University at Buffalo
School of Social Work

TRAUMA-INFORMED ORGANIZATIONAL CHANGE MANUAL

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January 2019

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 trauma, adversity and its impact, and promoting the implementation of Trauma-Informed Care across various disciplines and service settings. Recognizing the centrality of trauma is the key to accomplishing ITTIC's overall mission of establishing a multidisciplinary trauma-informed system of care, thus ensuring that service systems are not re-traumatizing the individuals within them.

ITTIC was started at the University at Buffalo in 2012 by Research Professor Thomas Nochajski, PhD, and Clinical Professor Susan A. Green, LCSW, out of the need for additional trauma-related services, training and support within the community. Since its inception, ITTIC has provided education, training, consultation/coaching and evaluation within adult mental health, criminal justice, developmental disabilities, education and health care systems.

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 that it does not replace the need for individualized care and treatment decisions. Rather, it is intended to work in tandem with other services that can lead to desired outcomes.

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Samantha P. Koury and Susan A. Green from The Institute on Trauma and Trauma-Informed Care (ITTIC) developed the Trauma-Informed Organizational Change Manual out of a labor of love.

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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 towards healing and re-birth
for people that have experienced 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 below, visit 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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Acronyms

CPT: Cognitive Processing Therapy

EMDR: Eye Movement Desensitization and Reprocessing

PE: Prolonged Exposure

TF-CBT: Trauma-Focused Cognitive Behavioral Therapy

TI-EP: Trauma-Informed Educational Practices

TIM: Trauma-Informed Medicine

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 lifespan.

Burnout

A gradual process of a staff member 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.

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.

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.

Post-Traumatic Growth (PTG)

The process of making meaning out of one's experience of trauma and experiencing a positive change as a result.

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, needs and resources for trauma-informed organizational change. Includes Pre-Implementation, Implementation and Sustainability.

Trauma-Informed

One of the three levels of a trauma-informed approach; the overarching umbrella that provides the filter for everything we do in a way that ensures universal precaution.

Trauma-Sensitive

One of the three levels of a trauma-informed approach; the way that an organization/system/individual responds to trauma and adversity in a sensitive manner.

Trauma-Specific

One of the three levels of a trauma-informed approach; the trauma-specific treatment interventions.

Universal Precaution

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

Vicarious Post-Traumatic Growth (VPTG)

Development of positive changes and growth in a worker's world view 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 world view of a worker as a result of the cumulative impact of witnessing the trauma/adversity of others over time.

Introduction

Foreword

The purpose of the *Trauma-Informed Care Implementation 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/system's current state and plan for next steps.

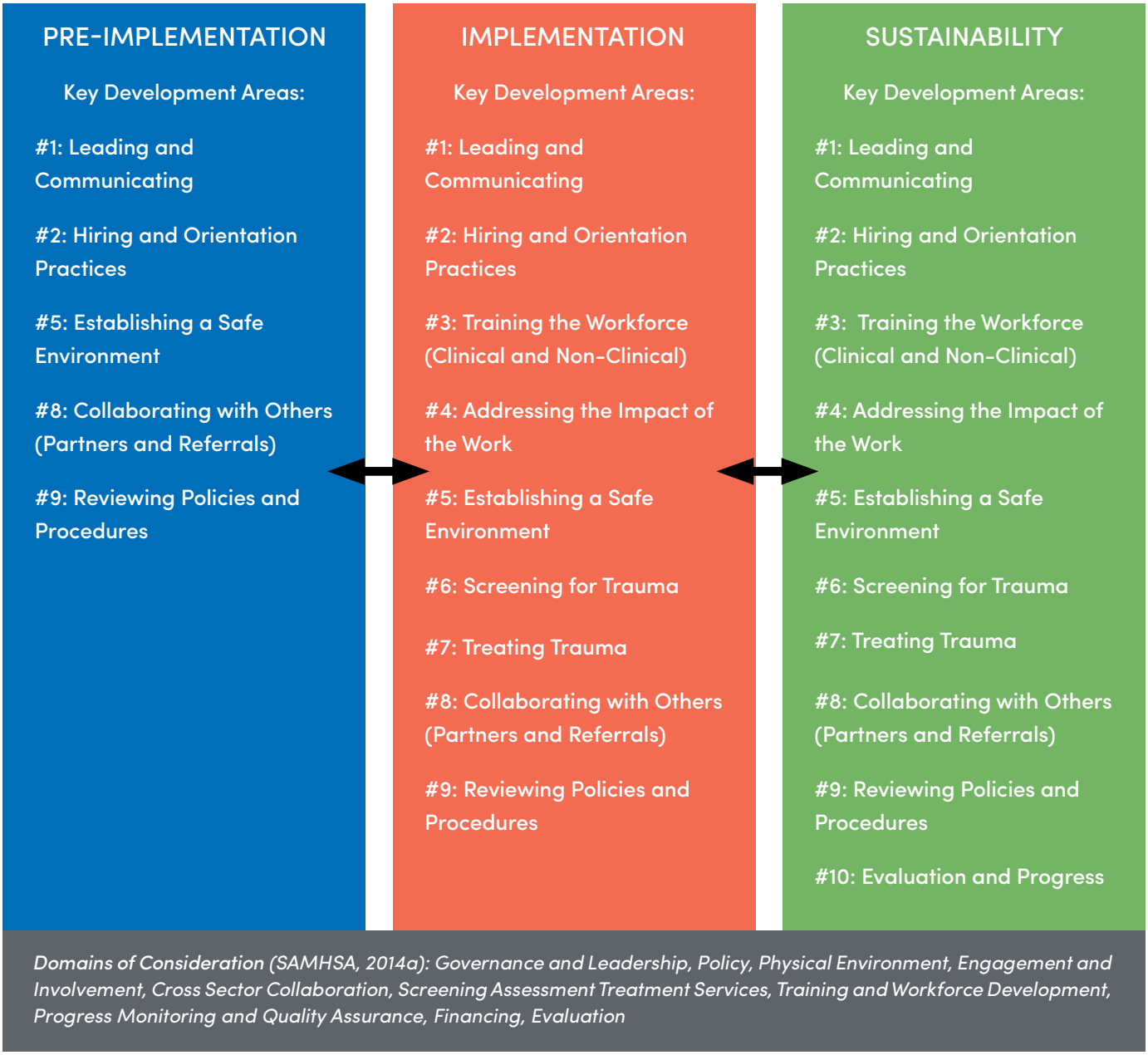
Our best hope is that this manual will:

1. Be a means of acknowledging the work your organization/system is engaging in already in response to trauma, and
2. Provide a framework with guidance for moving forward.

The *Trauma-Informed Care Implementation Manual* is intended for: organizations, systems of care, hospitals, schools and businesses that are considering and/or interested in implementing a trauma-informed approach.

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.

TRAUMA-INFORMED ORGANIZATIONAL MODEL



Adapting to your System

Different systems adapt TIC as an approach 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 and Trauma-Informed Medicine (TIM) in our work with health care settings. It is important to note that similarly to how we worked with systems to adapt TIC to TI-EP or TIM, the language in this manual can always be adapted to your specific system. For the sake of consistency throughout this manual, TI-EP and TIM 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 different organizations/systems.*

Universal

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

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 32.

Legacy

Being trauma-informed and providing Trauma-Informed Care (TIC) have their origins in Dr. Sandra Bloom's work of creating sanctuary (The Sanctuary Model). Others—notably Dr. Roger Fallot and Dr. Maxine Harris (2001) in their Using Trauma Theory to Design Service Systems: New Directions for Mental Health Services and Dr. Ann Jennings (The Anna Institute, formally the Anna Foundation)—have contributed a substantial platform for the world to understand, accept and respond effectively to the impacts trauma and adversity have.

The comprehensive trauma-informed treatment approaches introduced by Dr. Ricky Greenwald (2005) and Dr. Lisa Najavits (2002) profoundly influence how we treat trauma. The Substance Abuse and Mental Health Services Administration (SAMHSA)'s (2014) Trauma-Informed Care in Behavioral Health Services (TIP-57) has provided a practical tool for us all.

Background

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).

Trauma and adversity are growing public health concerns that impact all. 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 is often used within the medical field to denote preventative measures of containment of potentially hazardous or infectious materials/fluids.

When taking *universal precaution*, a professional approaches all fluid in the same manner without first determining the level of hazard—generally this is done by putting on gloves or *gloving up* to protect against exposure.

Trauma-Informed Care is also *universal precaution* in that a professional is asked to just assume that all individuals have a history of trauma by *gloving up* metaphorically (i.e., changing interaction style, policies, procedures, etc.) in order to reduce the possibility of triggering or re-traumatizing others.

Post-traumatic stress disorder (PTSD) and acute stress disorder (ASD) are the two diagnoses related to trauma

Trauma and Adversity: What Do I Need to 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 importantly is the individual's perception of the event/circumstances, which is ultimately what determines if it is traumatic or not (SAMHSA, 2014a).

- Trauma overwhelms an individual's ability to cope.
- Post-traumatic stress disorder (PTSD) and acute stress disorder (ASD) are the two diagnoses related to trauma.
- The Adverse Childhood Experiences (ACE) Study found a relationship between childhood adversity and negative health outcomes in adulthood (Felitti et al., 1998).
- The 10 types of childhood adversity (referred to as ACEs) included in the study were: 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 divorced.
- While ACEs can be considered traumatic, experiencing adversity does not necessarily equal trauma.

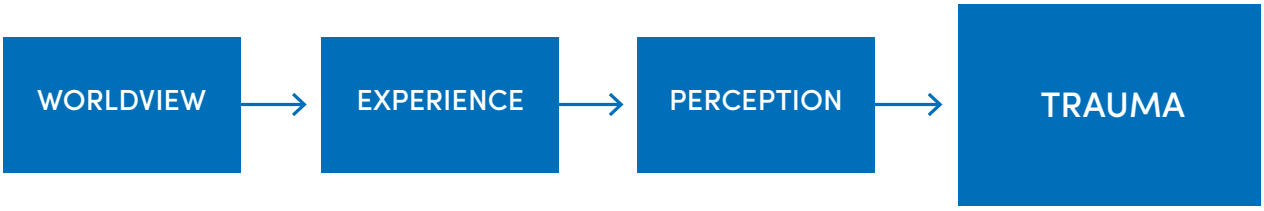


Figure 1 – What Shapes Trauma

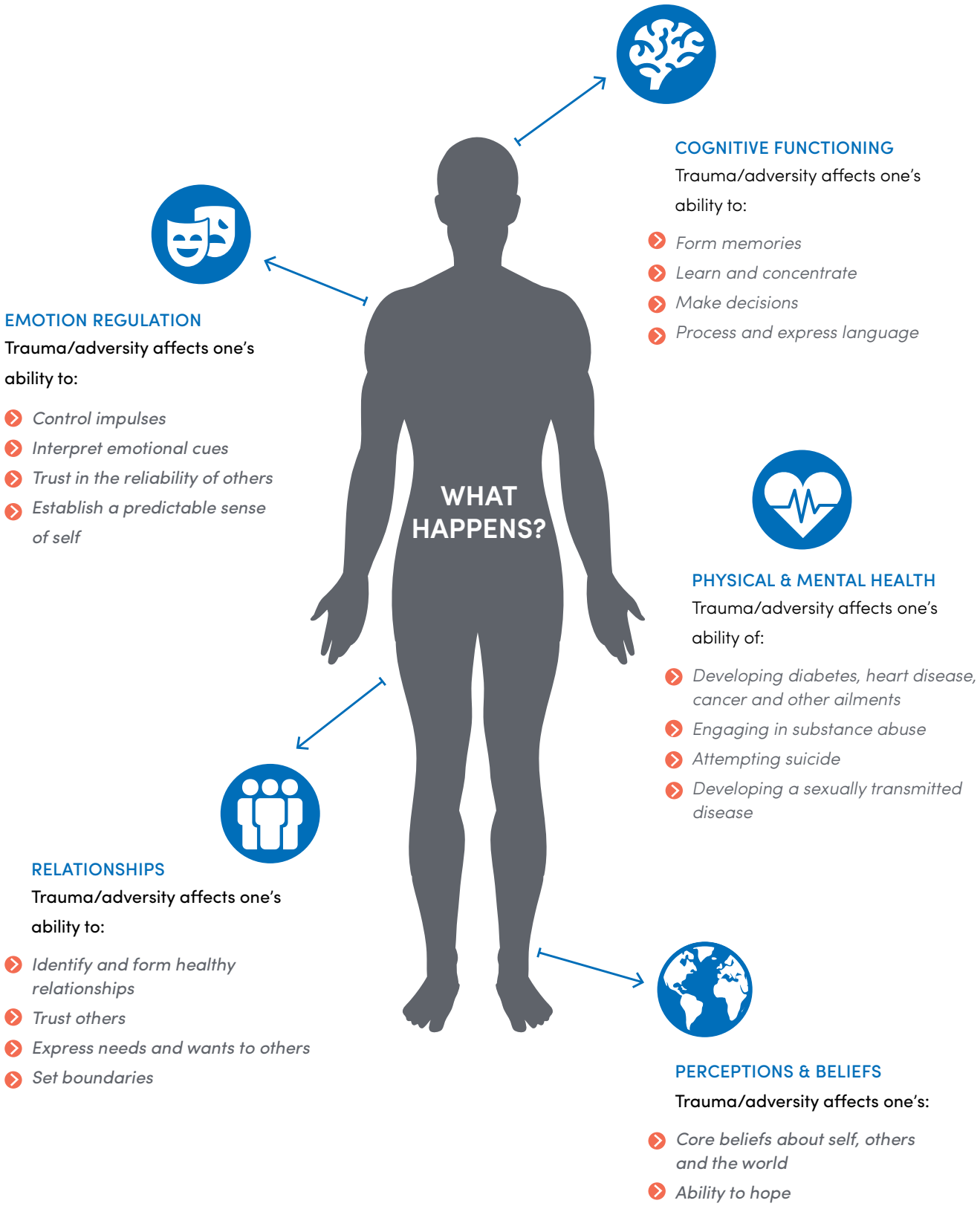


Figure 2 – The Imoact of Trauma and Adversity

Resilience and Post-Traumatic Growth

As noted in Figure 2, experiencing trauma/adversity can lead to varying levels of impairment and distress. The reaction could illicit 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 (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.

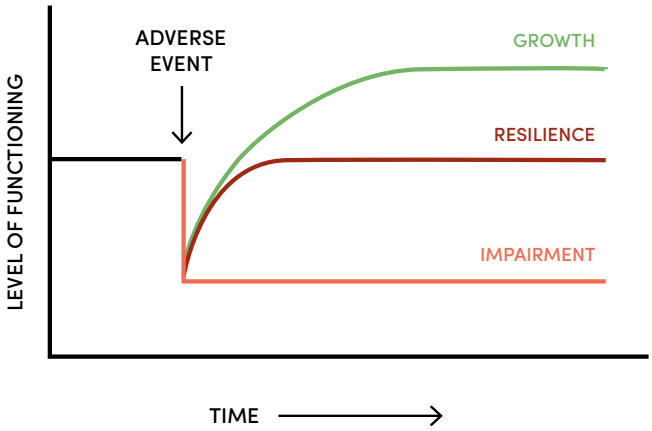


Figure 3 – Trajectories Following Trauma (Butler, 2010; O'Leary & Ickovics, 1995)

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

Experiencing trauma/adversity can lead to varying levels of impairment and distress. The reaction could illicit several different outcomes: resilience, growth and impairment.

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 trauma and/or adversity. Figure 4 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 world view as a result of the cumulative impact of witnessing trauma/adversity over time
Compassion Fatigue (CF)	Experiencing the combination of STS, VT and/or burnout
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 world view as a result of witnessing the post-traumatic growth of others

Figure 4 – The Impact of the Work, Adapted from Krause & Green (2015) and Tedeschi & Calhoun (2004)

Examples to operationalize some of the concepts above are indicated in Figure 5 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.

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 5 – Examples of STS, VT, VR & VPTG

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 which asks staff (and sometimes client/patient/student/consumer) 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 6 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 under the Evaluating and Monitoring Progress section.

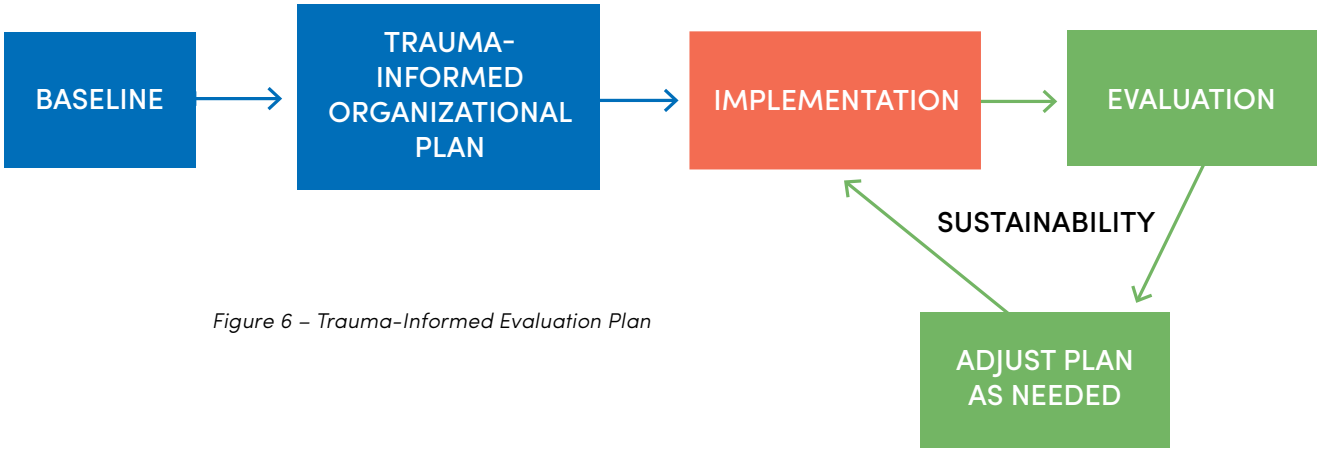


Figure 6 – Trauma-Informed Evaluation Plan

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 7, 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.

