocols posted 1 2 3 4
- Individual rights/expectations posted 1 2 3 4
- Signage:
  - Positive language/images 1 2 3 4
  - Clear, visible and updated 1 2 3 4
  - Accessible (language, reading level, braille, etc.) 1 2 3 4

Narrative/Comments:

Service/Common Areas

- Area is clean, free of odor 1 2 3 4
- Area is accessible 1 2 3 4
- Private spaces are used to meet with individuals 1 2 3 4
- Designated "safe space" for staff and individuals 1 2 3 4
- Emergency protocols posted 1 2 3 4
- Staff rights/expectations posted 1 2 3 4
- Staff have choice in seating position 1 2 3 4
- Individuals have choice in seating type 1 2 3 4
- Area is welcoming and comfortable:
  - Diverse and inclusive artwork/photos 1 2 3 4
  - Plants 1 2 3 4
  - Soothing colors on walls 1 2 3 4
  - Choice in lighting available 1 2 3 4
  - Child-friendly area, as appropriate 1 2 3 4
  - Information available in different languages 1 2 3 4
- Signage:
  - Positive language/images 1 2 3 4
  - Clear, visible and updated 1 2 3 4
  - Accessible (language, reading level, braille, etc.) 1 2 3 4

Narrative/Comments:

Bathrooms

• Easily accessible (for both individuals and staff)	1	2	3	4
• Clean, free of odor	1	2	3	4
• Well-lit	1	2	3	4
• Gender neutral option available	1	2	3	4

Narrative/Comments:

Workforce Interactions and Culture

• Individuals are verbally welcomed when arriving	1	2	3	4
• Individuals are informed of what to expect	1	2	3	4
• Interactions respect confidentiality and privacy of individuals	1	2	3	4
• Interactions demonstrate empathy and support	1	2	3	4
• Interactions are validating and affirming	1	2	3	4
• Interactions express patience and acceptance	1	2	3	4
• Interactions utilize person-first and inclusive language	1	2	3	4
• Interactions respond sensitively to individuals experiencing triggers/trauma reactions	1	2	3	4

Narrative/Comments:

Action Plan

NEXT STEPS	TIMEFRAME/PERSON(S) RESPONSIBLE
Outside:	
Waiting Area:	
Service/Common Areas:	
Bathrooms:	
Workforce Interactions/Culture:	

Trauma-Informed Organizational Model Planning

USING APPENDIX Y

Purpose: The chart in Appendix Y will invite you to re-visit the Establishing a Safe Environment Key Development Area within the **Pre-Implementation Stage**. The purpose of this chart is to provide an opportunity to rate where your organization/system currently is for each consideration, so that you can notice what is already in place and begin to consider what aspects of this key development area to focus on for action planning.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see a numeric scale from 1 to 10 that corresponds to each consideration.

- Please use the following rating system to indicate where you feel your organization/system currently is for each:

1 = not yet started	5 = halfway there	10 = ideal implementation

** Note: **This appendix can be used alongside Appendix Z**, which will ask you to write responses to follow-up questions for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Pre-Implementation

5. Establishing a Safe Environment

a) Organization/system has a plan to regularly assess the environment for physical and emotional safety.	1 2 3 4 5 6 7 8 9 10
b) Organization/system adapts the trauma-informed walk-through tool to match their own environment.	1 2 3 4 5 6 7 8 9 10

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

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Trauma-Informed Organizational Model Planning

USING APPENDIX Z

Purpose: The chart in Appendix Z will invite you to re-visit the Establishing a Safe Environment Key Development Area within the **Pre-Implementation Stage**. The purpose of this chart is to provide an opportunity to respond to specific follow-up questions for each consideration.

The questions are designed so that you can both notice what is already in place and begin thinking about specific implementation items that may be needed within this key development area as you move forward.

Directions: The left-hand column of the chart lists different aspects of organizational functioning to consider. On the right, you will see follow-up questions regarding that consideration with space to write short responses.

** **Note:** **This appendix can be used alongside Appendix Y**, which will ask you to rate where your organization/system is on a scale from 1-10 for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Pre-Implementation

5. Establishing a Safe Environment

a) Organization/system has a plan to regularly assess the environment for physical and emotional safety.	What is the plan? What tool(s) will be used?
b) Organization/system adapts the trauma-informed walk-through tool to match their own environment.	How was it adapted? Who was involved?

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

Substance Abuse and Mental Health Services Administration (2014). Concept of trauma and guidance for a trauma-informed approach. Retrieved from https://store.samhsa.gov/system/files/sma14-4884.pdf

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Trauma-Informed Organizational Model Planning

USING APPENDIX AA

Purpose: The chart in Appendix AA will invite you to re-visit the Establishing a Safe Environment Key Development Area within the Implementation Stage. The purpose of this chart is to provide an opportunity to rate where your organization/system currently is for each consideration, so that you can notice what is already in place and begin to consider what aspects of this key development area to focus on for action planning.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see a numeric scale from 1 to 10 that corresponds to each consideration.

- Please use the following rating system to indicate where you feel your organization/system currently is for each:

1 = not yet started	5 = halfway there	10 = ideal implementation

** Note: **This appendix can be used alongside Appendix BB**, which will ask you to write responses to follow-up questions for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Implementation

5. Establishing a Safe Environment

a) Organization/system regularly conducts trauma-informed walk-throughs to identify strengths and areas for improvement.	1 2 3 4 5 6 7 8 9 10
b) Organization/system elicits feedback about the safety of the environment from all individuals.	1 2 3 4 5 6 7 8 9 10
c) Areas outside the organization/system, common areas and bathrooms are well-lit.	1 2 3 4 5 6 7 8 9 10
d) Workers monitor who enters and exits the building.	1 2 3 4 5 6 7 8 9 10
e) Organization/system is welcoming and aesthetically comfortable (e.g., color of walls, presence of artwork/photos, plants, etc.)	1 2 3 4 5 6 7 8 9 10

f) Signs use positive, welcoming language and state the desired or "prosocial" behavior.	1 2 3 4 5 6 7 8 9 10
g) Organization/system has a designated "safe space" for workers to practice self-care.	1 2 3 4 5 6 7 8 9 10
h) Organization/system's environment is culturally responsive (e.g., languages, décor that represent individuals using the space).	1 2 3 4 5 6 7 8 9 10
i) Common areas, service areas, bathrooms and bedrooms are inclusive, and consider privacy and accessibility.	1 2 3 4 5 6 7 8 9 10
j) Leadership and workers ensure individuals feel welcomed, respected, included, and supported in all interactions.	1 2 3 4 5 6 7 8 9 10
k) Leadership and workers maintain consistent, open, and compassionate communication.	1 2 3 4 5 6 7 8 9 10
l) Organization/system anchors emotional safety by conveying the message that everyone's voice is valued, and that feedback is important and welcomed.	1 2 3 4 5 6 7 8 9 10

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

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Trauma-Informed Organizational Model Planning

USING APPENDIX BB

Purpose: The chart in Appendix BB will invite you to re-visit the Screening for Trauma Key Development Area within the Implementation Stage. The purpose of this chart is to provide an opportunity to respond to specific follow-up questions for each consideration.