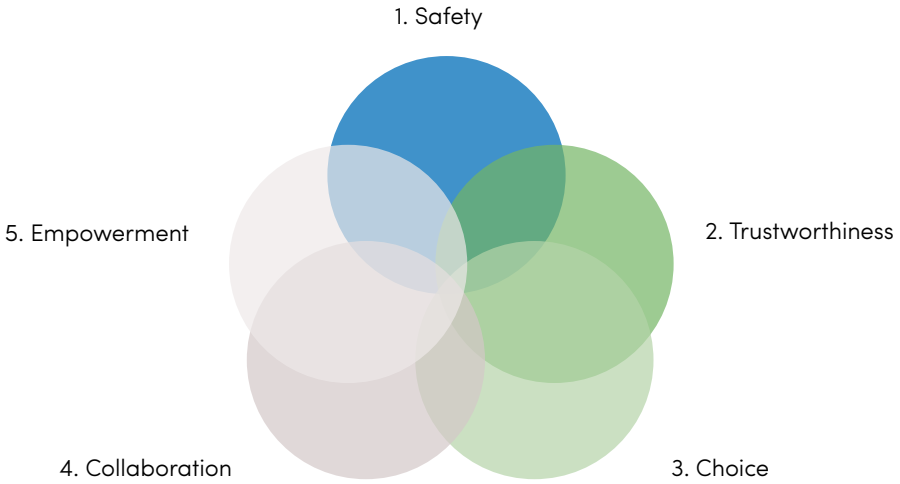


Figure 7 – The Five Guiding Values and Principles Adapted from Harris & Fallot (2001)

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, accessibility, etc.) and the effect that those may have on individuals. Emotional safety can be ensured by being attentive to signs of individual discomfort, recognizing these signs in a trauma-informed way, checking in, debriefing and providing support to staff, 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

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.). It also 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).

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.

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).

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.

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).

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.

Empowerment pertains to recognizing and building on individual strengths/skills, 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 and every contact (Harris & Fallot, 2001). It is important to note that empowerment is different than 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 inquires about what a patient is already doing that helps her be successful in reaching her goal of losing weight.

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 the concrete implementation steps 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.

Re-Traumatization

Due to the high prevalence of trauma and adversity, we know that organizations and systems can unintentionally 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 clearer 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 8 below illustrates system and relationship dynamics/themes that are often experienced as being re-traumatizing:

Figure 8 – Trauma Dynamics/Themes

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

Three Levels of a Trauma-Informed Approach

We identify three levels of the trauma-informed approach. They are 1) trauma-informed 2) trauma-sensitive, and 3) trauma-specific. Figure 9 below depicts each of the three levels:

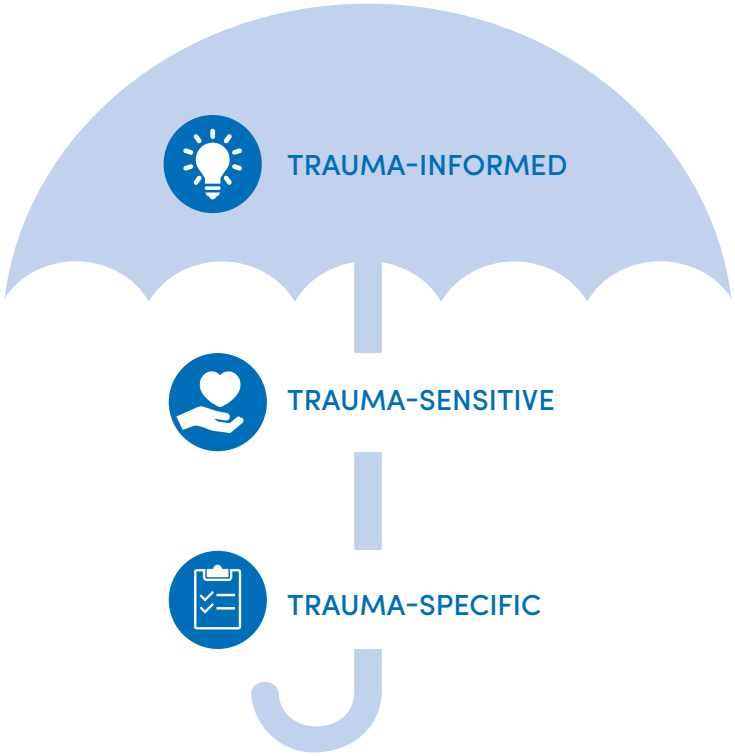


Figure 9 – Three Levels of a Trauma-Informed Approach

Trauma-informed is the overarching level—what we consider the umbrella. It provides the *filter* for everything we do. Being trauma-informed ensures universal precaution.

Trauma-sensitive is the way that the organization, system and individuals respond to trauma and adversity. Being trauma-sensitive requires individuals, organizations and systems to look at all aspects of their interactions, policies, procedures, the physical environment, etc. for the potential of re-traumatization, and adjust in a way that allows them to be responsive and sensitive to trauma histories.

Organizations and systems that are trauma-sensitive have mechanisms in place to address the potential negative impact of the work, such as secondary traumatic stress, vicarious trauma and compassion fatigue. Trauma-sensitive organizations/systems will also have structures in place to promote resilience, vicarious resilience (VR) post-traumatic growth (PTG) and vicarious post-traumatic growth (VPTG). Implementing supports for the workforce, such as supervision, debriefing and providing space for self-care, are examples of structures organizations/systems can put in place to address the potential negative impact and promote resilience and vicarious resilience of workers (Butler, Carello & Maguin, 2017; Meichenbaum, n.d.).

Trauma-specific refers to trauma-specific treatment interventions. The treatments currently available for children and adults in individual and group formats are listed on page 78 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-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.

Figure 10 – Applying the Three Levels of a Trauma-Informed Approach to Organizations

Trauma-Informed Organizational Model

The trauma-informed organizational model provides a framework 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 a trauma-informed approach. 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.

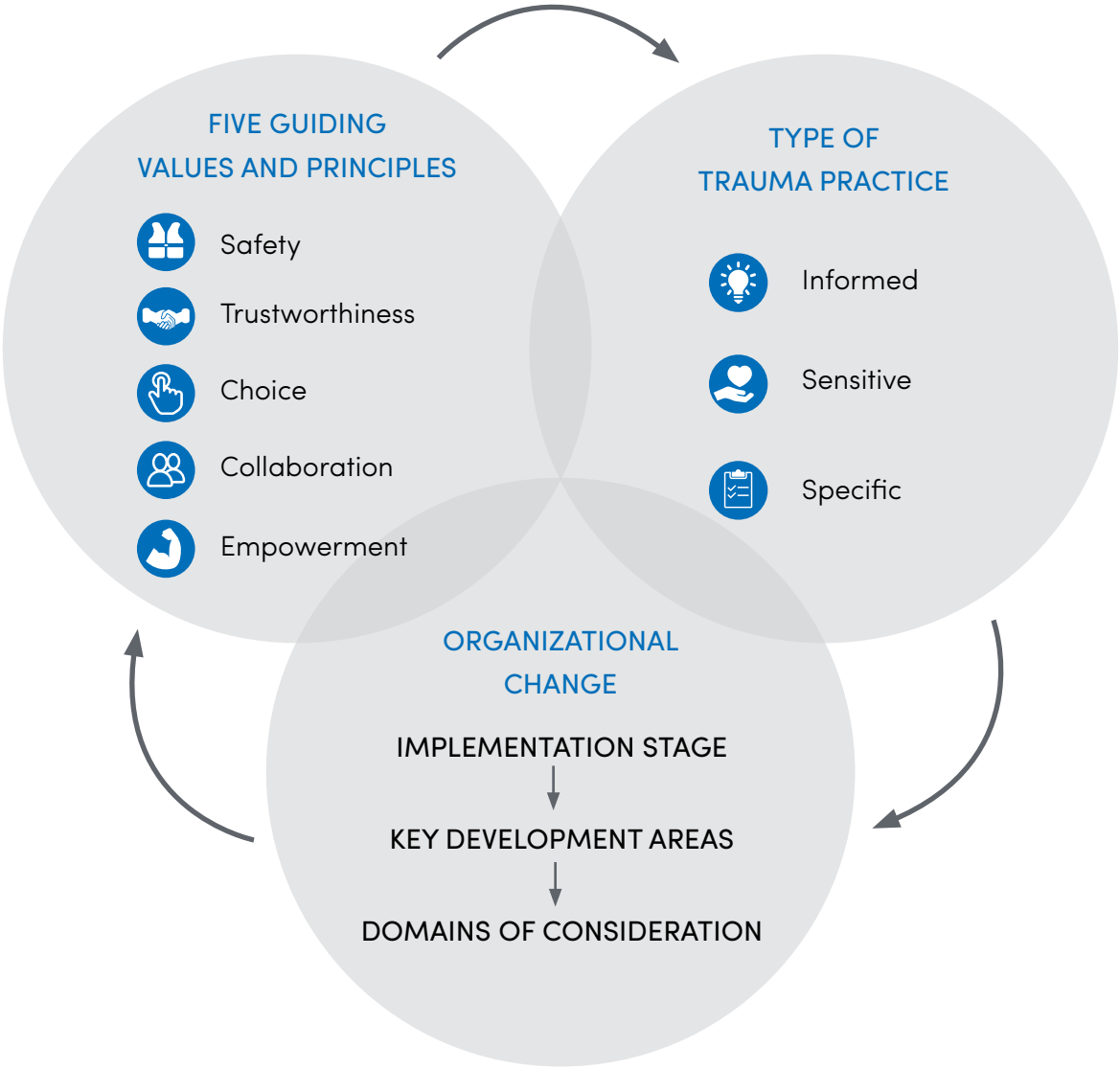


Figure 10 – Trauma-Informed Organizational Model

Overview of the Trauma-Informed Organizational Model

Stages

1. Pre-Implementation – Organization/system prepares for and builds a foundation for trauma-informed organizational change.

2. Implementation – Organization/system implements action steps specific to trauma-informed organizational change.

3. Sustainability – Organization/system further integrates trauma-informed practices into its fabric by establishing mechanisms to consolidate gains, monitor progress and tweak implementation as needed.

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. **Hiring and Orientation Practices** – 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 voice 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.

Stages of the Trauma-Informed Organizational Model

The first 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 in order 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, More & Steane, 2018; Tsoukas & Chia, 2002). Therefore, the three stages are dimensional and flexible.

Figure 11 – Stages of the Trauma-Informed Organizational Model

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 to the Implementation Stage once more. 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 in Treating Trauma).

Figure 12 – Trauma-Informed Organizational Model

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.

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 28.

Lastly, 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 29). 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 timeframe 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*

Stage: Pre-Implementation

Key Development Areas:

1. Leading and Communicating *(Governance and Leadership; Engagement and Involvement; Financing; Evaluation)*
2. Hiring and Orientation Practices *(Training and Workforce Development; Governance and Leadership; Policy)*
5. Establishing a Safe Environment *(Physical Environment; Engagement and Involvement; Financing)*
8. Collaborating with Others (Partners and Referrals) *(Cross Sector Collaboration; Training and Workforce Development)*
9. Reviewing Policies and Procedures *(Policy; Engagement and Involvement)*

Stage: Implementation

Key Development Areas:

1. Leading and Communicating *(Governance and Leadership; Engagement and Involvement; Financing)*
2. Hiring and Orientation Practices *(Governance and Leadership; 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; Engagement and Involvement; Financing)*
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)*
9. Reviewing Policies and Procedures *(Policy; Engagement and Involvement)*

Stage: Sustainability

Key Development Areas:

1. Leading and Communicating *(Governance and Leadership; Engagement and Involvement; Financing)*
2. Hiring and Orientation Practices *(Governance and Leadership; 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; Engagement and Involvement; Financing)*
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)*
9. Reviewing Policies and Procedures *(Policy; Engagement and Involvement)*
10. Evaluating and Monitoring Progress *(Evaluation; Progress Monitoring and Quality Assurance)*

Getting Started

How to Use the Manual

The trauma-informed organizational model has three stages. The remainder of the manual is divided by stage:

Stage 1 – Pre-Implementation

Stage 2 – Implementation

Stage 3 – Sustainability

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. Stages 1 and 2 include narrative describing the components of each of the key development areas with examples and worksheets to fill out. Stage 3 provides narrative around evaluating and monitoring progress, as well as a checklist to revisit each of the key development areas.

While the manual can be used in any professional role, we recommend that it be shared with formal leadership and those individuals identified to oversee the implementation process due to its focus on creating organizational change.

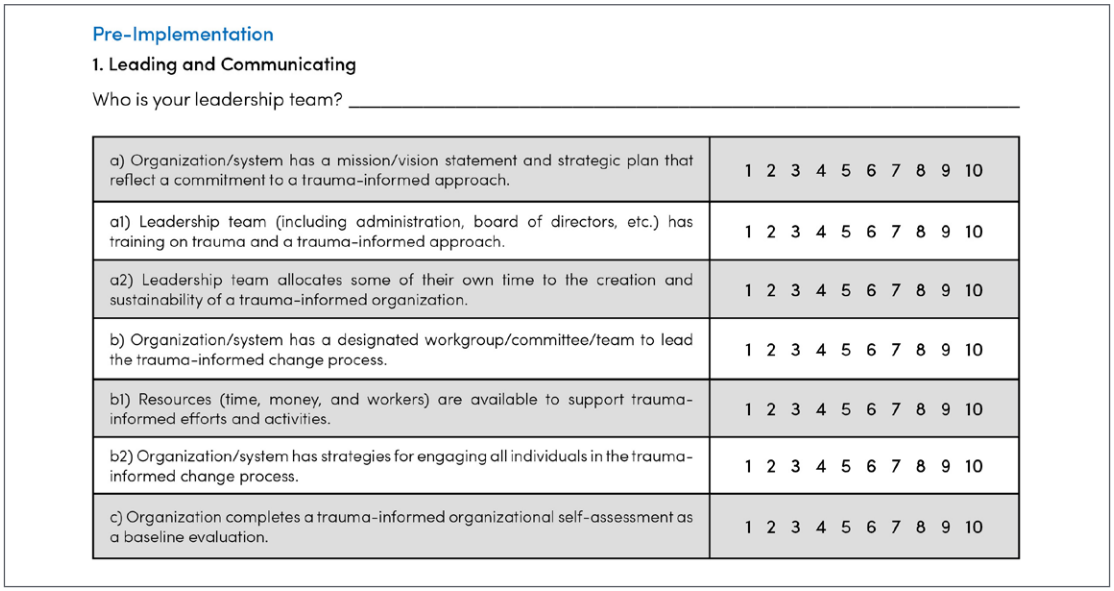
Our recommendations to those using this manual are as follows:

1. Read the Our Approach section starting on page 20.
2. Use Appendix A (directions on page 34) as an initial assessment of where your organization/system is with regard to 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.*
3. Based on your responses to Appendix A, read the sections of the manual that correspond to the areas you identified for more narrative, examples from our work, tools and resources.

*** We recommend that those overseeing the implementation 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 in order 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 A 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) Organization/system has a mission/vision statement and strategic plan that reflect a commitment to a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
a1) Leadership team (including administration, board of directors, etc.) has training on trauma and a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
a2) Leadership team allocates some of their own time to the creation and sustainability of a trauma-informed organization.	1 2 3 4 5 6 7 8 9 10
b) Organization/system has a designated workgroup/committee/team to lead the trauma-informed change process.	1 2 3 4 5 6 7 8 9 10
b1) Resources (time, money, and workers) are available to support trauma-informed efforts and activities.	1 2 3 4 5 6 7 8 9 10
b2) Organization/system has strategies for engaging all individuals in the trauma-informed change process.	1 2 3 4 5 6 7 8 9 10
c) Organization completes a trauma-informed organizational self-assessment as a baseline evaluation.	1 2 3 4 5 6 7 8 9 10

Figure 13 – Preview of Assessment in Appendix A

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; and

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

Stage 1: Pre-Implementation

Overview

During the Pre-Implementation Stage, organizations/systems focus on preparing for and building a foundation for trauma-informed organizational change. A trauma-informed approach requires true organizational culture change; it is a process that needs leadership involvement from the beginning, engagement and buy-in from all individuals within the organization/system, and an organizational change plan that addresses all of the key development areas in each of the three stages. Additionally, when an organization/system's mission and vision reflect a trauma-informed approach, there will be a need to start adjusting hiring and orientation practices to align with the changes made within this stage. For new organization/systems, there may be a need to consider the physical environment, collaborations with other entities and the creation of formal policies and procedures. Therefore, the key development areas within the **Pre-Implementation Stage** are: 1) Leading and Communicating, 2) Hiring and Orientation Practices, 5) Establishing a Safe Environment, 8) Collaborating with Others (Partners and Referrals), and 9) Reviewing Policies and Procedures. This section of the manual will help you think about and plan for the critical components and key development areas of this stage by providing structure, examples and things to consider based on your organization/system.

KEY DEVELOPMENT AREAS

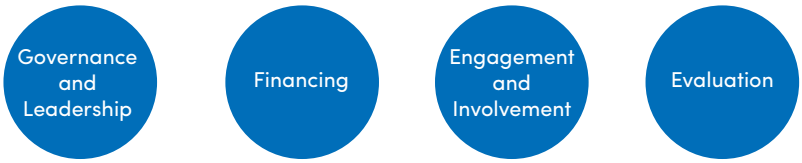
1. Leading and Communicating
2. Hiring and Orientation Practices
3. Establishing a Safe Environment
4. Collaborating with Others (Partners and Referrals)
5. Reviewing Policies and Procedures

Critical Components of the Pre-Implementation Stage

- Leadership investment, support and buy-in
- Organization/system readiness
- Formation of a trauma-informed committee/work group
- Baseline evaluation
- Creation of a trauma-informed organizational plan
- Preparation to hire a workforce that is knowledgeable in a trauma-informed approach
- Consideration of the physical space of the building(s)
- Consideration of partners in light of the three levels of a trauma-informed approach
- Creation of written policies and procedures

Key Development Area #1 - Leading and Communicating (Pre-I)

The Leading and Communicating Key Development Area 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. The domains of consideration are:



Leading and Communicating Pre-Implementation Objectives:

- Understand the importance of leadership commitment and buy-in
- Develop strategies to increase organizational/system readiness for change
- Form a trauma-informed committee/work group/team
- Develop strategies to evaluate the trauma-informed change process
- Begin thinking about creating a trauma-informed change committee/workgroup
- Create a trauma-informed organizational plan

Leadership Investment and Commitment

It is critical for any type of organizational change to start with leadership. Without a strong commitment and buy-in from leadership, it will be difficult for an organization/system to address many of the key development areas in a way that is strategic and efficient. As Dr. Sandra Bloom (2008) stated, 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 is identifying 1) who your leaders are—the CEO, executive director, board, etc., and 2) are they invested and bought-in to 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.

Leading and Communicating Pre-Implementation Objectives:

- Have a full understanding of what it means to be trauma-informed
- 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
- Are involved in the trauma-informed oversight committee
- Talk about a trauma-informed approach in meetings, newsletters, supervision, etc.

Leadership commitment starts from having a true understanding of how trauma impacts all individuals in the organization/system, the importance of being trauma-informed, and what it takes for an organization/system to create and sustain trauma-informed change. Many organizations need to start with initial presentations to their board, leadership team, etc. in order to increase their awareness of how trauma impacts their organization 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, Nochajski, Green, Hitzel & Woike-Ganga, 2017; Hales et al., 2018). If your leadership is not currently invested in trauma-informed organizational change, we recommend considering what is important to your leadership and promoting the trauma-informed approach as a means of accomplishing that.

Another successful strategy we have seen and used is deliberately connecting the values and principles of a trauma-informed approach to the organization/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 clearly and concisely make the argument 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.

A small group of teachers wishing to bring TI-EP to their school district and needing leadership buy-in present first to the board of education on how trauma/adversity impact learning and how TI-EP connects with their district's values and the restorative justice practices they already have.

In order to get leadership buy-in, 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. 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, incorporate the language of the five values and principles, and/or language about how they plan to respond to the prevalence of trauma. *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.

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 time, staff time, money—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/workforce training funds and apply for grant funding as a means of securing money for trauma-informed change. However, it is important to note that if funding specific to the trauma-informed initiative is limited or not currently possible, discussion of what is possible with the resources available with regard to the key development areas can still happen. Part of incorporating the intent to become trauma-informed in an agency/organization/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 than simply checking the boxes associated with each key development area.

Organization/System Readiness

Once leaders are committed, the next step is assessing whether or not the organization/system is ready for trauma-informed change. While being trauma-informed arguably leads to the work being easier in the long run, it does require a larger time commitment from the workforce upfront because of the need for short- and long-term training, planning and implementation.

There are a few factors that contribute to an organization/system's readiness for change. The first is leadership. Overall readiness to change increases when the workforce has trust in its leaders and feel that they are supportive of the change efforts (Santhidran, Chandran & Borromeo, 2013). Clear, transparent communication about the proposed trauma-informed change plan is central for building trustworthiness with staff. Further, readiness to change depends on workforce perceptions of the change process and how it fits with their organization/system (Santhidran et al., 2013; Weiner et al., 2017). Thus, the way leadership introduces and communicates about the trauma-informed change process is critical to workforce buy-in and support. It is important for leadership to promote readiness to change by increasing workforce awareness of the trauma-informed approach and its significance to the organization/system. Communicating a plan to support the workforce during the change process (e.g., training, resources, etc.) is recommended, as the workforce's perceptions of how feasible the change process can be implemented is another factor in organizational readiness to change (Weiner et al., 2017).

Equally important to workforce buy-in and readiness to change is leadership providing opportunities for choice and collaboration by allowing forums for all levels of the workforce to engage in discussions, provide feedback and ask questions.

The *checking the boxes* approach refers to a mentality that is solely focused on ensuring tasks are completed. A trauma-informed approach is more than a list of tasks—it is a paradigm shift deliberately infused into everything, every day. In other words, being trauma-informed is an on-going process rather than a destination.

We have seen that if the workforce feels that the trauma-informed change process is something the organization/system is striving to undertake together as a team rather than leadership telling them what to do, there will likely be more buy-in and engagement.

Further, research suggests that if leadership does not address workforce-perceived barriers to change, the workforce will be less likely to engage in and implement the change process (Lundgren et al., 2013; Weiner et al., 2017). Again, transparent communication with opportunities for workers to provide feedback and have their concerns addressed will assist in increasing the organization/system's readiness to change.

Forming a Trauma-Informed Committee, Work Group or Team

Given the multifaceted nature of trauma-informed organizational change, leaders that 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 too much for one or two people, thus it is important for your organization/system to form a committee, work group or team prior to moving into the Implementation Stage. The purpose of this group may change over time—however, at least while in Pre-Implementation and Implementation, it will be important for group members to oversee, plan and manage the change process.

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 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 then, the committee will be the most successful with representation from leadership and all levels of staff, and will consider how the voice of clients/patients/students/consumers will be incorporated—whether that means having one as a member and/or a deliberate plan to elicit feedback from them throughout the change process. In addition to the voices of those staff directly involved, the trauma-informed committee needs to establish a system in which members can propose decisions and action steps with 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 the teachers/staff to be a part of the TI-EP committee. He also extended invitations to specific teachers/staff whom he thought would be a good fit based on the needs of the school.

Baseline Evaluation

As previously discussed in the Our Approach section, 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 conduct a baseline evaluation that occurs before any formal training or implementation steps occur. Not only can the organization/system use the baseline to monitor progress along the way, the trauma-informed committee can use the results to make deliberate decisions about where in the organization/system to focus energy and resources first.

Evaluation of how trauma-informed an organization/system is involves looking at the culture and climate and its policies and procedures through a trauma-informed lens. In our work with organizations/systems, we survey the workforce by asking for its perceptions of the five values and principles of a trauma-informed approach and about specific policies and procedures that a trauma-informed organization/system has. When possible, we like to survey clients/patients/students/consumers with a modified form of the evaluation tools. Evaluations can be conducted via paper and pencil, or the questions can be inputted into an online platform like SurveyMonkey and emailed to the workforce to respond to. There are various trauma-informed organizational assessment tools to choose from. As an example of an assessment tool, you can see our shortened Trauma-Informed Climate Scale-10 (TICS-10) on the following page.

In the resources section for Leading and Communicating on page 92, you will find a list of additional assessment tools of varying lengths and possible questions eliciting qualitative feedback via focus groups or interviews. We recommend that your organization/system pick an assessment tool that best fits your needs.

Anytime an organization/system asks for feedback, it is important that there is a deliberate system for collecting, organizing and reporting out the results and any action steps that will be taken. In order to promote trustworthiness, we recommend that leaders are 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.

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.

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

_____ 2. There are opportunities for me to gain additional skills through workshops and trainings.

_____ 3. The leadership listens only to their favorite employees.

_____ 4. I don't have many choices when it comes to doing my job.

_____ 5. I may disagree with administration, but at least I always know where they stand.

_____ 6. Areas within the building sometimes make me feel trapped or unsafe.

_____ 7. Staff is not supported when they try and find new and better ways to do things.

_____ 8. This organization doesn't seem to care whether staff gets what they need to do their jobs well.

_____ 9. Supervisors and administrators recognize my strengths and skills.

_____ 10. I am uncomfortable with a co-worker at work.

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

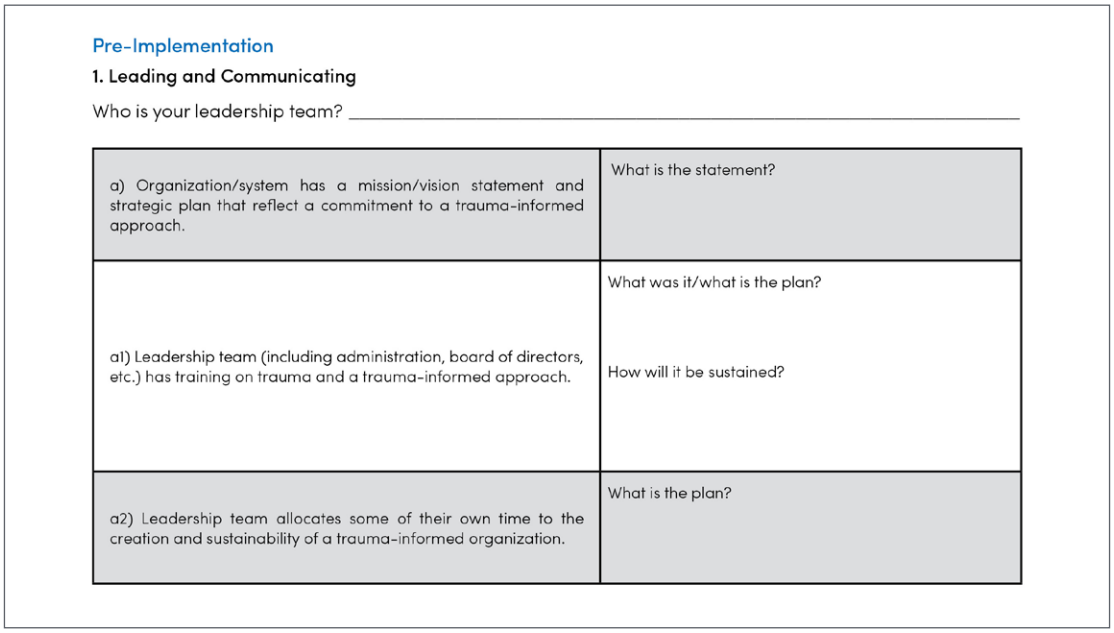
Creating the Trauma-Informed Organizational Plan

With leadership and organization/system commitment, a trauma-informed committee and baseline evaluation 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, anchored in the mission/vision, overall organization/system's strategic plan and baseline evaluation results, and that it is flexible enough that adjustments can be made along the way.

Although there are recommendations and strategies throughout this manual for how to think about trauma-informed implementation, there is not a 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 key development areas in this manual, and then applying that knowledge to what makes sense for your organization/system. Some spots may begin with Establishing a Safe Environment, while others begin with Training the Workforce (Clinical and Non-Clincal), etc. While the trauma-informed organizational plan will address all of the key development areas at some point, the order in which they are addressed is flexible based on the organization/system's strengths, needs and resources.

Planning and Discussion

The charts found in Appendix B and Appendix C can be used within 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 considerations and format in these worksheets are similar to Appendix A that you 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.



Pre-Implementation

1. Leading and Communicating

Who is your leadership team? _____

a) Organization/system has a mission/vision statement and strategic plan that reflect a commitment to a trauma-informed approach.	What is the statement?
a1) Leadership team (including administration, board of directors, etc.) has training on trauma and a trauma-informed approach.	What was it/what is the plan? How will it be sustained?
a2) Leadership team allocates some of their own time to the creation and sustainability of a trauma-informed organization.	What is the plan?

Figure 14 – Preview of Appendix C

Key Development Area #2 - Hiring and Orientation Practices (Pre-I)

The Hiring and Orientation Practices Key Development Area involves ensuring hiring, new-hire orientation and other human resources practices are conducted in ways that are trauma-informed and trauma-sensitive. The domains of consideration are:

Hiring and Orientation Practices Pre-Implementation Objectives:

- Recognize effective methods to increase your organization/system's ability to build a trauma-informed workforce.
- Develop trauma-informed interview questions to be used in the hiring process.
- Plan for the inclusion of trauma-informed education into new-hire orientation.

Recruitment Job Postings

Planning to hire a 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 is important to trauma-informed organizational change (SAMHSA, 2014b). Given that organizational change requires all of the workforce 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 around 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 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 in the Implementation part of this manual for more details).

TRAUMA-INFORMED RECRUITMENT: A SUMMARY

- Look for formal education, training and experience in using a trauma-informed approach.
- Look for 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 by ensuring the job postings and interview questions are anchored in the five guiding/values principles.

Another 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 take on a coordinator role of all the 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 administration and us at ITTIC to create and modify the trauma-informed organizational plan, coordinated meetings and trainings, provided trainings and coaching and assisted in the review of some procedures and forms.

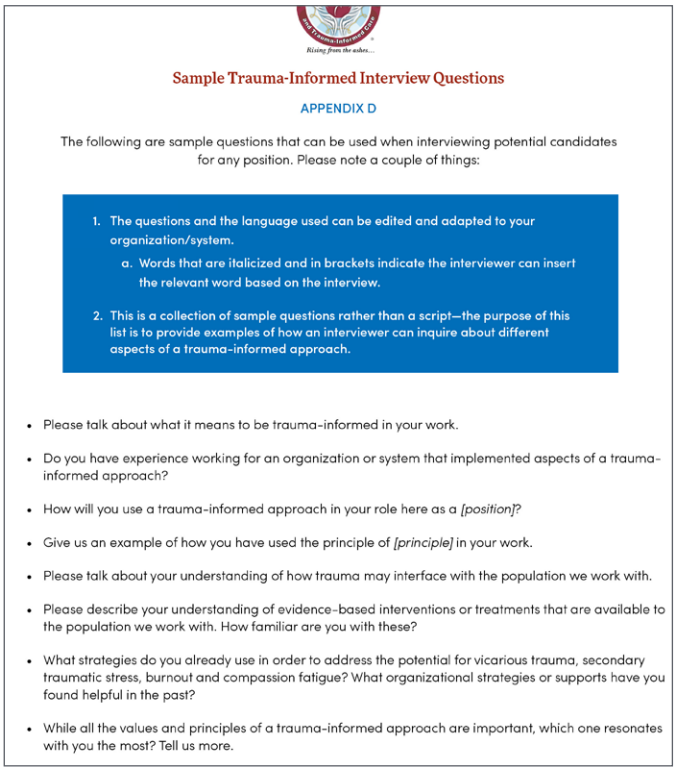
Again, trauma-informed organizational change involves many moving parts. Having someone whose job is dedicated to coordinating, tracking and facilitating many of these components can help ensure consistency and overall sustainability. Ideally, this individual already has expertise in the trauma-informed approach and 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 which job posting is in question, it is important that the posting itself models the model of a trauma-informed approach by considering the five guiding values and principles. Does the posting ensure trustworthiness by including clear, accurate, transparent job descriptions, 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?

Interview Questions

The next step within this key development area is to develop interview questions that have a focus on hiring individuals who are knowledgeable in trauma and a trauma-informed approach. 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 the expectation 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 with follow-up questions to assess how applicants see themselves aligning with the organization/system's trauma-informed perspective.

Depending on the position being interviewed for, the organization/system will need to create questions that assess the applicant's experience working with individuals who have trauma, knowledge of trauma and its impact, knowledge and experience with the trauma-informed approach, and experience with evidence-based treatment interventions for trauma. Please see **Appendix D** for a list of sample trauma-informed interview questions.



Sample Trauma-Informed Interview Questions

APPENDIX D

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.

- Please talk about what it means to be trauma-informed in your work.
- 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 principle of *[principle]* in your work.
- Please talk about your understanding of how trauma 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 and principles of a trauma-informed approach are important, which one resonates with you the most? Tell us more.

Figure 15 – Preview of Appendix D

A *digestive process* refers to the need for time to process the information in order to integrate the new knowledge into older knowledge constructs. By having multiple opportunities for formal education/learning with some time elapsed between them, individuals are better able to operationalize and integrate the material.

New-Hire Orientation

The last consideration for this key development area in the **Pre-Implementation Stage** is planning for how **foundation education on trauma and a trauma-informed approach will be incorporated into new hire-orientation**. New workers will likely come to the organization/system with different 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 the job, while others require that workers attend a 101 presentation or watch existing online modules within the first few months of being hired.