The questions are designed so that you can both notice what is already in place and begin thinking about specific implementation items that may be needed within this key development area as you move forward.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see follow-up questions regarding that consideration with space to write short responses.

** **Note: This appendix can be used alongside Appendix AA**, which will ask you to rate where your organization/system is on a scale from 1-10 for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Implementation

5. Establishing a Safe Environment

a) Organization/system regularly conducts trauma-informed walk-throughs to identify strengths and areas for improvement.	How often does this occur?
b) Organization/system elicits feedback about the safety of the environment from all individuals.	How is this done? Who is involved?
c) Areas outside the organization/system, common areas and bathrooms are well-lit.	When was this checked? How often will it be revisited?
d) Workers monitor who enters and exits the building.	What is the protocol?

e) Organization/system is welcoming and aesthetically comfortable (e.g., color of walls, presence of artwork/photos, plants, etc.)	How is this done?
f) Signs use positive, welcoming language and state the desired or "prosocial" behavior.	What language is focused on? How much time is spent focused on the problem versus what will be happening instead?
g) Organization/system has a designated "safe space" for workers to practice self-care.	What does this look like?
h) Organization/system's environment is culturally responsive (e.g., languages, décor that represent individuals using the space).	When was this checked? How often will it be revisited?
i) Common areas, service areas, bathrooms and bedrooms are inclusive, and consider privacy and accessibility.	How is privacy, inclusivity and accessibility considered?
j) Leadership and workers ensure individuals feel welcomed, respected, included, and supported in all interactions.	How is this done?
k) Leadership and workers maintain consistent, open, and compassionate communication.	How is this done?
l) Organization/system anchors emotional safety by conveying the message that everyone's voice is valued, and that feedback is important and welcomed.	How is this done?

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

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Trauma-Informed Organizational Model Planning

USING APPENDIX CC

Purpose: The chart in Appendix CC will invite you to re-visit the Screening for Trauma Key Development Area within the **Pre-Implementation Stage**. The purpose of this chart is to provide an opportunity to rate where your organization/system currently is for each consideration, so that you can notice what is already in place and begin to consider what aspects of this key development area to focus on for action planning.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see a numeric scale from 1 to 10 that corresponds to each consideration.

- Please use the following rating system to indicate where you feel your organization/system currently is for each:

1 = not yet started	5 = halfway there	10 = ideal implementation

** Note: **This appendix can be used alongside Appendix DD**, which will ask you to write responses to follow-up questions for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Pre-Implementation

6. Screening for Trauma

a) Organization/system reviews specific tools to screen and assess for trauma.	1 2 3 4 5 6 7 8 9 10
b) Organization/system has a plan to create protocols for screening and assessment of trauma.	1 2 3 4 5 6 7 8 9 10

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

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Trauma-Informed Organizational Model Planning

USING APPENDIX DD

Purpose: The chart in Appendix DD will invite you to re-visit the Screening for Trauma Key Development Area within the **Pre-Implementation Stage.** The purpose of this chart is to provide an opportunity to respond to specific follow-up questions for each consideration.

The questions are designed so that you can both notice what is already in place and begin thinking about specific action items that may be needed within this key development area as you move forward

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see follow-up questions regarding that consideration with space to write short responses.

** **Note:** **This appendix can be used alongside Appendix CC**, which will ask you to rate where your organization/system is on a scale from 1-10 for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Pre-Implementation

6. Screening for Trauma

a) Organization/system reviews specific tools to screen and assess for trauma.	What tools were reviewed? Who was involved in the review process?
b) Organization/system has a plan to create protocols for screening and assessment of trauma.	What is the plan? How will staff be trained on the plan?

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

Substance Abuse and Mental Health Services Administration (2014). Concept of trauma and guidance for a trauma-informed approach. Retrieved from https://store.samhsa.gov/system/files/sma14-4884.pdf

Trauma Informed Oregon (2015). Standards of practice for trauma informed care. Retrieved from http://traumainformedoregon.org/wp-content/uploads/2016/07/Guidelines-and-Standards-of-Practice-for-Trauma-Informed-Care-07-16.pdf

Trauma Informed Oregon (2017). The Roadmap to trauma informed care. Retrieved from http://traumainformedoregon.org/roadmap-trauma-informed-care/

Trauma-Informed Organizational Model Planning

USING APPENDIX EE

Purpose: The chart in Appendix EE will invite you to re-visit the Screening for Trauma Key Development Area within the Implementation Stage. The purpose of this chart is to provide an opportunity to rate where your organization/system currently is for each consideration, so that you can notice what is already in place and begin to consider what aspects of this key development area to focus on for action planning.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see a numeric scale from 1 to 10 that corresponds to each consideration.