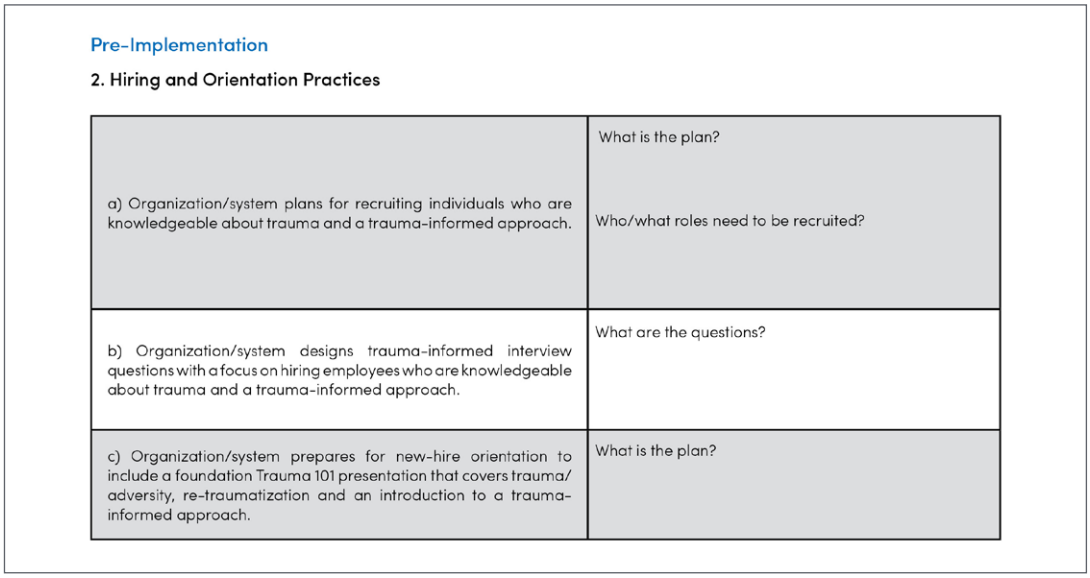
Schools often provide a 101 presentation during staff development days shortly before the school year begins, or use time during a half-day or staff development day in the fall.

Even if the formal education cannot be provided prior to workers starting the job, we recommend that deliberate messaging regarding the organization/system's commitment to being trauma-informed is still included in order to set the tone. 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, as well as various agency staff describing and acting out what a trauma-informed approach looks like in their programs.

It is important to remember that offering education during new-hire orientation is just one part of the organization/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 is 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) section of the **Implementation Stage** in this manual.

Planning and Discussion

The charts found in **Appendix E** and **Appendix F** can be used within the trauma-informed committee to discuss, assess and plan for the components of the Hiring and Orientation Practices Key Development Area within the **Pre-Implementation Stage**. The considerations and format of these worksheets are similar to Appendix A that you reviewed in the Getting Started section of this manual—however, there are 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.



Pre-Implementation

2. Hiring and Orientation Practices

a) Organization/system plans 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 designs trauma-informed interview questions with a focus on hiring employees who are knowledgeable about trauma and a trauma-informed approach.	What are the questions?
c) Organization/system prepares for new-hire orientation to include a foundation Trauma 101 presentation that covers trauma/adversity, re-traumatization and an introduction to a trauma-informed approach.	What is the plan?

Figure 16 – Preview of Appendix F

Key Development Area #5 - Establishing a Safe Environment (Pre-I)

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 physical space/aesthetics and culture are trauma-informed and trauma-sensitive. The domain of consideration is:

Establishing a Safe Environment Pre-Implementation 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.

Considerations for a Safe Environment

There are a number of considerations when thinking about the environment of your organization/system within a trauma-informed and trauma-sensitive approach. The list below summarizes the aspects of the physical environment that we have learned make a difference when it comes to individuals feeling comfortable and welcomed. How this list can be used during the Pre-Implementation Stage depends on your organization/system.

Generally speaking, a trauma-sensitive environment is one that is **welcoming, friendly and aesthetically comfortable**. The following five categories of things to consider will help create such an environment:

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

- If your organization/system is starting from the ground up (and thus does not yet have a physical space), the list is helpful to have as a tool in conversations with builders and other stakeholders regarding designing the physical building and decorating the interior.
- If your organization/system is moving to a new building, the following list can be used as another consideration when choosing between multiple options and/or informing design and space decisions when moving into the space.
- If your organization/system has an already-established physical space, we advise that you consider what you have already done with regard to making improvements in each of these areas.

2 Security – Includes noting what security measures are/will be in place (e.g., locked doors, cameras, security personnel, etc.) and being mindful of possible discomfort they may cause individuals.

3 Accessibility – Includes considerations of how accessible the building is/will be to individuals with physical disabilities, transportation difficulties, etc. and how easily accessible bathrooms are/will be to all individuals (workers and clients/patients/students/consumers).

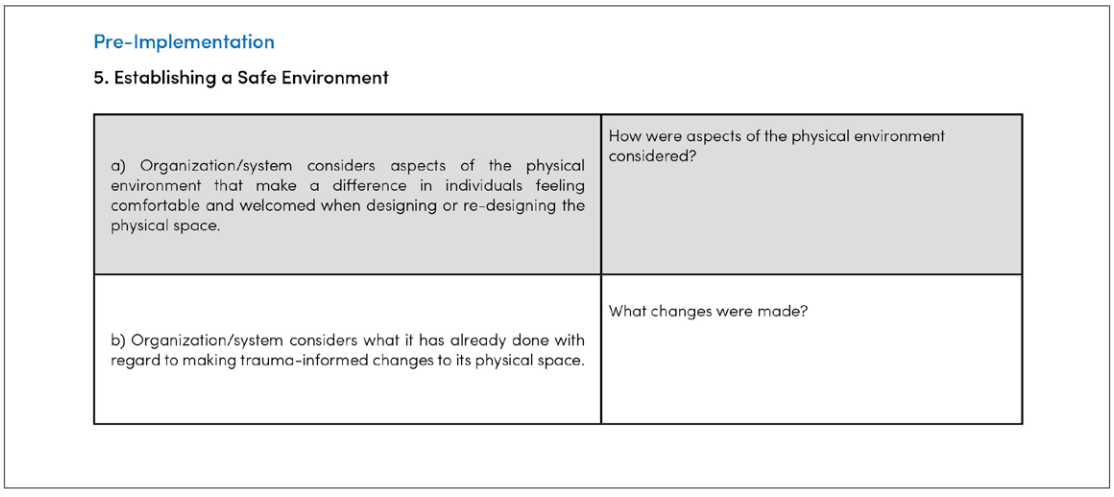
4 Private Spaces – Includes reviewing for the possibility/existence of private spaces that ensure confidentiality for sensitive conversations—which may include separate rooms, screens/dividers, white-noise makers, etc. It also includes considerations for adequate spacing between seating in waiting areas.

5 Décor – Includes considering the color of walls, use of plants/aquariums, reading materials and murals/artwork/photos—which are culturally relevant and appropriate for those utilizing the space (e.g., different languages, child-friendly, etc. as applicable).

In the Implementation Stage, we will discuss tools that can be used to review and continue to ensure your organization/system's environment is physically and emotionally safe and trauma-sensitive.

Planning and Discussion

The charts found in Appendix G and Appendix H can be used within 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 considerations and format of these worksheets are similar to Appendix A that you reviewed in the Getting Started section of this manual—however, there are 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.



Pre-Implementation

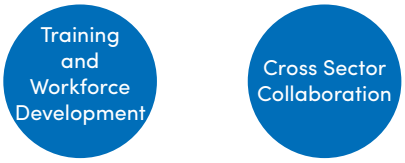
5. Establishing a Safe Environment

a) Organization/system considers aspects of the physical environment that make a difference in individuals feeling comfortable and welcomed when designing or re-designing the physical space.	How were aspects of the physical environment considered?
b) Organization/system considers what it has already done with regard to making trauma-informed changes to its physical space.	What changes were made?

Figure 17 – Preview of Appendix H

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

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



Collaborating with Others (Partners and Referrals) Pre-Implementation Objectives:

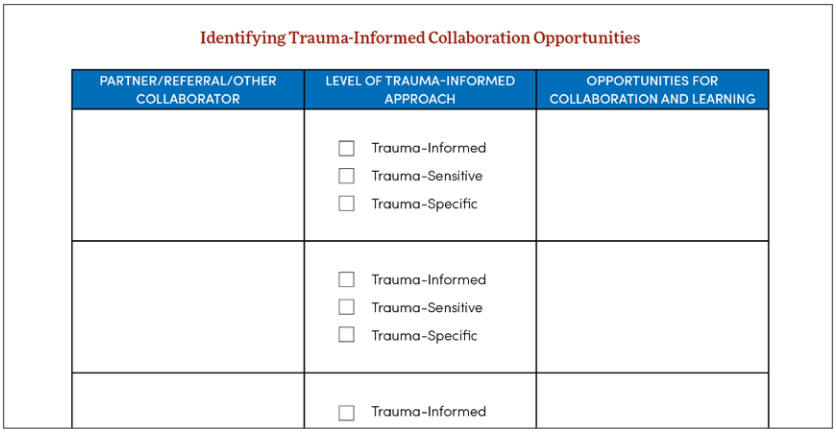
- Identify collaborative partners, referrals and/or other entities your organization/system regularly interfaces with.
- Identify opportunities to learn from partners who have already started the trauma-informed change process
- Identify opportunities to create trauma-informed networks through education, advocacy and mutual trauma-informed goals.

Identifying Opportunities in Collaboration

Consider those you collaborate with—whether that means partner organizations, referrals and/or other entities that your organization/system regularly interfaces with. The focus of this key development area in the Pre-Implementation Stage is 1) identifying where those collaborations are with regard to a trauma-informed approach and 2) considering where there may be opportunities for your organization/system and other entities to deliberately incorporate a trauma-informed approach together.

When thinking about other entities in relation to being trauma-informed, you will need to consider the three levels of a trauma-informed approach discussed previously on page 25.

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 itself, there is the potential that individuals will be sent 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. If that is the case, identifying opportunities to learn from them can certainly be beneficial to your organization/system as well. At its essence, this key development area hopes to build trauma-informed networks and communities via education, advocacy and creating collaborations based on mutual understanding of a trauma-informed approach.



Identifying Trauma-Informed Collaboration Opportunities

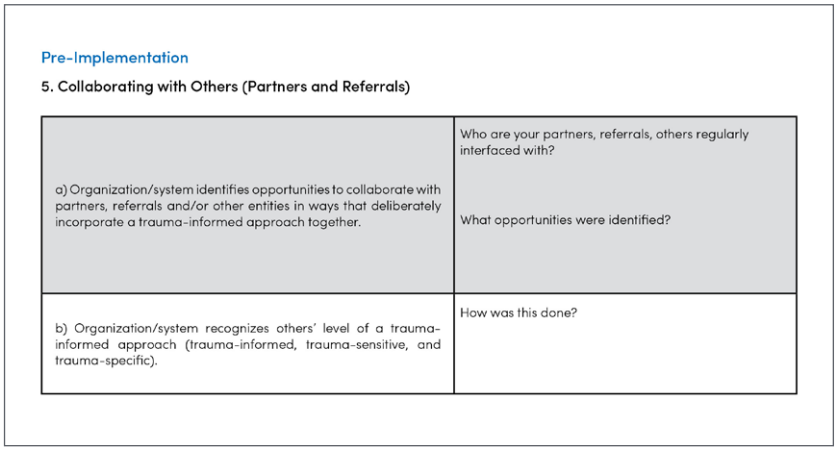
PARTNER/REFERRAL/OTHER COLLABORATOR	LEVEL OF TRAUMA-INFORMED APPROACH	OPPORTUNITIES FOR COLLABORATION AND LEARNING
	☐ Trauma-Informed ☐ Trauma-Sensitive ☐ Trauma-Specific	
	☐ Trauma-Informed ☐ Trauma-Sensitive ☐ Trauma-Specific	
	☐ Trauma-Informed	

Figure 18 – Preview of Appendix I

Appendix I has a worksheet you can use to identify your partners, referrals and other collaborators. Once you have a list, 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. Take some time to indicate your organization/system's relationship with them. Where and in what ways do you already communicate? Collaborate? If they have already started the process of becoming trauma-informed, what can you learn from them? If not, what possibilities are there to include them in your organization/system's trauma-informed change process? This list will be referenced again in the Implementation Stage.

Planning and Discussion

The charts found in Appendix J and Appendix K can be used within 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 considerations and format of these worksheets are similar to Appendix A that you reviewed in the Getting Started section of this manual—however, there are 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



Pre-Implementation

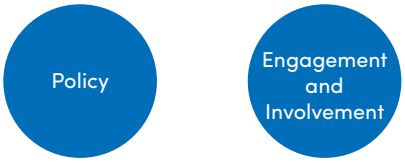
5. Collaborating with Others (Partners and Referrals)

a) Organization/system identifies opportunities to collaborate with partners, referrals and/or other entities in ways that deliberately incorporate a trauma-informed approach together.	Who are your partners, referrals, others regularly interfaced with? What opportunities were identified?
b) Organization/system recognizes others' level of a trauma-informed approach (trauma-informed, trauma-sensitive, and trauma-specific).	How was this done?

Figure 19 – Preview of Appendix K

Key Development Area #9 - Reviewing Policies and Procedures (Pre-I)

The Reviewing Policies and Procedures Key Development Area 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. The domains of consideration are:



Reviewing Policies and Procedures Pre-Implementation Objectives:

- Establish the group of individuals who will review policies/procedures.
- Create a plan for how often policies/procedures will be reviewed.
- Ensure written policies/procedures are accessible to those they apply to.
- Identify policies/procedures that are already in-line with a trauma-informed approach.

Setting the Stage for Trauma-Informed Policies and Procedures

Reviewing policies and procedures 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 your organization/system is to prepare for the reviewing process. 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 reviewing team/committee. We recommend having at least two individuals directly involved as part of this process. Organizations/systems often have many written policies and procedures to move through. Additionally, one person may identify or think of something that someone else may not, so having multiple viewpoints is important. With regard to who, having an individual involved that has the power to make changes to policies and procedures is critical. We also recommend considering having different roles and perspectives—meaning involving representation from at least a few different levels of the workforce and hearing the voice of clients/patients/students/consumers. How will there be opportunity to provide feedback about policy changes anonymously? If they cannot be directly involved, how will your organization/system gather feedback prior to finalizing changes?

2 How Often: Next, your organization/system will need to consider and plan for how often the review of policies and procedures will occur. Certain policies and procedures may no longer make sense or be relevant after time, regulations may 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 voice of others.

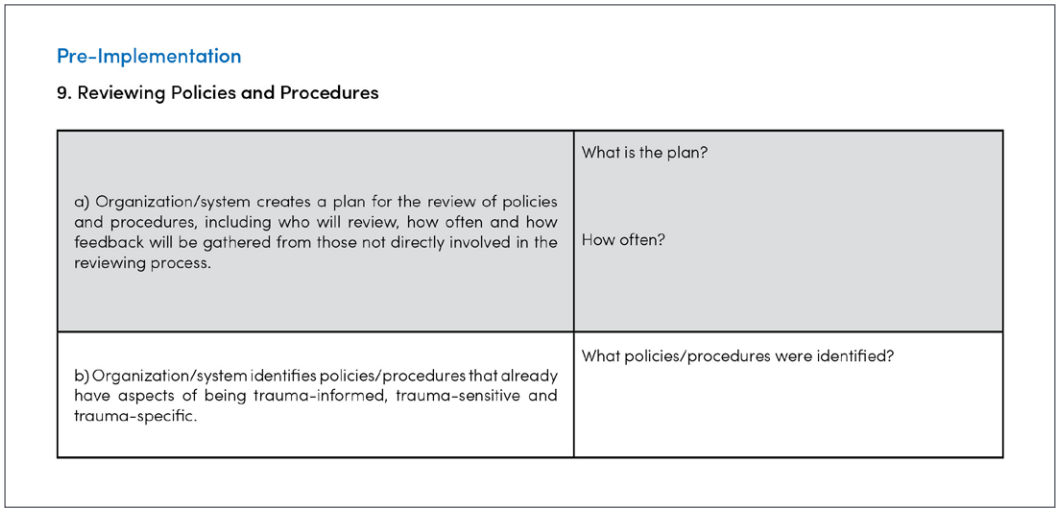
3 Accessibility: In addition to the policies and procedures being trauma-informed themselves, the organization/system also needs to ensure that individuals have access to them in writing—whether access is online or printed is up to you. How does the workforce already have access to your current policies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

4 What is Already in Place: The last consideration for this key development area within the **Pre-Implementation Stage** is deliberately acknowledging the policies/procedures that already have aspects of a trauma-informed, trauma-sensitive and/or trauma-specific approach. For example, what policies/procedures does your organization/system already have pertaining to safety, such as requiring written safety/crisis plans, or requiring annual mandatory safety training for the workforce? Does your organization/system have a de-escalation policy? How do you see aspects of the other five guiding values and principles?

Once your organization/system has considered and made a plan based on the four items above, you will be ready to start reviewing individual policies and procedures. This process will be discussed in more detail during the **Implementation Stage**.

Planning and Discussion

The charts found in **Appendix L** and **Appendix M** can be used within 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 considerations and format of these worksheets are similar to Appendix A that you reviewed in the Getting Started section of this manual—however, there are 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.



Pre-Implementation

9. Reviewing Policies and Procedures

a) Organization/system creates a plan for the review of policies and procedures, including who will review, how often and how feedback will be gathered from those not directly involved in the reviewing process.	What is the plan? How often?
b) Organization/system identifies policies/procedures that already have aspects of being trauma-informed, trauma-sensitive and trauma-specific.	What policies/procedures were identified?