- Please use the following rating system to indicate where you feel your organization/system currently is for each:

1 = not yet started	5 = halfway there	10 = ideal implementation

** Note: **This appendix can be used alongside Appendix FF**, which will ask you to write responses to follow-up questions for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Implementation

6. Screening for Trauma

a) Organization/system uses specific tools when screening and assessing for trauma.	1 2 3 4 5 6 7 8 9 10
b) Identified workers are trained in trauma screening and conducting appropriate follow-up discussions with individuals.	1 2 3 4 5 6 7 8 9 10
c) Workers conducting screening and/or assessment are trained in trauma-informed, anti-racist and anti-oppressive protocols.	1 2 3 4 5 6 7 8 9 10
d) Organization/system screens for trauma only once and shares results across settings with informed consent to avoid re-traumatization from re-screening.	1 2 3 4 5 6 7 8 9 10
e) Organization/system has a protocol for all screening results, including an updated list of referrals if trauma assessment and/or treatment is not offered on-site.	1 2 3 4 5 6 7 8 9 10

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

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Trauma Informed Oregon (2015). Standards of practice for trauma informed care. Retrieved from http://traumainformedoregon.org/wp-content/uploads/2016/07/Guidelines-and-Standards-of-Practice-for-Trauma-Informed-Care-07-16.pdf

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Trauma-Informed Organizational Model Planning

USING APPENDIX FF

Purpose: The chart in Appendix FF will invite you to re-visit the Screening for Trauma Key Development Area within the **Implementation Stage**. The purpose of this chart is to provide an opportunity to respond to specific follow-up questions for each consideration..

The questions are designed so that you can both notice what is already in place and begin thinking about specific action items that may be needed within this key development area as you move forward.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see follow-up questions regarding that consideration with space to write short responses.

**** Note: This appendix can be used alongside Appendix EE**, which will ask you to rate where your organization/system is on a scale from 1-10 for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Implementation

6. Screening for Trauma

a) Organization/system uses specific tools when screening and assessing for trauma.	What tool(s) are used?
b) Identified workers are trained in trauma screening and conducting appropriate follow-up discussions with individuals.	How are workers trained?
c) Workers conducting screening and/or assessment are trained in trauma-informed, anti-racist and anti-oppressive protocols.	How are workers trained?
d) Organization/system screens for trauma only once and shares results across settings with informed consent to avoid re-traumatization from re-screening.	When in the process is screening implemented?
e) Organization/system has a protocol for all screening results, including an updated list of referrals if trauma assessment and/or treatment is not offered on-site.	What is the protocol? What options are available for trauma treatment on-site or via referral?

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

Substance Abuse and Mental Health Services Administration (2014). Concept of trauma and guidance for a trauma-informed approach. Retrieved from https://store.samhsa.gov/system/files/sma14-4884.pdf

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Trauma Informed Oregon (2017). The Roadmap to trauma informed care. Retrieved from http://traumainformedoregon.org/roadmap-trauma-informed-care/

Trauma-Informed Organizational Model Planning

USING APPENDIX GG

Purpose: The chart in Appendix GG will invite you to re-visit the Treating Trauma Key Development Area within the **Pre-Implementation Stage**. The purpose of this chart is to provide an opportunity to rate where your organization/system currently is for each consideration, so that you can notice what is already in place and begin to consider what aspects of this key development area to focus on for action planning.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see a numeric scale from 1 to 10 that corresponds to each consideration.

- Please use the following rating system to indicate where you feel your organization/system currently is for each:

1 = not yet started	5 = halfway there	10 = ideal implementation

** Note: **This appendix can be used alongside Appendix HH**, which will ask you to write responses to follow-up questions for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Pre-Implementation

7. Treating Trauma

a) Organization/system has a plan to offer or refer out to evidence-based, trauma-specific treatment interventions (e.g., EMDR, CPT, Seeking Safety, TF-CBT).	1 2 3 4 5 6 7 8 9 10
b) Organization/system has a plan to develop supervision/consultation protocols for workers who provide trauma-specific treatment.	1 2 3 4 5 6 7 8 9 10

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

Substance Abuse and Mental Health Services Administration (2014). Concept of trauma and guidance for a trauma-informed approach. Retrieved from https://store.samhsa.gov/system/files/sma14-4884.pdf

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Trauma Informed Oregon (2017). The Roadmap to trauma informed care. Retrieved from http://traumainformedoregon.org/roadmap-trauma-informed-care/

Trauma-Informed Organizational Model Planning

USING APPENDIX HH

Purpose: The chart in Appendix HH will invite you to re-visit the Treating Trauma Key Development Area within the **Pre-Implementation Stage**. The purpose of this chart is to provide an opportunity to respond to specific follow-up questions for each consideration.

The questions are designed so that you can both notice what is already in place and begin thinking about specific action items that may be needed within this key development area as you move forward.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see follow-up questions regarding that consideration with space to write short responses.

** **Note:** **This appendix can be used alongside Appendix GG**, which will ask you to rate where your organization/system is on a scale from 1-10 for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Pre-Implementation

7. Treating Trauma

a) Organization/system has a plan to offer or refer out to evidence-based, trauma-specific treatment interventions (e.g., EMDR, CPT, Seeking Safety, TF-CBT).	Will treatment be offered internally or externally? What is the plan?
b) Organization/system has a plan to develop supervision/consultation protocols for workers who provide trauma-specific treatment.	What is the plan? How will supervisors be trained?

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

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Trauma Informed Oregon (2017). The Roadmap to trauma informed care. Retrieved from http://traumainformedoregon.org/roadmap-trauma-informed-care/

Trauma-Informed Organizational Model Planning

USING APPENDIX II

Purpose: The chart in Appendix II will invite you to re-visit the Treating Trauma Key Development Area within the **Implementation Stage**. The purpose of this chart is to provide an opportunity to respond to specific follow-up questions for each consideration.

The questions are designed so that you can both notice what is already in place and begin thinking about specific action items that may be needed within this key development area as you move forward.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see a numeric scale from 1 to 10 that corresponds to each consideration.

- Please use the following rating system to indicate where you feel your organization/system currently is for each:

1 = not yet started	5 = halfway there	10 = ideal implementation

** Note: **This appendix can be used alongside Appendix JJ**, which will ask you to write responses to follow-up questions for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Implementation

7. Treating Trauma

a) Organization/system offers or refers out to evidence-based, trauma-specific treatment interventions (e.g., EMDR, CPT, Seeking Safety, TF-CBT).	1 2 3 4 5 6 7 8 9 10
b) Organization/system has some form of supervision or consultation available to workers who provide trauma-specific treatment.	1 2 3 4 5 6 7 8 9 10
c) Organization/system monitors fidelity to and/or inclusion of evidence-based, trauma-specific treatments in service plans.	1 2 3 4 5 6 7 8 9 10
d) Organization/system considers cultural practices that address the healing of trauma in service plans.	1 2 3 4 5 6 7 8 9 10

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

Substance Abuse and Mental Health Services Administration (2014). Concept of trauma and guidance for a trauma-informed approach. Retrieved from https://store.samhsa.gov/system/files/sma14-4884.pdf

Trauma Informed Oregon (2015). Standards of practice for trauma informed care. Retrieved from http://traumainformedoregon.org/wp-content/uploads/2016/07/Guidelines-and-Standards-of-Practice-for-Trauma-Informed-Care-07-16.pdf

Trauma Informed Oregon (2017). The Roadmap to trauma informed care. Retrieved from http://traumainformedoregon.org/roadmap-trauma-informed-care/

Trauma-Informed Organizational Model Planning

USING APPENDIX JJ

Purpose: The chart in Appendix JJ will invite you to re-visit the Treating Trauma Key Development Area within the **Implementation Stage**. The purpose of this chart is to provide an opportunity to respond to specific follow-up questions for each consideration.

The questions are designed so that you can both notice what is already in place and begin thinking about specific action items that may be needed within this key development area as you move forward.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see follow-up questions regarding that consideration with space to write short responses.

** **Note:** **This appendix can be used alongside Appendix II**, which will ask you to rate where your organization/system is on a scale from 1-10 for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Implementation

7. Treating Trauma

a) Organization/system offers or refers out to evidence-based, trauma-specific treatment interventions (e.g., EMDR, CPT, Seeking Safety, TF-CBT).	What treatment interventions?
b) Organization/system has some form of supervision or consultation available to workers who provide trauma-specific treatment.	What is in place?
c) Organization/system monitors fidelity to and/or inclusion of evidence-based, trauma-specific treatments in service plans.	How is fidelity/inclusion monitored?
d) Organization/system considers cultural practices that address the healing of trauma in service plans.	What practices are considered? How are individuals receiving services included in this process?

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

Substance Abuse and Mental Health Services Administration (2014). Concept of trauma and guidance for a trauma-informed approach. Retrieved from https://store.samhsa.gov/system/files/sma14-4884.pdf

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Trauma Informed Oregon (2017). The Roadmap to trauma informed care. Retrieved from http://traumainformedoregon.org/roadmap-trauma-informed-care/

Identifying Trauma-Informed Collaboration Opportunities

USING APPENDIX KK

Purpose: The chart in Appendix I will assist in mapping out your organization/system's current partners, referrals and other collaborators and what opportunities there may be for learning and collaboration specific to the trauma-informed change process.

Directions:

1. Use the left column to indicate your organization/system's current partners, referrals and other collaborators.

2. Use the middle column to indicate their level(s) of a trauma-informed approach: trauma-informed, trauma-sensitive and trauma-specific. This may involve someone doing some research—making phone calls, visiting the other entity, etc.

- A **trauma-informed** organization is aware of the prevalence and impact of trauma and engages in universal precaution for re-traumatization by anchoring in the five guiding values and principles.
- A **trauma-sensitive** organization deliberately looks at all levels of operation/functioning in order to respond to others in a way that is sensitive potential trauma histories.
- A **trauma-specific** organization offers evidence-based, trauma treatments interventions specifically designed to treat and help individuals heal from trauma.

3. Use the right column to brainstorm what opportunities there may be for learning and collaboration specific to the trauma-informed change process.

- Consider what ways communication/collaboration is already happening.
- Is there opportunity to learn from them if they are already levels of trauma-informed or trauma-sensitive?
- May they be appropriate referrals if they are offering trauma-specific treatment?
- What possibilities are there to include them in your organization/system's trauma-informed change process (e.g., training)?

Identifying Trauma-Informed Collaboration Opportunities

PARTNER/REFERRAL/OTHER COLLABORATOR	LEVEL OF TRAUMA-INFORMED APPROACH	OPPORTUNITIES FOR COLLABORATION AND LEARNING
	☐ Trauma-Informed ☐ Trauma-Sensitive ☐ Trauma-Specific	
	☐ Trauma-Informed ☐ Trauma-Sensitive ☐ Trauma-Specific	
	☐ Trauma-Informed ☐ Trauma-Sensitive ☐ Trauma-Specific	
	☐ Trauma-Informed ☐ Trauma-Sensitive ☐ Trauma-Specific	
	☐ Trauma-Informed ☐ Trauma-Sensitive ☐ Trauma-Specific	
	☐ Trauma-Informed ☐ Trauma-Sensitive ☐ Trauma-Specific	

Trauma-Informed Organizational Model Planning

USING APPENDIX LL

Purpose: The chart in Appendix LL will invite you to re-visit the Collaborating with Others (Partners and Referrals) Key Development Area within the **Pre-Implementation Stage**. The purpose of this chart is to provide an opportunity to rate where your organization/system currently is for each consideration, so that you can notice what is already in place and begin to consider what aspects of this key development area to focus on for action planning.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see a numeric scale from 1 to 10 that corresponds to each consideration.

- Please use the following rating system to indicate where you feel your organization/system currently is for each:

1 = not yet started	5 = halfway there	10 = ideal implementation

** Note: **This appendix can be used alongside Appendix MM**, which will ask you to write responses to follow-up questions for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Pre-Implementation

8. Collaborating with Others (Partners and Referrals)

a) Organization/system identifies opportunities to collaborate with partners, referrals and/or other community entities in the trauma-informed change process.	1 2 3 4 5 6 7 8 9 10
b) Organization/system has a plan to maintain an up-to-date list of affordable, accessible referral sources for the needs of individuals with trauma histories.	1 2 3 4 5 6 7 8 9 10

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

Substance Abuse and Mental Health Services Administration (2014). Concept of trauma and guidance for a trauma-informed approach. Retrieved from https://store.samhsa.gov/system/files/sma14-4884.pdf

Trauma Informed Oregon (2015). Standards of practice for trauma informed care. Retrieved from http://traumainformedoregon.org/wp-content/uploads/2016/07/Guidelines-and-Standards-of-Practice-for-Trauma-Informed-Care-07-16.pdf

Trauma Informed Oregon (2017). The Roadmap to trauma informed care. Retrieved from http://traumainformedoregon.org/roadmap-trauma-informed-care/

Trauma-Informed Organizational Model Planning

USING APPENDIX MM

Purpose: The chart in Appendix MM will invite you to re-visit the Collaborating with Others (Partners and Referrals) Key Development Area within the **Pre-Implementation Stage**. The purpose of this chart is to provide an opportunity to respond to specific follow-up questions for each consideration.