Figure 20 – Preview of Appendix M

Stage 2: Implementation

Overview

During the Implementation Stage, organizations/systems build on the trauma-informed foundation created during the Pre-Implementation Stage through continued, active leadership involvement. Within the Implementation Stage, the trauma-informed committee or work group identifies, plans for and acts in the various key development areas based on the trauma-informed organizational plan. There are nine key development areas within this stage. Being deliberate and strategic about how your organization/system goes about working through each of these will be important and take time. As a reminder, there is no one-size-fits-all approach to addressing the key development areas. The order of when each of the areas is focused on will depend on the baseline evaluation, the organization/system's strategic plan, mission/vision and what resources are currently available. In some instances, it makes the most sense for organizations/systems to focus on areas of improvement based on the baseline evaluation. For others, it may make sense to continue to build upon their strengths and see those areas through to the Sustainability Stage first. Considering what key development areas have the *lowest-hanging fruit* for your organization/system is yet another option when deciding where to start. Again, it is critical to keep in mind that trauma-informed organizational change can take a few years—not all nine of these areas will necessarily be addressed in the first year. As mentioned previously, being realistic, deliberate and flexible in your planning will help ensure your organization/system steadily continues down the road to being trauma-informed.

KEY DEVELOPMENT AREAS

1. Leading and Communicating
2. Hiring and Orientation Practices
3. Training Clinical and Non-Clinical Staff
4. Preventing Secondary Traumatic Stress in Staff
5. Safe Environment
6. Screening for Trauma
7. Treating Trauma
8. Collaborating with Others (Partners and Referrals)
9. Reviewing Policies and Procedures

Lowest-hanging fruit refers to easily obtainable action steps toward trauma-informed organizational change.

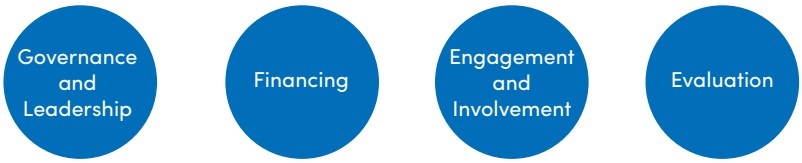
The nine key development areas in the Implementation Stage are 1) Leading and Communicating, 2) Hiring and Orientation Practices, 3) Training the Workforce (Clinical and Non-Clinical), 4) Addressing the Impact of the Work, 5) Establishing a Safe Environment, 6) Screening for Trauma, 7) Treating Trauma, 8) Collaborating with Others (Partners and Referrals) and 9) Reviewing Policies and Procedures. This section of the manual will help you consider and plan for the critical components of this stage by providing structure, examples from our experience working with organizations/systems, and tools that can be used during action planning for each of the areas.

Critical Components of the Implementation Stage

- Leadership of the trauma-informed committee/work group
- Deliberate trauma-informed messaging from administration
- Short- and long-term trauma-informed training for the workforce
- Supports for workforce wellness and resilience
- Changes to the physical environment
- Decisions regarding screening and treatment of trauma
- Engagement of partners and referrals
- Review of all policies, procedures and forms

Key Development Area #1 - Leading and Communicating (I)

The Leading and Communicating Key Development Area 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. The domains of consideration are:



Leading and Communicating Implementation Objectives:

- Have a regularly meeting trauma-informed committee to implement the trauma-informed organizational plan.
- Elicit feedback from all individuals regarding trauma-informed implementation steps.
- Integrate a trauma-informed approach into organizational/system messaging.

Leadership of Trauma-Informed Committee

The task of the trauma-informed committee during the Implementation Stage is to lead the trauma-informed change process. In order 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 the previous stage. The trauma-informed committee can use the guidance of this manual alongside various tools within the appendices in order to identify priority areas within each key development area and formulate action steps.

It is critical that the committee uses portions of the meeting in order to reflect on progress and challenges, and make changes to the trauma-informed organizational plan as needed based on those conversations. Though the overall framework of what organizations intend to follow in order 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 in order to do follow-up activities and structured consultation after the initial 101 presentation. We quickly realized with the hospital that our original plan was not feasible or sustainable based on staffing concerns, so the plan was modified in order to incorporate the use of more visuals depicting trauma-informed education and an increase in real-time coaching/education.

The goal of providing short- and long-term follow-up to the original 101 presentation stayed the same, but the means of how we achieved it needed to be modified based on the feedback received once we started implementing it.

A second critical consideration for the trauma-informed committee is how it **elicits feedback about implementation from 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 holding focus groups, to using some form of survey, to forming subcommittees of the trauma-informed team in order to address specific areas of implementation. Regardless of the method chosen, it is key that feedback and suggestions are actively asked for (as opposed to only a passive approach of feeling people can provide feedback if they wish) 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 are two examples of how we have seen committees be transparent about incorporating feedback and decision-making.

Lastly, it is important for **executive leadership/administration to be involved with the trauma-informed committee.** We recommend having representation on the actual 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 need to be fully informed of all trauma-informed efforts, activities and changes in order 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 in order to implement action steps and make changes—many of which need approval from and resource investment from those in charge.

Especially if not directly in the committee, it is advised that leadership/administration be deliberate about defining the committee's role, empowering members to make decisions about planning and implementation, and scheduling time specific for discussing and approving their action plans.

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 communication about all trauma-informed efforts, activities and changes.** In order 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 newsletters, emails, posting the trauma-informed committee's meeting minutes, dedicating a few minutes at each workforce meeting for updates to be reported, etc.

Second, it is critical to overall buy-in 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 how your agency/organization/system already communicates information, what locations individuals often pass by or spend prolonged time in, and what has worked well in the past to convey messages.

Many organizations/systems we have worked with make use of their internal/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 the five 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.) related to the trauma-informed approach.

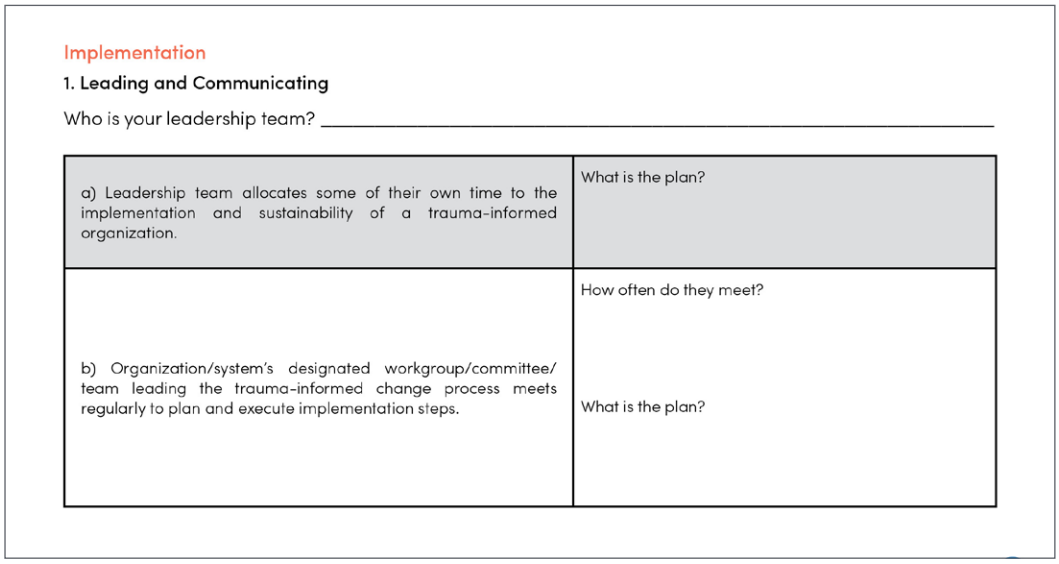
*Having reading and other visual materials in common spaces can go a long way—especially when incorporated deliberately with other messaging strategies. See **Appendix N** for sample posters/visuals that can be printed to use.*

When thinking about an overall messaging strategy, 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 around 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/system's fabric.

Figure 21 – Preview of Appendix N

Planning and Discussion

The charts found in **Appendix O** and **Appendix P** can be used within 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 considerations and format of these worksheets are similar to Appendix A that you reviewed in the Getting Started section of this manual—however, there are 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

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 is the plan?
b) Organization/system's designated workgroup/committee/ team leading the trauma-informed change process meets regularly to plan and execute implementation steps.	How often do they meet? What is the plan?

Figure 22 – Preview of Appendix P

Key Development Area #1 - Hiring and Orientation Practices (I)

The Hiring and Orientation Practices Key Development Area involves ensuring hiring, new-hire orientation and other human resources practices are conducted in ways that are trauma-informed and trauma-sensitive. The domains of consideration are:

Hiring and Orientation Practices Implementation Objectives:

- Hire individuals who have a full understanding of what it means to be trauma-informed.
- Interview individuals and conduct new-hire orientation in a way that "models the model" of being trauma-informed.
- Review employee handbooks and other human resources documents with a trauma-informed lens.

Trauma-Informed Hiring and Orientation Protocols

Now that the organization/system has established questions and job postings with a focus on hiring staff who are knowledgeable in trauma and a trauma-informed approach, the focus of this domain within the Implementation Stage is to ensure that all aspects of the recruiting, hiring and orientation process are trauma-informed. In order to do this, protocols and procedures will need to be reviewed for how well they are anchored in the five guiding values and principles (Harris & Fallot, 2001). Figure 23 below gives examples of how various aspects of hiring and orientation can be trauma-informed:

In addition to adjusting protocols as needed, we also recommend those who are conducting the interviews, new-hire orientation and other human resources (HR) personnel be trained on the trauma-informed approach and how it applies to their roles in the organization/system. Trauma-informed training strategies are discussed in more detail in the next key development area—Training the Workforce (Clinical and Non-Clinical).

SAFETY

- Conduct interview and orientation processes 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
- Provide an overview of the environment (e.g., emergency exits, location of bathroom, breaks that will occur, etc.)
- Provide the opportunity to access refreshments (e.g., water, coffee) and the bathroom prior to starting an interview 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
- 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 timeframes for interviews whenever possible
- 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 whenever possible

EMPOWERMENT

- Inquire about strengths and capacities during the interview
- Provide job training/opportunity for shadowing during the orientation process

Figure 23 – Example Trauma-Informed Hiring and Orientation Practices

Reviewing Employee Handbooks and Other HR Documents

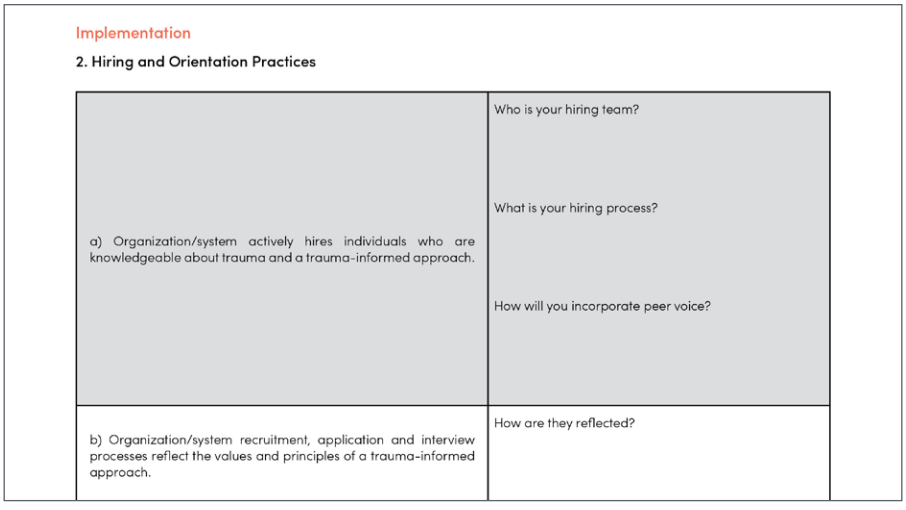
The second component this key development area within the Implementation Stage is to ensure that all written documents related to HR (such as employee handbooks, employee rights and responsibilities, job descriptions and other new-hire paperwork) are reviewed and revised to be more trauma-informed. Much like the protocols discussed in the previous section, these written documents can build trustworthiness with staff by being transparent and accurate. For example, do job descriptions accurately define roles, responsibilities and what is expected of someone in that position? Are job descriptions revised based on changes in the organization/system and/or changes to the position 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)?

Being trauma-informed includes recognizing the potential of re-traumatization by verbal and written communication. Therefore, in addition to clarity and accuracy, HR documents are reviewed for the use of **positive, solution-focused and trauma-informed language**. While trauma-informed documentation and language will be discussed in more detail later in the Reviewing Policies and Procedures Key Development Area on page 83, the table below provides some initial guidelines to consider in light of 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 are expected to...)*

Planning and Discussion

The charts found in **Appendix Q** and **Appendix R** can be used within the trauma-informed committee to discuss, assess and plan for the components of the Hiring and Orientation Practices Key Development Area within the Implementation Stage. The considerations and format of these worksheets are similar to Appendix A that you reviewed in the Getting Started section of this manual—however, there are 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

2. Hiring and Orientation Practices

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 recruitment, application and interview processes reflect the values and principles of a trauma-informed approach.	How are they reflected?

Figure 24 – Preview of Appendix R

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

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

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

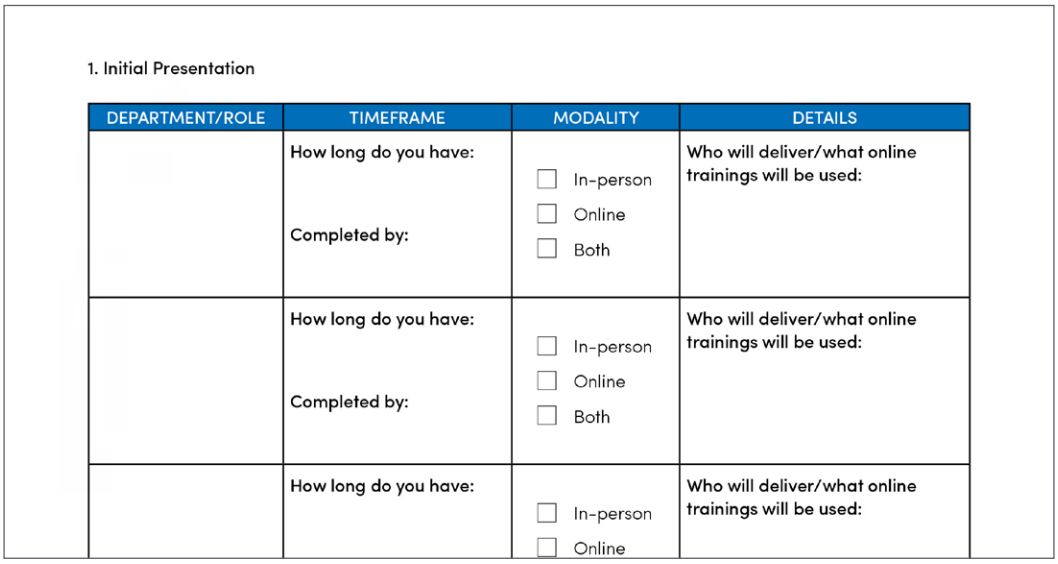
- Create a plan for ongoing training of the workforce on all components of a trauma-informed approach.
- Allocate resources for trauma-specific training (e.g., evidence-based interventions) when appropriate.
- Form an internal Champion Team that includes trainers and mentors.

Creating a Training Plan

An important component of becoming a trauma-informed organization/system is staff training. Given that a trauma-informed approach requires an organizational culture 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 30-45 days of the initial presentation in our work with organizations. Therefore, we highly recommend that organizations/systems **create a training plan** before providing any education.

There are many layers to think about—is there capacity (time, funds, other resources) to train all of the workforce at once, given the need for short- and long-term follow-ups? Or does it make sense to train certain groups (e.g., departments, job role) first and others later? Who will provide the different components of the training plan? What trainings make sense for which workforce roles?

*The two-page worksheet found in **Appendix S** 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 prior to printing and filling out the worksheet.*



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:	☐ In-person ☐ Online	Who will deliver/what online trainings will be used:

Figure 25 – Preview of Appendix S

Foundational Education

The first consideration for training the workforce is how and when workers will receive foundation education on trauma and a trauma-informed approach. Currently, there is not a 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).

Some organizations/systems choose to hire outside consultants to provide psychoeducational presentations focused on this content, while others make use of different 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 orientation.

We recommend that whatever education and training vehicle you choose, the knowledge base being built incorporates information on trauma and its impact, Adverse Childhood Experiences (ACEs), an awareness of re-traumatization, vicarious trauma, resilience and post-traumatic growth, and an understanding of a trauma-informed approach within your system of care. If your organization/system decides to use online education, the additional resources section of this key development area on page 92 provides a few options to start your search.

Ongoing Training

Once workers receive psychoeducation on trauma and a trauma-informed approach, it is important to ensure there are means for ongoing trainings 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 allowing the digestive process to occur. 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, 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. Other examples include how supervisors can benefit from training specific to providing trauma-informed supervision, as well as leadership/administration with training specific to trauma-informed organizational and leadership strategies.

Much of the content of follow-up training is similar to that of the initial education—impact of trauma/adversity, re-traumatization, 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 role and the organization/system.

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/after the work day, as well as making use of times during which workers are already together, such as workforce meetings and supervision. For example:

Leadership can include presenting and/or discussing something related to a trauma-informed approach as a bullet point on a meeting agenda (even for five to 10 minutes), and ensure that the use of trauma-informed values and principles are discussed during supervision.

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 **Implementation Stage** under the Leading and Communicating Key Development Area.

In addition to 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 and support workers in building a trauma-informed environment.** For example:

*If your organization/system has clinical staff, 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 in the **Implementation Stage** for more information about trauma-specific interventions.)*

Leadership can include presenting and/or discussing something related to a trauma-informed approach as a bullet point on a meeting agenda (even for five to 10 minutes), and ensure that the use of trauma-informed values and principles are discussed during supervision.