The questions are designed so that you can both notice what is already in place and begin thinking about specific implementation items that may be needed within this key development area as you move forward.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see follow-up questions regarding that consideration with space to write short responses.

** **Note:** **This appendix can be used alongside Appendix LL**, which will ask you to rate where your organization/system is on a scale from 1-10 for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Pre-Implementation

8. Collaborating with Others (Partners and Referrals)

a) Organization/system identifies opportunities to collaborate with partners, referrals and/or other community entities in the trauma-informed change process.	What partners, referrals and/or other entities were identified? What opportunities are there?
b) Organization/system has a plan to maintain an up-to-date list of affordable, accessible referral sources for the needs of individuals with trauma histories.	What is the plan? Who will be involved?

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

Substance Abuse and Mental Health Services Administration (2014). Concept of trauma and guidance for a trauma-informed approach. Retrieved from https://store.samhsa.gov/system/files/sma14-4884.pdf

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Trauma Informed Oregon (2017). The Roadmap to trauma informed care. Retrieved from http://traumainformedoregon.org/roadmap-trauma-informed-care/

Trauma-Informed Organizational Model Planning

USING APPENDIX NN

Purpose: The chart in Appendix NN will invite you to re-visit the Collaborating with Others (Partners and Referrals) Key Development Area within the **Implementation Stage**. The purpose of this chart is to provide an opportunity to rate where your organization/system currently is for each consideration, so that you can notice what is already in place and begin to consider what aspects of this key development area to focus on for action planning.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see a numeric scale from 1 to 10 that corresponds to each consideration.

- Please use the following rating system to indicate where you feel your organization/system currently is for each:

1 = not yet started	5 = halfway there	10 = ideal implementation

** Note: **This appendix can be used alongside Appendix OO**, which will ask you to write responses to follow-up questions for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Implementation

8. Collaborating with Others (Partners and Referrals)

a) Organization/system has an up-to-date list of affordable, accessible referral sources for the needs of individuals with trauma histories.	1 2 3 4 5 6 7 8 9 10
b) Organization/system works together with partners, referrals, and other community entities to create a trauma-informed network/community.	1 2 3 4 5 6 7 8 9 10
c) Organization/system has mechanisms in place to promote cross-sector training on trauma and a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
d) Organization/system has a method of communication in place with other entities working with the same individuals for making trauma-informed decisions.	1 2 3 4 5 6 7 8 9 10
e) Discharge/transitions from services is thoughtful, gradual and includes referrals to trauma-informed and community-based resources.	1 2 3 4 5 6 7 8 9 10
f) Organization/system has mechanisms to acknowledge and witness organizational, historical trauma narratives of collaborative partners and communities.	1 2 3 4 5 6 7 8 9 10

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

Substance Abuse and Mental Health Services Administration (2014). Concept of trauma and guidance for a trauma-informed approach. Retrieved from https://store.samhsa.gov/system/files/sma14-4884.pdf

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Trauma Informed Oregon (2017). The Roadmap to trauma informed care. Retrieved from http://traumainformedoregon.org/roadmap-trauma-informed-care/

Trauma-Informed Organizational Model Planning

USING APPENDIX OO

Purpose: The chart in Appendix OO will invite you to re-visit the Collaborating with Others (Partners and Referrals) Key Development Area within the **Implementation Stage**. The purpose of this chart is to provide an opportunity to respond to specific follow-up questions for each consideration.

The questions are designed so that you can both notice what is already in place and begin thinking about specific implementation items that may be needed within this key development area as you move forward.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see follow-up questions regarding that consideration with space to write short responses.

**** Note: This appendix can be used alongside Appendix NN**, which will ask you to rate where your organization/system is on a scale from 1-10 for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Implementation

8. Collaborating with Others (Partners and Referrals)

a) Organization/system has an up-to-date list of affordable, accessible referral sources for the needs of individuals with trauma histories.	How was the list made? How often is it checked for accuracy?
b) Organization/system works together with partners, referrals, and other community entities to create a trauma-informed network/community.	How are you aware of others' level of being trauma-informed, sensitive, and specific?
c) Organization/system has mechanisms in place to promote cross-sector training on trauma and a trauma-informed approach.	What is in place?
d) Organization/system has a method of communication in place with other entities working with the same individuals for making trauma-informed decisions.	What is in place?
e) Discharge/transitions from services is thoughtful, gradual and includes referrals to trauma-informed and community-based resources.	How is this done?
f) Organization/system has mechanisms to acknowledge and witness organizational, historical trauma narratives of collaborative partners and communities.	What is in place?

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

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Trauma-Informed Organizational Model Planning

USING APPENDIX PP

Purpose: The chart in Appendix PP will invite you to re-visit the Reviewing Policies and Procedures Key Development Area within the **Pre-Implementation Stage.** The purpose of this chart is to provide an opportunity to rate where your organization/system currently is for each consideration, so that you can notice what is already in place and begin to consider what aspects of this key development area to focus on for action planning.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see a numeric scale from 1 to 10 that corresponds to each consideration.

- Please use the following rating system to indicate where you feel your organization/system currently is for each:

1 = not yet started	5 = halfway there	10 = ideal implementation

** Note: **This appendix can be used alongside Appendix QQ**, which will ask you to write responses to follow-up questions for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Pre-Implementation

9. Reviewing Policies and Procedures

a) Organization/system has a plan for the regular review of policies and procedures with a trauma-informed lens.	1 2 3 4 5 6 7 8 9 10
b) Organization/system has a plan for the individuals reviewing policies and procedures to be trained on re-traumatization themes, trauma-informed language and diversity, equity, inclusion and accessibility considerations.	1 2 3 4 5 6 7 8 9 10
c) Organization/system identifies policies/procedures that already have aspects of being trauma-informed, trauma-sensitive, and trauma-specific.	1 2 3 4 5 6 7 8 9 10

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

Substance Abuse and Mental Health Services Administration (2014). Concept of trauma and guidance for a trauma-informed approach. Retrieved from https://store.samhsa.gov/system/files/sma14-4884.pdf

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Trauma-Informed Organizational Model Planning

USING APPENDIX QQ

Purpose: The chart in Appendix QQ will invite you to re-visit the Reviewing Policies and Procedures Key Development Area within the **Pre-Implementation Stage**. The purpose of this chart is to provide an opportunity to respond to specific follow-up questions for each consideration.