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 principle of empowerment.

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 workforce. While all staff need to have education and training on a trauma-informed approach, Champions are those who think 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 also 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.

There are a few considerations regarding the formation of a Champion Team to think about. 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 different 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. 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 also among those to consider. Additionally, having a variety of workforce roles (i.e. direct care staff, support staff, leadership) is important, as members are better able to provide the 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 to take on this role based on the system. For example:

Our experience in schools is often that the mental health teams become the Champions because of their ability to already push into classrooms and provide learning opportunities for others in the building.

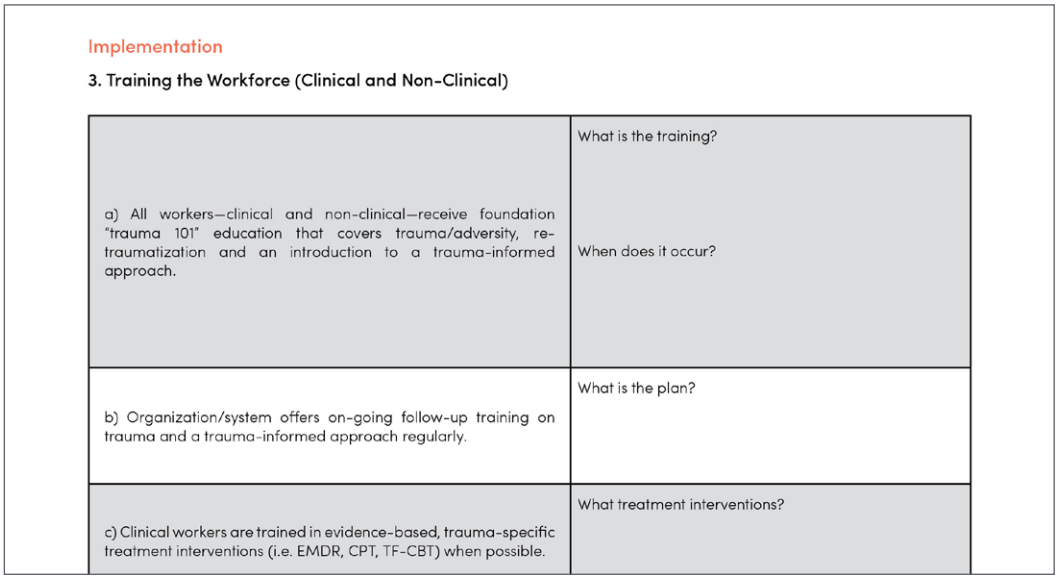
The second thing to consider is the purpose of the Champion Team. In some organizations, the initial trauma-informed committee previously discussed will expand to include workers who want to be trainers and mentors, and the full team will be referred to as the Champion Team. Other times, the committee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

Champions are individuals who are trained specifically to take on roles such as educator, trainer, mentor, coach and/or advocate for the trauma-informed approach.

(Koury & Green, 2017)

Planning and Discussion

The charts found in **Appendix T** and **Appendix U** can be used within 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 considerations and format of these worksheets are similar to Appendix A that you reviewed in the Getting Started section of this manual—however, there are 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

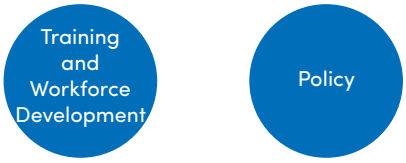
3. Training the Workforce (Clinical and Non-Clinical)

a) All workers—clinical and non-clinical—receive foundation "trauma 101" education that covers trauma/adversity, 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 on trauma and a trauma-informed approach regularly.	What is the plan?
c) Clinical workers are trained in evidence-based, trauma-specific treatment interventions (i.e. EMDR, CPT, TF-CBT) when possible.	What treatment interventions?

Figure 26 – Preview of Appendix U

Key Development Area #4 - Addressing the Impact of the Work (I)

The Addressing the Impact of the Work Key Development Area includes 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. The domains of consideration are:



Addressing the Impact of the Work Implementation Objectives:

- Provide education and training on the positive and negative impact 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 structures to promote vicarious resilience and vicarious post-traumatic growth of the workforce.
- Ensure an organizational/system culture of collaboration and empowerment.

Education and Training

As previously discussed in the Background section of the manual, as result of having empathy while working with individuals who have histories of trauma and adversity, workers can experience negative impacts on their health and well-being in the form of secondary traumatic stress (STS), vicarious trauma (VT) and compassion fatigue. They can also be impacted positively in the form of vicarious resilience (VR) and vicarious post-traumatic growth (VPTG).

Part of an organization/system's anchoring of emotional safety and empowering the workforce within a trauma-informed work environment is having supports in place that acknowledge the potential negative impact of the work and facilitate VR and VPTG. Further, STS, VT and compassion fatigue are associated with high staff turnover, more random sick days, low morale and overall job dissatisfaction, so addressing them will increase overall organizational productivity (Meichenbaum, n.d., Northeastern University's Institute on Urban Health Research, n.d.).

One of the first steps an organization/system can take in order to help prevent and manage STS, VT and compassion fatigue is to provide education and training on what each of these are, what symptoms may be present, risk and protective factors, as well as how to manage and prevent them from occurring. Not all workers may know that their interactions with individuals who have histories of trauma can have negative

implications—awareness is critical so the workforce can identify signs and implement strategies to help mitigate the impact or prevent it all together. It is also important to provide opportunities for workers in training that help them identify what self-care/wellness strategies they already engage in and what works for them in managing stress and other potential negative impacts from the work they do.

The organization/system can provide general resilience trainings, as well as those that teach workers acceptance-based and mindfulness techniques as a means of coping (Meichenbaum, n.d.). Similarly, teaching and encouraging the workforce to notice what is working, what is going well and what successes occurred that day (however small) will help transform VT into the possibility of VR and VPTG.

Supervision

A second form of support that is recommended to support the workforce is regularly scheduled and consistent supervision—some form of which is important for all levels of the workforce (individual, group, etc.). Supervision is especially critical for those workers providing the evidence-based trauma-specific treatment interventions. Regardless of worker role, 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. The supervision category within the additional resources section on page 87 includes various resources regarding providing supervision in a trauma-informed way.

Organization/System Supports

In addition to training and supervision, there can be organization/system structures in place to support the workforce and promote VR/VPTG. Implementing regular check-ins at the beginning of workforce meetings, during quick morning huddles and/or at other times workers already meet/gather provides an opportunity for leadership to quickly get a sense of how the workforce is doing, what is going on that day and what workers may need moving forward.

Checking in with the workforce 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 or for staff to elaborate on personal details.

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

When incidents do occur—whether that means an internal event to the organization like the loss of a client or an external event that still has an impact on the workforce such as acknowledging a school shooting with school staff—it is critical that debriefing occurs. In our work, workers will often report feeling like documentation and discussion around how to prevent an incident like that from occurring in the future is all that is important to the organization. While certainly those conversations are necessary and useful, there is a need to provide emotional debriefing first. Organizations may have their own internal workforce to provide debriefing (e.g., on a hospital floor), or have an external resource such as Crisis Services come in to talk with staff.

Empowering workers by having formal means of recognizing and appreciating them for their hard work and success can help prevent burnout.

One specific 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 provided the opportunity to debrief and connected to other resources as necessary.

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

Lastly, **different HR and workforce wellness practices** can be structures in place that support workers at the organization/system level.

Employee Assistance Programs (EAP), allowing and encouraging workers to take time off, offering workers flextime when possible and holding workforce wellness days or other wellness committee events/activities are a few examples.

Other practices such as ensuring workers have manageable caseloads, respecting work-life boundaries and creating a culture of wellness where it is expected that workers will engage in strategies to take care of themselves are important. While leaders certainly cannot force workers to engage in practices for their wellness, they can model the model, as well as encourage workers to take breaks, have time for lunch and other means of creating balance while at work.

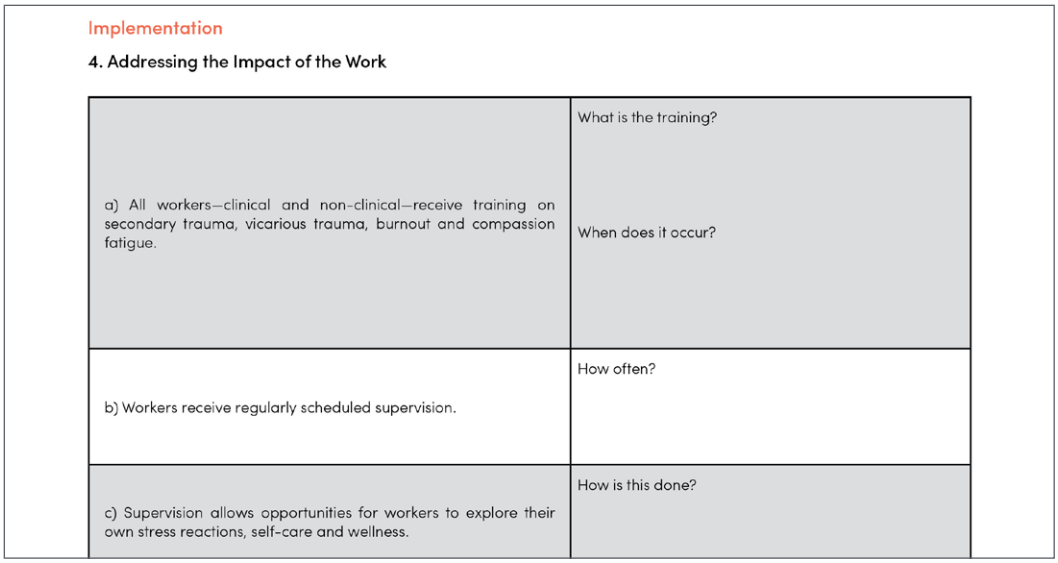
Culture of Collaboration and Empowerment

While flattening the traditional power hierarchy is a critical component of becoming a trauma-informed organization/system as previously discussed earlier in this manual, it also contributes to creating an environment that can help prevent burnout of the workforce. This can happen by ensuring that there are **meaningful opportunities for workers to provide input** and collaborate in decision-making processes—especially around factors that impact their work. Encouraging and providing **formal and informal team-building** to increase collaboration and trust between co-workers can also be a useful strategy (Meichenbaum, n.d.). Opportunities for facilitating increased workforce morale include engaging workers in structured team-building activities, staff retreats, holiday parties, potlucks, etc. Lastly, empowering workers by having formal means of recognizing and appreciating them for their hard work and success can help prevent burnout.

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

Planning and Discussion

The charts found in **Appendix V** and **Appendix W** can be used within 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 of the worksheets are similar to Appendix A that you reviewed in the Getting Started section of this manual—however, there are 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

4. Addressing the Impact of the Work

a) All workers—clinical and non-clinical—receive training on secondary trauma, vicarious trauma, burnout and compassion fatigue.	What is the training? When does it occur?
b) Workers receive regularly scheduled supervision.	How often?
c) Supervision allows opportunities for workers to explore their own stress reactions, self-care and wellness.	How is this done?

Figure 27 – Preview of Appendix W

Key Development Area #5 - Establishing a Safe Environment (I)

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 physical space/aesthetics and culture are trauma-informed and trauma-sensitive. The domain of consideration is:

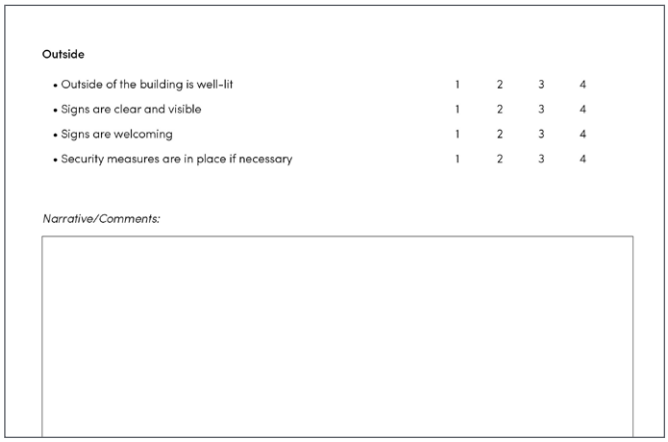
Establishing a Safe Environment Implementation Objectives:

- Schedule and conduct regular trauma-informed environment walk-throughs.
- Provide opportunity for all individuals to give feedback regarding their experience of safety.
- Implement changes from the results of the trauma-informed environment walk-through and feedback gathered when feasible.

Education and Training

Reviewing your organization/system for potential trauma triggers in the physical 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, there are tools called trauma-informed environment walk-throughs that provide checklists and things to consider.

Appendix X has a trauma-informed environment walk-through that can be used to assess the physical environment of your organization/system. 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 building, as well as space to write a narrative and other comments that arise while completing the walk-through.



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
• Security measures are in place if necessary	1	2	3	4

Narrative/Comments:

Figure 28 – Preview of Appendix X

A COUPLE OF THINGS TO NOTE PRIOR TO USING THIS WALK-THROUGH:

1. We recommend reading the remainder of this key development area before completing the walk-through for a full understanding of what to look for.

2. In order to most effectively use the walk-through, we advise that 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.

3. Consider how you will incorporate client/patient/student/consumer voices in your review of the physical 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.

4. 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 or may not make sense given the services you provide. 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. Our recommendation is to complete the walk-through and make note of considerations that may need to be added/changed to better match your organization/system.

5. The last page of the walk-through has a space for action planning in each of the four main areas. We advise selecting one or two of your lowest numbers in each area and considering what it would take to raise your rating just one number higher.

6. 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. 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. For example, although décor may be limited on a behavioral health inpatient unit, replacing traditional light panels with those that have a cloud overlay is a small change that can make the unit feel less sterile and more welcoming.

Ensuring a Safe Environment

You will notice that the majority of the trauma-informed environment walk-through considers factors that help create a sense of safety and feeling welcomed. The following list summarizes the main areas of focus—many of which are similar to what we previously discussed in the **Pre-Implementation Stage**:

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 reasoning for the security measures and being mindful of the possible discomfort they may cause individuals.

3 **Accessibility** – Includes considerations of how accessible the building is to individuals with physical disabilities, how easily accessible bathrooms are to all individuals, 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. This includes considerations for adequate spacing between seating in waiting areas and whether there is designated space for individuals to engage in self-care.

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.

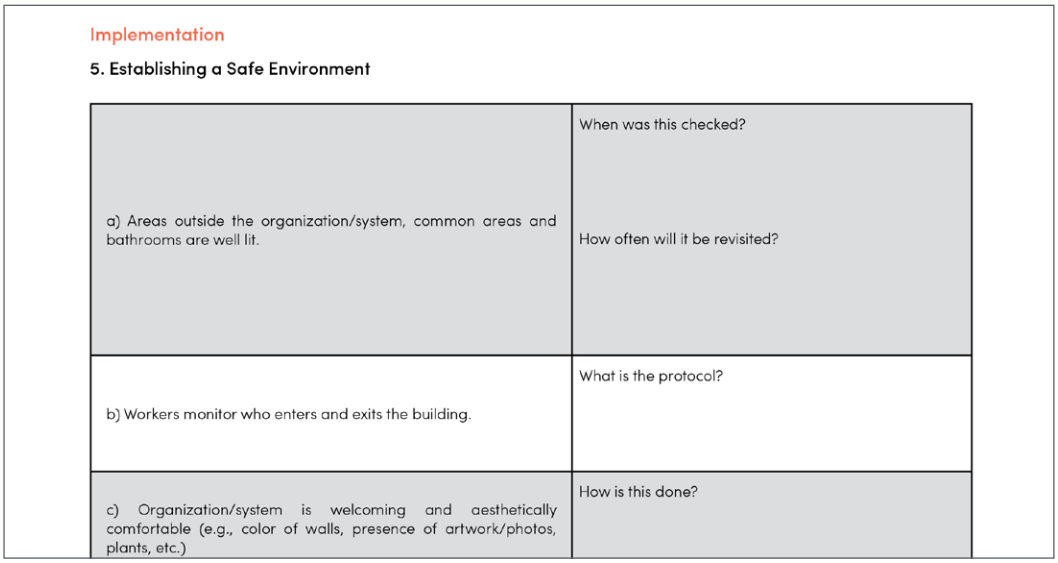
6 **Signage** – Includes reviewing all signs and posted memos for the use of positive language that depicts what is expected rather than what is not allowed (e.g., a sign that says "smoke-free environment" rather than "no smoking"). This also includes ensuring signage is clear, accurate and can be read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

In addition to the considerations listed above, it is important for your organization/system to consider how **workforce interactions and culture** contribute to the overall environment and how safe it feels. Ensuring that all interactions between are validating, affirming and welcoming builds the foundation for an individual's sense of emotional safety. Communication that is **consistent, open and transparent** builds on that foundation—as previously discussed in the Leading and Communicating Key Development Area in both **Pre-Implementation** and **Implementation**. Lastly, considering how the organization/system **conveys the message that everyone's voice truly is important and welcomed** without retaliation is critical to creating an emotionally safe environment.

The majority of the trauma-informed environment walk-through considers factors that help create a sense of safety and feeling welcomed.

Planning and Discussion

The charts found in **Appendix Y** and **Appendix Z** can be used within 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 considerations and format of these worksheets are similar to Appendix A that you reviewed in the Getting Started section of this manual—however, there are 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

5. Establishing a Safe Environment

a) Areas outside the organization/system, common areas and bathrooms are well lit.	When was this checked? How often will it be revisited?
b) Workers monitor who enters and exits the building.	What is the protocol?
c) Organization/system is welcoming and aesthetically comfortable (e.g., color of walls, presence of artwork/photos, plants, etc.)	How is this done?