The questions are designed so that you can both notice what is already in place and begin thinking about specific implementation items that may be needed within this key development area as you move forward.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see follow-up questions regarding that consideration with space to write short responses.

** **Note:** **This appendix can be used alongside Appendix PP**, which will ask you to rate where your organization/system is on a scale from 1-10 for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Pre-Implementation

9. Reviewing Policies and Procedures

a) Organization/system has a plan for the regular review of policies and procedures with a trauma-informed lens.	What is the plan? How often will it occur?
b) Organization/system has a plan for the individuals reviewing policies and procedures to be trained on re-traumatization themes, trauma-informed language and diversity, equity, inclusion and accessibility considerations.	Who will be involved in reviewing? What is the training?
c) Organization/system identifies policies/procedures that already have aspects of being trauma-informed, trauma-sensitive, and trauma-specific.	What policies/procedures were identified?

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

Substance Abuse and Mental Health Services Administration (2014). Concept of trauma and guidance for a trauma-informed approach. Retrieved from https://store.samhsa.gov/system/files/sma14-4884.pdf

Trauma Informed Oregon (2015). Standards of practice for trauma informed care. Retrieved from http://traumainformedoregon.org/wp-content/uploads/2016/07/Guidelines-and-Standards-of-Practice-for-Trauma-Informed-Care-07-16.pdf

Trauma Informed Oregon (2017). The Roadmap to trauma informed care. Retrieved from http://traumainformedoregon.org/roadmap-trauma-informed-care/

Trauma-Informed Policy Review Checklist

APPENDIX RR

The following checklist can be used to review any identified policy or procedure with a trauma-informed lens and a commitment to diversity, equity, inclusion and accessibility. After moving through the full checklist for the identified policy/procedure, there will be space to write additional comments and indicate recommended changes when necessary.

Policy/Procedure: _____

Date Reviewed: _____

General

CONSIDERATION	YES	NO	N/A	NOTES
The policy/procedure is accessible in writing to all individuals it applies to.	☐	☐	☐	
Review of the policy/procedure includes the opinions and feedback from multiple, diverse individuals.	☐	☐	☐	
The policy/procedure is currently relevant to the organization/system.	☐	☐	☐	
The policy/procedure is written in prosocial language (what is expected, what the organization/system wants to see).	☐	☐	☐	
The policy/procedure is written in language that is inclusive and culturally-sensitive.	☐	☐	☐	
The policy/procedure is trauma-informed.	☐	☐	☐	
The policy/procedure is trauma-sensitive.	☐	☐	☐	
The policy/procedure is trauma-specific.	☐	☐	☐	
The policy/procedure is reviewed for the potential of re-traumatization.	☐	☐	☐	
The policy/procedure is reviewed through an anti-racism and anti-oppression lens.	☐	☐	☐	
The policy/procedure is reviewed with considerations of power, control and equity.	☐	☐	☐	
The policy/procedure is reviewed for accessibility considerations.	☐	☐	☐	

Safety

CONSIDERATION	YES	NO	N/A	NOTES
The policy/procedure considers emotional safety of individuals, including acceptance, belonging and inclusion.	☐	☐	☐	
The policy/procedure considers physical safety of individuals, including addressing barriers to accessibility.	☐	☐	☐	
The policy/procedure is reviewed for diversity and cultural considerations.	☐	☐	☐	
The policy/procedure is reviewed for opportunities to increase safety.	☐	☐	☐	

Trustworthiness

CONSIDERATION	YES	NO	N/A	NOTES
The policy/procedure is written at an appropriate level for the intended audience to ensure understanding.	☐	☐	☐	
The policy/procedure is available in additional languages as needed for those it pertains to.	☐	☐	☐	
The policy/procedure clearly outlines what to expect and what is expected.	☐	☐	☐	
The policy/procedure provides role clarity, especially when multiple roles are involved.	☐	☐	☐	
The policy/procedure is consistent across the organization/system.	☐	☐	☐	
The policy/procedure delineates any relevant consequences.	☐	☐	☐	
The policy/procedure provides for an appropriate level of confidentiality and privacy.	☐	☐	☐	
The policy/procedure is consistent with other policies/procedures in the organization/system (e.g. does not contradict another).	☐	☐	☐	
The policy/procedure encourages appropriate boundaries where relevant.	☐	☐	☐	
The policy/procedure is reviewed for opportunities to increase trustworthiness.	☐	☐	☐	

Choice

CONSIDERATION	YES	NO	N/A	NOTES
The policy/procedure incorporates individual choice.	☐	☐	☐	
The policy/procedure is written to provide the individual with the greatest amount of autonomy possible.	☐	☐	☐	
The policy/procedure reflects options regarding race, gender, and culture.	☐	☐	☐	
The policy/procedure incorporates a list of at least two options that can be provided when possible.	☐	☐	☐	
The policy/procedure is reviewed for opportunities to increase choice.	☐	☐	☐	

Collaboration

CONSIDERATION	YES	NO	N/A	NOTES
The policy/procedure conveys the message that individuals are the experts of their own experience/role.	☐	☐	☐	
The policy/procedure is informed by feedback and suggestions by diverse individuals within the organization/system	☐	☐	☐	
The policy/procedure acknowledges power dynamics in relationships and systems	☐	☐	☐	
The policy/procedure is reviewed for opportunities to increase collaboration.	☐	☐	☐	

Empowerment

CONSIDERATION	YES	NO	N/A	NOTES
The policy/procedure acknowledges the skills and capacities of individuals.	☐	☐	☐	
The policy/procedure acknowledges and builds on cultural strengths, capacities and resources.	☐	☐	☐	
The policy/procedure refers to individuals using person-first and inclusive language.	☐	☐	☐	
The policy/procedure promotes resilience, compassion resilience and/or vicarious resilience.	☐	☐	☐	
The policy/procedure incorporates validation when possible.	☐	☐	☐	
The policy/procedure is reviewed for opportunities to increase empowerment.	☐	☐	☐	

Other Comments:

Revisions/Changes Recommended:

Trauma-Informed Organizational Model Planning

USING APPENDIX SS

Purpose: The chart in Appendix SS will invite you to re-visit the Reviewing Policies and Procedures Key Development Area within the **Implementation Stage**. The purpose of this chart is to provide an opportunity to rate where your organization/system currently is for each consideration, so that you can notice what is already in place and begin to consider what aspects of this key development area to focus on for action planning.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see a numeric scale from 1 to 10 that corresponds to each consideration.

- Please use the following rating system to indicate where you feel your organization/system currently is for each:

1 = not yet started	5 = halfway there	10 = ideal implementation

** Note: **This appendix can be used alongside Appendix TT**, which will ask you to write responses to follow-up questions for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Implementation

9. Reviewing Policies and Procedures

a) Organization/system regularly reviews and revises policies and procedures with a trauma-informed lens.	1 2 3 4 5 6 7 8 9 10
b) Policies and procedures are clear, consistent, visible, and accessible to those they pertain to.	1 2 3 4 5 6 7 8 9 10
c) Policies and procedures are anchored in the values/principles of a trauma-informed approach: safety, trustworthiness, choice, collaboration, and empowerment.	1 2 3 4 5 6 7 8 9 10
d) Policies and procedures reflect a commitment to diversity, equity, inclusion, and accessibility.	1 2 3 4 5 6 7 8 9 10
e) Policies and procedures are written in positive language that depicts the desires or "prosocial" behavior.	1 2 3 4 5 6 7 8 9 10

f) Organization/system has a de-escalation policy to minimize the potential for re-traumatization.	1 2 3 4 5 6 7 8 9 10
g) Written safety/crisis plans are incorporated into treatment, service, or work plans.	1 2 3 4 5 6 7 8 9 10
h) Individual rights, responsibilities and expectations are clear and easily accessible to those they pertain to.	1 2 3 4 5 6 7 8 9 10

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

Substance Abuse and Mental Health Services Administration (2014). Concept of trauma and guidance for a trauma-informed approach. Retrieved from https://store.samhsa.gov/system/files/sma14-4884.pdf

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Trauma Informed Oregon (2017). The Roadmap to trauma informed care. Retrieved from http://traumainformedoregon.org/roadmap-trauma-informed-care/

Trauma-Informed Organizational Model Planning

USING APPENDIX TT

Purpose: The chart in Appendix TT will invite you to re-visit the Reviewing Policies and Procedures Key Development Area within the **Implementation Stage**. The purpose of this chart is to provide an opportunity to respond to specific follow-up questions for each consideration.

The questions are designed so that you can both notice what is already in place and begin thinking about specific implementation items that may be needed within this key development area as you move forward.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see follow-up questions regarding that consideration with space to write short responses.

** **Note:** **This appendix can be used alongside Appendix SS**, which will ask you to rate where your organization/system is on a scale from 1-10 for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Implementation

9. Reviewing Policies and Procedures

a) Organization/system regularly reviews and revises policies and procedures with a trauma-informed lens.	Who reviews? How often? How are the voices of all individuals in the organization/system incorporated in the review?
b) Policies and procedures are clear, consistent, visible, and accessible to those they pertain to.	Where are they posted/kept?
c) Policies and procedures are anchored in the values/principles of a trauma-informed approach: safety, trustworthiness, choice, collaboration, and empowerment.	How was this ensured?
d) Policies and procedures reflect a commitment to diversity, equity, inclusion, and accessibility.	How was this ensured?
e) Policies and procedures are written in positive language that depicts the desires or "prosocial" behavior.	How was this ensured?

f) Organization/system has a de-escalation policy to minimize the potential for re-traumatization.	What is the policy?
g) Written safety/crisis plans are incorporated into treatment, service, or work plans.	How is this done?
h) Individual rights, responsibilities and expectations are clear and easily accessible to those they pertain to.	Where are they posted/kept?

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Trauma-Informed Climate Scale-10 (TICS-10)

APPENDIX UU

The following questionnaire may be used to assess your perceptions of the agency you currently work for. The TICS-10 is a reduced version of the Trauma-Informed Climate Scale (Hales, Kusmaul, & Nochajski, 2017), based on Harris and Fallot's (2001) five values of TIC. The TICS-10 has been validated in research (Hales, Kusmaul, Sundborg, & Nochajski, 2019).

Please select the extent to which you agree or disagree with the following statements using the following rating scale:

1= Strongly Disagree 2 = Disagree 3 = Not Sure 4 = Agree 5 = Strongly Agree

_____ 1. When I come to work here, I feel emotionally safe.

_____ 2. If I am upset at work, I know that other staff and supervisors will understand.

_____ 3. I'm not sure who I can trust among my coworkers, supervisors, and administrators.

_____ 4. I can trust my supervisor to be fair in dealing with all staff.

_____ 5. I feel like I have a great deal of control over my job satisfaction.

_____ 6. I don't have many choices when it comes to doing my job.

_____ 7. The leadership listens only to their favorite employees.

_____ 8. The administration here does not share decision-making with the rest of the staff.

_____ 9. This organization doesn't seem to care whether staff gets what they need to do their jobs well.

_____ 10. Staff is not supported when they try to find new and better ways to do things.

Scoring the TICS-10

To obtain your TICS-10 score, add the scores for each of the questions. The table 'Interpreting your score' is designed to help with interpretation.

1. _____

2. _____

* 3. _____ = _____

4. _____

5. _____

* 6. _____ = _____

* 7. _____ = _____

* 8. _____ = _____

* 9. _____ = _____

* 10. _____ = _____

Interpreting your score

TICS-10 Total	Interpretation
40-50	High TI Environment
35-39	Moderate TI Environment
< 35	Low TI Environment

** Reverse the score before totaling: 1 = 5, 2 = 4, 3 = 3, 4 = 2, 5 = 1.*

Note: If you wish to assess the organizational climate as opposed to individual perceptions, you may average the total scores of numerous staff members within a single agency. Averages can be yielded by summing the total scores and dividing by the number of participants.