Figure 29 – Preview of Appendix Z

Key Development Area #6 - Screening for Trauma (I)

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, what tools and follow-up structures are in place to do so. The domain of consideration is:

Screening for Trauma Implementation 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.

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

1 **Setting** – Given that trauma is very personal and often is associated with feelings of shame, considering the setting and role of your organization/ system is important in order for the screening to be less likely to be perceived as intrusive. Settings that focus on the promotion of health (physical and behavioral), 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 office or other specialists).

2 **Ability to Follow Up** – Organizations and systems implementing universal screening need to ensure they have follow-up protocols for positive and negative screens. If the screen is positive and the organization/system does not provide trauma assessment and/or treatment, there needs to be a list of accessible and affordable referrals to

providers who do that is included in the follow-up conversation with the individuals screened. If the screenings are negative, it is still equally important to have a debriefing conversation with them, including the reason for the screening, what the screening indicated and that if they experience symptoms or situations similar to the screening, they can inform the worker for appropriate follow-up and resources.

3 **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 and appropriate given their roles in order 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 to have follow-up conversations and further assess individuals who screen positively.

4 **Use of Screening Tools** – There are multiple validated tools available to conduct trauma screenings, so it is important to choose one of those rather than improvising or workers creating their own questions. (See the next section regarding choosing a tool.) Screening tools 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.

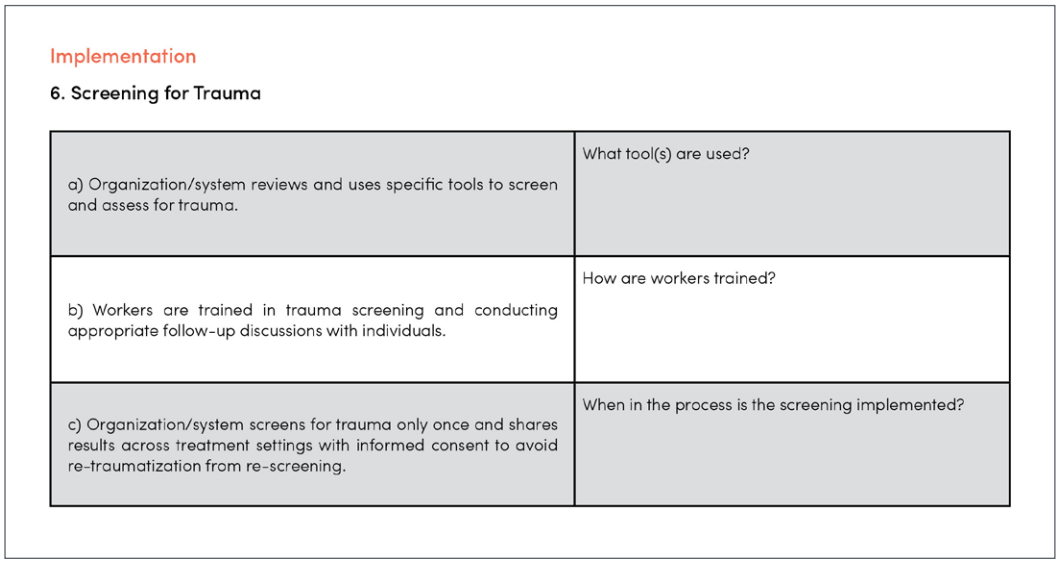
Picking a Screening Tool

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 96 includes references to lists of possible screening and assessment tools that are available. We recommend first checking any 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 prior to selecting a tool.

Self-assessment comprises of a tool that a person moves through on their own (e.g., a questionnaire), whereas a face-to-face interview requires a worker to administer the tool.

Planning and Discussion

The charts found in **Appendix AA** and **Appendix BB** can be used within 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 considerations and format of these worksheets are similar to Appendix A that you reviewed in the Getting Started section of this manual—however, there are 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

6. Screening for Trauma

a) Organization/system reviews and uses specific tools to screen and assess for trauma.	What tool(s) are used?
b) Workers are trained in trauma screening and conducting appropriate follow-up discussions with individuals.	How are workers trained?
c) Organization/system screens for trauma only once and shares results across treatment settings with informed consent to avoid re-traumatization from re-screening.	When in the process is the screening implemented?

Figure 30 – Preview of Appendix BB

Key Development Area #7 - Treating Trauma (I)

The Treating Trauma Key Development Area involves having on-site trauma-specific treatment interventions or accessible referrals in place for individuals who are seeking treatment for their trauma. The domain of consideration is:

Treating Trauma Implementation Objectives:

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

Trauma-Specific Treatment

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 them to general behavioral health services/counseling:. The following treatment interventions are evidence-based and trauma-specific:

1. Cognitive Processing Therapy (CPT)
2. Eye Movement Desensitization Reprocessing (EMDR)
3. Prolonged Exposure
4. Seeking Safety
5. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Individuals who provide any of these treatment interventions 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 their safety and healthy coping skills. Regardless of whether or not a provider states that their workers treat trauma, if they are not trained/certified in any of these treatment interventions, they are not appropriate providers for individuals in need of trauma treatment.

Access to Trauma-Specific Interventions

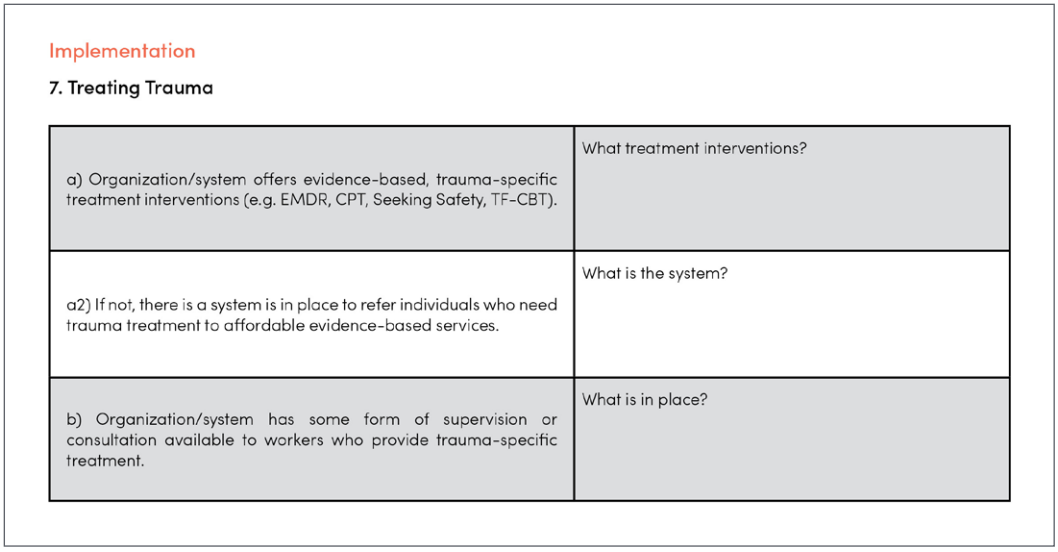
Especially if your organization/system decides to screen for trauma, it is critical that you have resources that individuals can access for trauma-specific treatment. This can occur in two ways:

1. Making the decision to have clinicians within your organization/system who are trained and certified in EMDR, CPT, PE or TF-CBT, or workers who are trained to provide Seeking Safety. If this is the option that you choose, there needs to be a system in place for workers to have regular supervision in order to ensure treatment fidelity and to serve as a support to manage/prevent secondary traumatic stress, vicarious trauma and/or compassion fatigue.

2. Deciding that it does not make sense/it is not possible to offer trauma-specific treatment internally and instead having a referral system in place to send individuals in need of treatment to those that do offer it. This means that your organization/system is aware of which providers and agencies in the community provide trauma-specific treatment that is affordable and accessible to the individuals you work with. Having a directory on-hand for the workforce to provide to individuals who are interested in trauma-specific treatment is also recommended. More information regarding the creation of a directory is discussed in the next key development area—Collaborating with Others (Partners and Referrals).

Planning and Discussion

The charts found in Appendix CC and Appendix DD can be used within the trauma-informed committee to discuss, assess and plan for the components of the Treating Trauma Key Development Area within the Implementation Stage. The considerations and format of these worksheets are similar to Appendix A that you reviewed in the Getting Started section of this manual—however, there are 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

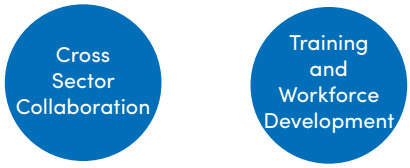
7. Treating Trauma

a) Organization/system offers evidence-based, trauma-specific treatment interventions (e.g. EMDR, CPT, Seeking Safety, TF-CBT).	What treatment interventions?
a2) If not, there is a system is in place to refer individuals who need trauma treatment to affordable evidence-based services.	What is the system?
b) Organization/system has some form of supervision or consultation available to workers who provide trauma-specific treatment.	What is in place?

Figure 31 – Preview of Appendix DD

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

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



Collaborating with Others (Partners and Referrals) Implementation Objectives:

- Determine what levels (trauma-informed, trauma-sensitive, trauma-specific) others are doing 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.

Creating a Referral List

Individuals who have histories of trauma often have a variety of needs. Given the likelihood that any given organization/system does not address all of those needs internally, the focus of this key development area is largely ensuring that partners and referrals are trauma-informed. The first step in the direction of this goal is to create an accurate, up-to-date referral list of agencies/organizations 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 options to find out what services they offer and to get more information about those services.
2. Making personal connections with providers at potential referral options and partner agencies in order to provide a warm handoff whenever possible.
3. Gathering feedback from clients/patients/students/consumers about their experiences in referral settings and take the feedback into consideration when updating the referral list.
4. Being aware to which partner agencies and possible referrals are trauma-informed, trauma-sensitive and trauma-specific—which can be assessed via the three considerations above.
5. Creating a protocol/schedule for regular review of the referral list for accuracy.

It is critical that organizations/systems that are trauma-informed actively collaborate with referrals, partners and other entities to create a trauma-informed network/system of care.

Promoting Cross-Sector Collaboration

Even if your organization/system is trauma-informed, if you refer out to another that is not, the risk for re-traumatization is high. As the trauma-informed movement is still growing, there are many organizations and systems that are in varying stages of understanding and implementation. 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 referrals, partners and other entities to create a trauma-informed network/system of care. In **Pre-Implementation**, you already started a list of those organizations/systems/entities that your organization/system already interacts with using **Appendix I**. 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 that have not yet begun the process of becoming trauma-informed, consider what structures are in place to **promote cross-sector education and training**. Such structures may include inviting partners and referrals 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) or having trainers from your trauma-informed Champion Team offer to go to partners and referrals to provide education and awareness. While larger-scale education efforts like the previous two mentioned are ideal and effective, it is important to consider additional opportunities where your workforce interfaces with others. For example, awareness building, education and advocacy for trauma-informed 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 referrals and partners by using the language of the guiding values and principles and reminding others to be mindful of re-traumatization and the impact of trauma.

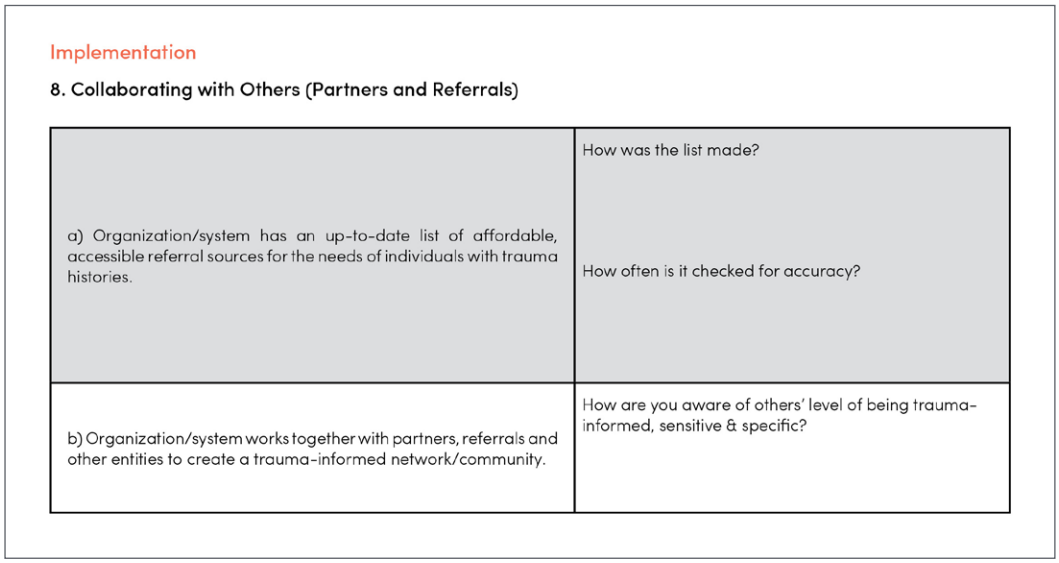
Having formal structures in place for **creating common trauma-informed goals** with partners and referrals is another consideration within this key development area. One example of how we have seen organizations do this is by incorporating language about a trauma-informed approach into their memorandum 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 their trauma-informed efforts and experience.

Such partnerships will continue to contribute to the creation and sustainability of trauma-informed networks and communities.

Planning and Discussion

The charts found in **Appendix EE** and **Appendix FF** can be used within 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 considerations and format of these worksheets are similar to Appendix A that you reviewed in the Getting Started section of this manual—however, there are 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

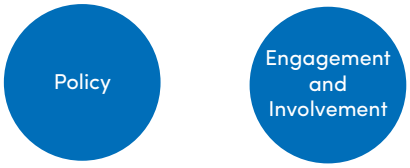
8. Collaborating with Others (Partners and Referrals)

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 entities to create a trauma-informed network/community.	How are you aware of others' level of being trauma-informed, sensitive & specific?

Figure 32 – Preview of Appendix FF

Key Development Area #9 - Reviewing Policies and Procedures (I)

The Reviewing Policies and Procedures Key Development Area 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. The domains of consideration are:



Reviewing Policies and Procedures Implementation Objectives:

- 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 to individuals they pertain to.

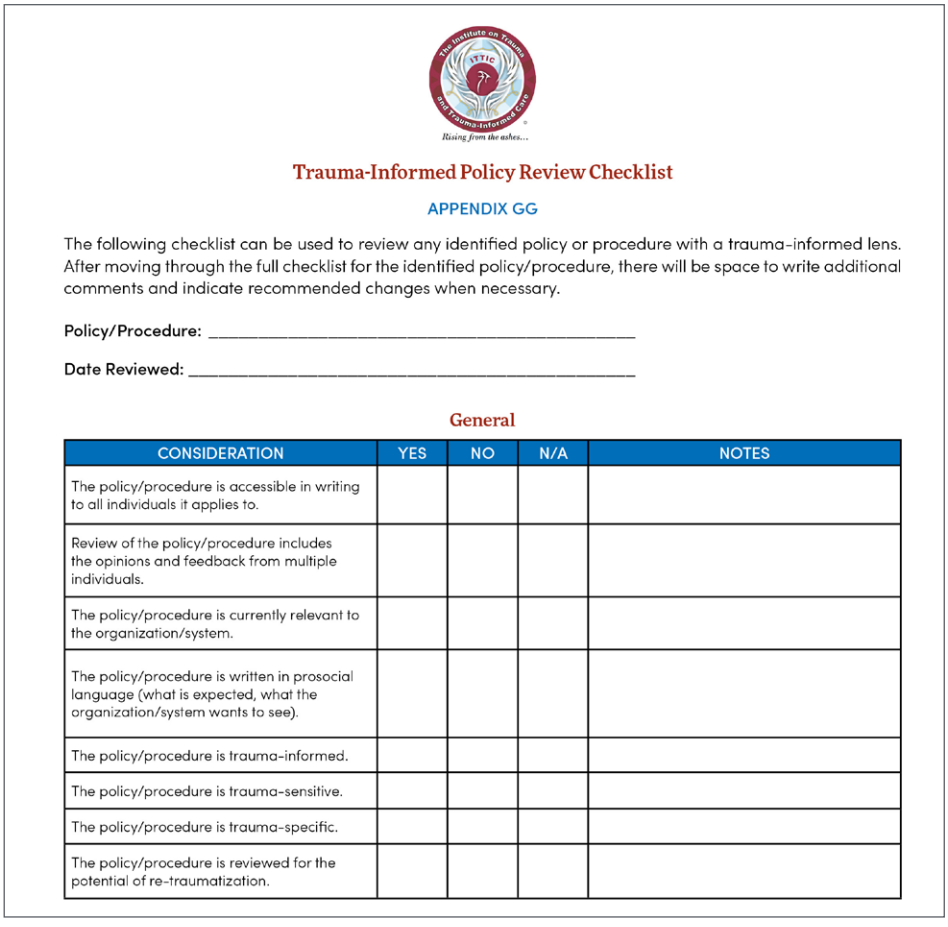
Reviewing Policies Using a Trauma-Informed Lens

The review of policies and procedures from a trauma-informed perspective is critical to the establishment and sustainability of trauma-informed culture change. As previously discussed and addressed during the **Pre-Implementation Stage**, general considerations for this key development area include delineating who is reviewing the policies and procedures, how often they are reviewed and how feedback from those not in charge of reviewing is gathered before formalizing changes. Additionally, where and when are policies/procedures given to staff and clients as applicable, and how are they accessible? 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. 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 GG 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.