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Hales, T., Kusmaul, N., & Nochajski, T. (2017). Exploring the dimensionality of trauma-informed care: Implications for theory and practice. *Human Service Organizations: Management, Leadership & Governance, 41,* 317-325. DOI: 10.1080/23303131.2016.1268988

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Trauma-Informed Organizational Model Planning

USING APPENDIX VV

Purpose: The chart in Appendix VV will invite you to re-visit the Evaluating and Monitoring Progress Key Development Area within the **Pre-Implementation Stage**. The purpose of this chart is to provide an opportunity to rate where your organization/system currently is for each consideration, so that you can notice what is already in place and begin to consider what aspects of this key development area to focus on for action planning.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see a numeric scale from 1 to 10 that corresponds to each consideration.

- Please use the following rating system to indicate where you feel your organization/system currently is for each:

1 = not yet started	5 = halfway there	10 = ideal implementation

** Note: **This appendix can be used alongside Appendix WW**, which will ask you to write responses to follow-up questions for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Pre-Implementation

10. Evaluating and Monitoring Progress

a) Organization/system reviews existing trauma-informed evaluation tools.	1 2 3 4 5 6 7 8 9 10
b) Organization/system has an evaluation plan to elicit feedback and monitor progress of the trauma-informed change process.	1 2 3 4 5 6 7 8 9 10

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

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Trauma-Informed Organizational Model Planning

USING APPENDIX WW

Purpose: The chart in Appendix WW will invite you to re-visit the Evaluating and Monitoring Progress Key Development Area within the **Pre-Implementation Stage**. The purpose of this chart is to provide an opportunity to respond to specific follow-up questions for each consideration.

The questions are designed so that you can both notice what is already in place and begin thinking about specific implementation items that may be needed within this key development area as you move forward.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see follow-up questions regarding that consideration with space to write short responses.

** **Note:** **This appendix can be used alongside Appendix VV**, which will ask you to rate where your organization/system is on a scale from 1-10 for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Pre-Implementation

10. Evaluating and Monitoring Progress

a) Organization/system reviews existing trauma-informed evaluation tools.	What tools were reviewed? Who was involved in the review?
b) Organization/system has an evaluation plan to elicit feedback and monitor progress of the trauma-informed change process.	What is the plan?

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

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Trauma-Informed Organizational Model Planning

USING APPENDIX XX

Purpose: The chart in Appendix XX will invite you to re-visit the Evaluating and Monitoring Progress Key Development Area within the **Implementation Stage**. The purpose of this chart is to provide an opportunity to rate where your organization/system currently is for each consideration, so that you can notice what is already in place and begin to consider what aspects of this key development area to focus on for action planning.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see a numeric scale from 1 to 10 that corresponds to each consideration.

- Please use the following rating system to indicate where you feel your organization/system currently is for each:

1 = not yet started	5 = halfway there	10 = ideal implementation

** Note: **This appendix can be used alongside Appendix YY**, which will ask you to write responses to follow-up questions for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Implementation

10. Evaluating and Monitoring Progress

a) Organization/system has mechanisms in place for on-going evaluation of a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
b) Organization/system incorporates a trauma-informed approach into its quality improvement processes.	1 2 3 4 5 6 7 8 9 10
c) Leadership receives regular updates on trauma-informed progress and evaluation measures.	1 2 3 4 5 6 7 8 9 10
d) Evaluation measures include the perspective of all individuals within the organization/system.	1 2 3 4 5 6 7 8 9 10
e) Organization/system is transparent in sharing evaluation data and regularly responds to feedback/evaluation.	1 2 3 4 5 6 7 8 9 10

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

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Trauma-Informed Organizational Model Planning

USING APPENDIX YY

Purpose: The chart in Appendix YY will invite you to re-visit the Evaluating and Monitoring Progress Key Development Area within the **Implementation Stage**. The purpose of this chart is to provide an opportunity to respond to specific follow-up questions for each consideration.

The questions are designed so that you can both notice what is already in place and begin thinking about specific implementation items that may be needed within this key development area as you move forward.

Directions: The left-hand column of the charts list different aspects of organizational functioning to consider. On the right, you will see follow-up questions regarding that consideration with space to write short responses.

** **Note:** **This appendix can be used alongside Appendix XX**, which will ask you to rate where your organization/system is on a scale from 1-10 for each consideration. Once both are completed, take time to reflect on your responses and what they may indicate regarding what to focus on within this key development area.

Implementation

10. Evaluating and Monitoring Progress

a) Organization/system has mechanisms in place for on-going evaluation of a trauma-informed approach.	How often does evaluation occur? What is the process?
b) Organization/system incorporates a trauma-informed approach into its quality improvement processes.	How is it incorporated?
c) Leadership receives regular updates on trauma-informed progress and evaluation measures.	What is the process?
d) Evaluation measures include the perspective of all individuals within the organization/system.	How are individuals included? What steps are taken to ensure diversity, equity, inclusion, and accessibility in the process?
e) Organization/system is transparent in sharing evaluation data and regularly responds to feedback/evaluation.	How are evaluation results shared? To whom?

Adapted References

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://traumainformedoregon.org/wp-content/uploads/2014/10/CCTIC-A-Self-Assessment-and-Planning-Protocol.pdf

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Trauma-Informed Organizational Model Planning

ACTION PLANNING WORKSHEET

Purpose: Appendix ZZ can be used as a tool to plan goals and action steps within priority key development areas.

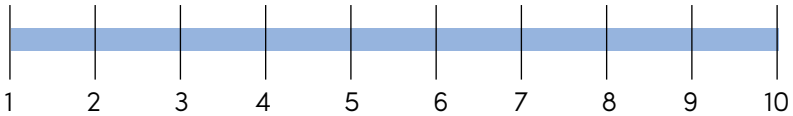
Directions: Using any of the previous paired key development area appendices (scaling and planning charts) as a starting point, fill out the following chart to plan for short- and long-term goals and action steps to reach them.

IDENTIFIED KEY DEVELOPMENT AREA

WHAT IS HAPPENING THAT YOU WANT TO MAINTAIN?	
2 Things That Could Be Different (Short-Term)	**2 Things That Could Be Different (LONG-Term)**

Draw an X below to indicate where the organization/system is in relation to the scale below:

1 = not yet started	5 = halfway there	10 = ideal implementation



What will be different when the organization/system is one point higher on the scale?

Next Steps:

ACTION	TIMEFRAME	WHO'S INVOLVED

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