• **Potential for Re-Traumatization** – Each policy and procedure need to be reviewed honestly for the potential of re-traumatization of any individual within the organization/system. The re-traumatization chart on page 24 of this manual can be referenced for common trauma dynamics/themes that often play out in service delivery/interactions and will likely bring up someone's trauma history, regardless of the details. 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.

• **Applying the Guiding Values and Principles** – If 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—in order 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 [worker], which could promote trustworthiness.



Trauma-Informed Policy Review Checklist

APPENDIX GG

The following checklist can be used to review any identified policy or procedure with a trauma-informed lens. 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 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 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.				

Figure 33 – Preview of Appendix GG

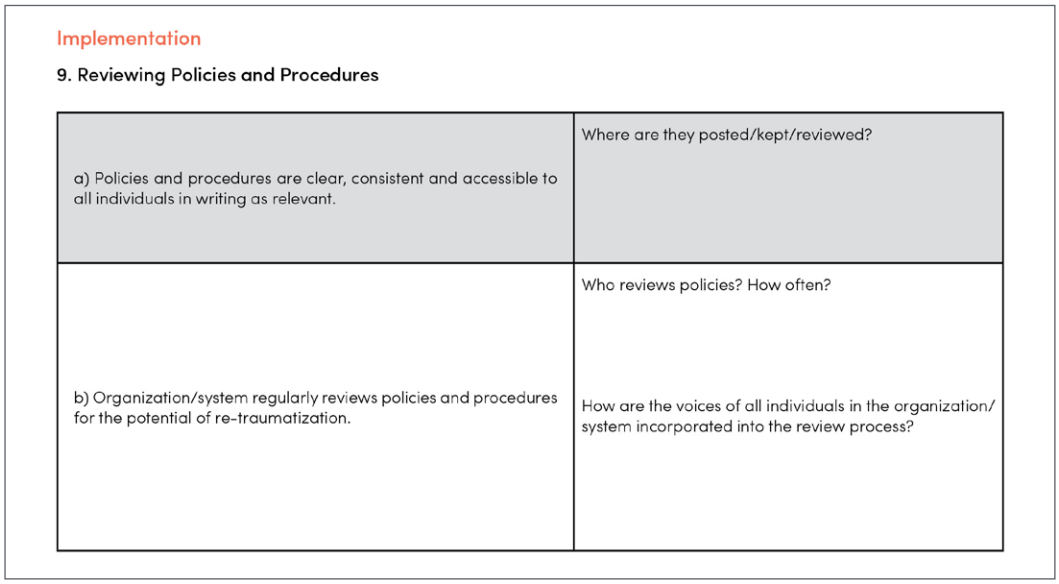
• **Written Language** – Once the policies/procedures are anchored in a trauma-informed approach, it is important to review the way they are written—looking at the language used. Similar to the considerations already discussed in the Hiring and Orientation Practices Key Development Area in relation to reviewing the employee handbook and other HR documents, 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 solution-focused language is not a black-and-white science, there are a few general guidelines to consider:

- **Ensure expectations are written in order to describe the desired behavior/outcome** rather than using "no," "not allowed," "cannot," etc. For example, reframing 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 the policy/procedure/form 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 supervisor." to "In the event of an emergency, workers are expected to first call 9-1-1 and then notify their supervisor."
- **Review the policy/procedure/form for any jargon or professional language** that may limit the ability of individuals to understand the meaning—thus increasing overall transparency.

While the use of trauma-informed and positive language is important, it is 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 absolute language or language that describes what is not allowed from a protocol may leave workers unclear regarding what is expected of them—thus not anchoring the principle of trustworthiness. We have learned in our experience 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 clear and well-defined expectations in the procedure.

Planning and Discussion

The charts found in **Appendix HH** and **Appendix II** can be used within 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 considerations and format of these worksheets are similar to Appendix A that you reviewed in the Getting Started section of this manual—however, there are 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

9. Reviewing Policies and Procedures

a) Policies and procedures are clear, consistent and accessible to all individuals in writing as relevant.	Where are they posted/kept/reviewed?
b) Organization/system regularly reviews policies and procedures for the potential of re-traumatization.	Who reviews policies? How often? How are the voices of all individuals in the organization/ system incorporated into the review process?

Figure 34 – Preview of Appendix II

Stage 3: Sustainability

Overview

The focus of the Sustainability Stage is for the organization/system to continue integrating the trauma-informed approach and practices into its fabric so it becomes a natural part of everything that the organization/system is and does. While there is a new key development area specific to this stage (Evaluating and Monitoring Progress), we advise you to consider sustainability as something that is fluid—key development areas may fluctuate between Implementation and Sustainability at any time. Once the organization/system addresses each of the considerations in the key development areas, it is critical for overall sustainability that there are mechanisms in place to monitor progress. Such mechanisms include formal and informal means of evaluation and assessment. In addition, the organization/system will want to consolidate gains in each of the key development areas, revisiting each of the considerations and tweaking the implementation plan as needed.

KEY DEVELOPMENT AREAS

1. Leading and Communicating
2. Hiring and Orientation Practices
3. Training Clinical and Non-Clinical Staff
4. Addressing the Impact of the Work
5. Establishing a Safe Environment
6. Screening for Trauma
7. Treating Trauma
8. Collaborating with Others (Partners and Referrals)
9. Reviewing Policies and Procedures
10. Evaluating and Monitoring Progress

All 10 key development areas need to be considered for overall sustainability of the trauma-informed change process. With the exception of Evaluating and Monitoring Progress, this section of the manual is structured differently from the rest in that it will ask you to revisit specific parts of the appendices referenced in the previous section. It focuses more on providing checklists for sustaining each of the key development areas rather than providing informational narrative.

Critical Components of the Sustainability Stage

- Ongoing evaluation of the trauma-informed change process, including:
  - Assessing the impact on culture, climate and outcome data
  - Acknowledging/consolidating successes and gains
  - Revisiting each key development area and tweaking implementation as needed
  - Getting feedback from all levels of the workforce and clients/patients/students/consumers

Key Development Area #10 - Evaluating and Monitoring Progress (S)

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 Sustainability Objectives:

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

Evaluating Impact on Culture and Climate

In the **Pre-Implementation Stage**, we discussed the importance of taking a baseline evaluation of how trauma-informed the organization/system is prior to any implementation. The first consideration within the Evaluating and Monitoring Progress Key Development Area is conducting subsequent evaluations to compare to the baseline. The purpose of this formal evaluation is to monitor overall culture and climate change through workforce perceptions of the five guiding values and principles of a trauma-informed approach. We recommend that when possible, use the same evaluation tool as the one used in the baseline so that it is possible to compare data and monitor overall progress. As previously mentioned, there is a list of evaluation tool options that can be used for this purpose in the Additional Resources section on page 98.

Evaluating Impact on Outcome Data and Quality Improvement

An important component to consider—especially if/when grant funding is sought out—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, evidence that implementing it contributes to or leads to positive benefits for the workforce and clients/patients/students/consumers is critical. Tracking changes in data already collected often does not require additional work on the part of the organization/system—just someone to look at any changes from prior to trauma-informed implementation and regularly 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.

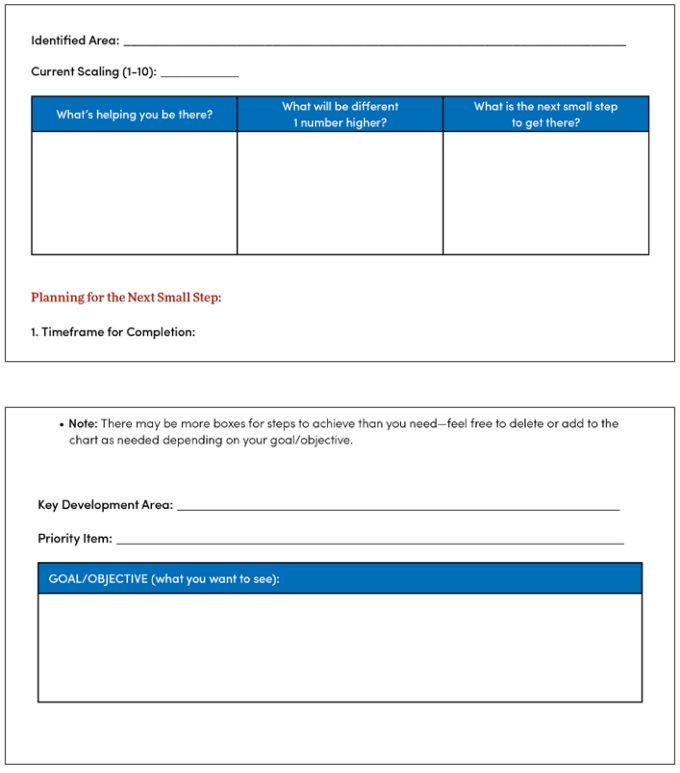
With regard to quality improvement measures specifically, part of this key development area is incorporating the trauma-informed approach directly into the measures already being used.

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.

Revisiting the Key Development Areas

In addition to formal evaluation of the impact of the trauma-informed change process on the organization/system, it is critical for overall sustainability to regularly revisit each of the key development areas. As a reminder, the boundary between Implementation and Sustainability is fluid—as the considerations for each development area are reviewed, the implementation plan may need to be tweaked, re-implemented and reassessed. This reevaluation process with the goal of further integration into the organization/system is the essence of sustainability.

Being in the Sustainability Stage means reviewing each of the considerations within the key development areas with the lens of what needs improvement or tweaking to ensure continued integration. The appendices referenced under each key development area below can be used to assess improvement by using the numerical scale for each. We advise for every consideration rated a 1-9 on the scale that you use either or both of the worksheets in Appendix JJ and Appendix KK in order to create action steps to improve the level of implementation within that identified area. Directions for their use can be found at the beginning of each appendix.



Identified Area: _____

Current Scaling (1-10): _____

What's helping you be there?	What will be different 1 number higher?	What is the next small step to get there?

Planning for the Next Small Step:

1. Timeframe for Completion:

• **Note:** There may be more boxes for steps to achieve than you need—feel free to delete or add to the chart as needed depending on your goal/objective.

Key Development Area: _____

Priority Item: _____

GOAL/OBJECTIVE (what you want to see):

Figure 34 – Preview of Appendix JJ and KK

Lastly, the brief checklists included below provide a quick means of ensuring you have mechanisms in place to sustain each development area.

LEADING AND COMMUNICATING

- [ ] Appendices B and O are regularly used to scale each consideration and create next steps as needed
- [ ] Resources needed to support ongoing trauma-informed integration are currently available
- [ ] The trauma-informed committee meets regularly to monitor implementation and integration

HIRING AND ORIENTATION PRACTICES

- [ ] Appendices E and Q are regularly used to scale each consideration and create next steps as needed

TRAINING THE WORKFORCE (CLINICAL AND NON-CLINICAL)

- [ ] Appendix T is regularly used to scale each consideration and create next steps as needed
- [ ] Ongoing trauma-informed training and education is provided to all levels of the workforce

ADDRESSING THE IMPACT OF THE WORK

- [ ] Appendix V is regularly used to scale each consideration and create next steps as needed

ESTABLISHING A SAFE ENVIRONMENT

- [ ] Appendices G and Y are regularly used to scale each consideration and create next steps as needed
- [ ] A program walk-through is regularly conducted to review physical environment
- [ ] Feedback from all individuals is regularly elicited regarding physical environment

SCREENING FOR TRAUMA

- [ ] Appendix AA is regularly used to scale each consideration and create next steps as needed
- [ ] A mechanism to track the use of trauma screening/assessment tools is in place

TREATING TRAUMA

- [ ] Appendix CC is regularly used to scale each consideration and create next steps as needed
- [ ] A mechanism to track the use of trauma treatment is in place as applicable
- [ ] Clinical supervision is given to workers who provide trauma treatment regularly

COLLABORATING WITH OTHERS (PARTNERS AND REFERRALS)

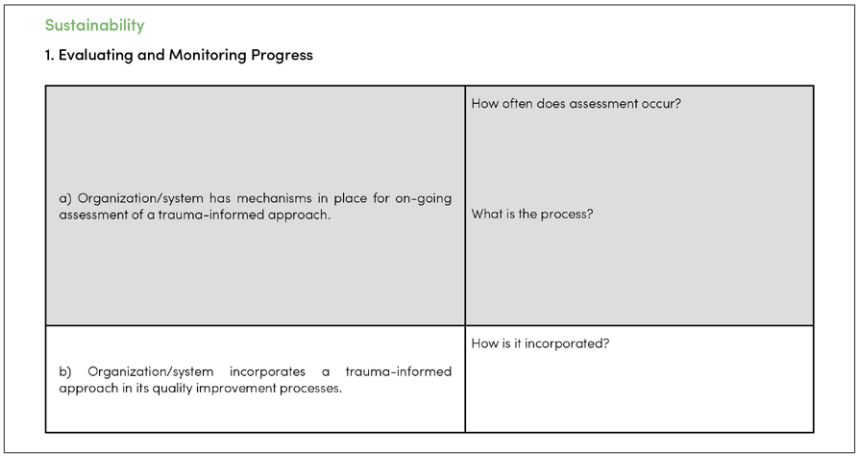
- [ ] Appendices J and EE are regularly used to scale each consideration and create next steps as needed
- [ ] A referral list is regularly reviewed for accuracy and accessibility

REVIEWING POLICIES AND PROCEDURES

- [ ] Appendices L and HH are regularly used to scale each consideration and create next steps as needed
- [ ] A plan is in place to regularly review all policies and procedures

Planning and Discussion

In addition to the appendices from previous key development areas mentioned throughout this section, the charts found in **Appendix LL** and **Appendix MM** can be used within the trauma-informed committee to discuss, assess and plan for the components specific to the Evaluating and Monitoring Progress Key Development Area within the Sustainability Stage. The considerations and format are similar to Appendix A that you reviewed in the Getting Started section of this manual—however, there are 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

1. Evaluating and Monitoring Progress

a) Organization/system has mechanisms in place for on-going assessment of a trauma-informed approach.	How often does assessment occur? What is the process?
b) Organization/system incorporates a trauma-informed approach in its quality improvement processes.	How is it incorporated?

Figure 36 – Preview of Appendix MM

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

http://traumainformedoregon.org/wp-content/uploads/2016/07/Sample-Trauma-Informed-Care-Newsletters.pdf

Baseline Evaluation

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

Hiring and Orientation Practices

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/trauma/docs/HRPolicyGuidance32017.pdf

- 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

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

Supervision

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

http://proqol.org/ProQol_Test.html

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

https://www.nctsn.org/sites/default/files/resources/fact-sheet/using_the_secondary_traumatic_stress_core_competencies_in_trauma-informed_supervision.pdf

- 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/

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

http://traumainformedoregon.org/wp-content/uploads/2016/01/Agency-Environmental-Components-for-Trauma-Informed-Care-1.pdf

Screening for Trauma

General Screening Considerations

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

https://www.centerforebp.case.edu/client-files/events-supportmaterials/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.acesconnection.com/g/resource-center/blog/resource-list-extended-aces-surveys

- 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://emdria.site-ym.com/general/custom.asp?page=findatherapistmain

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-Informed Care Organizational Self-Assessment Tool

https://www.ccsi.org/Pages/TIC-OSAT

- 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

http://www.traumainformedcareproject.org/resources/Trauam%20Informed%20Organizational%20Survey_9_13.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

Purpose: The charts in Appendix A 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 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) Organization/system has a mission/vision statement and strategic plan that reflect a commitment to a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
a1) Leadership team (including administration, board of directors, etc.) has training on trauma and a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
a2) Leadership team allocates some of their own time to the creation and sustainability of a trauma-informed organization.	1 2 3 4 5 6 7 8 9 10
b) Organization/system has a designated workgroup/committee/team to lead the trauma-informed change process.	1 2 3 4 5 6 7 8 9 10
b1) Resources (time, money, and workers) are available to support trauma-informed efforts and activities.	1 2 3 4 5 6 7 8 9 10
b2) Organization/system has strategies for engaging all individuals in the trauma-informed change process.	1 2 3 4 5 6 7 8 9 10
c) Organization completes a trauma-informed organizational self-assessment as a baseline evaluation.	1 2 3 4 5 6 7 8 9 10

Pre-Implementation

2. Hiring and Orientation Practices

a) Organization/system plans 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 designs trauma-informed interview questions with a focus on hiring employees who are knowledgeable about trauma and a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
c) Organization/system prepares for new-hire orientation to include a foundation Trauma 101 presentation that covers trauma/adversity, re-traumatization and an introduction to a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10

5. Establishing a Safe Environment

a) Organization/system considers aspects of the physical environment that make a difference in individuals feeling comfortable and welcomed when designing or re-designing the physical space.	1 2 3 4 5 6 7 8 9 10
b) Organization/system considers what it has already done with regard to making trauma-informed changes to its physical space.	1 2 3 4 5 6 7 8 9 10

6. Collaborating with Others (Partners and Referrals)

a) Organization/system identifies opportunities to collaborate with partners, referrals and/or other entities in ways that deliberately incorporate a trauma-informed approach together.	1 2 3 4 5 6 7 8 9 10
b) Organization/system recognizes others' level of a trauma-informed approach (trauma-informed, trauma-sensitive, and trauma-specific).	1 2 3 4 5 6 7 8 9 10

9. Reviewing Policies and Procedures

a) Organization/system creates a plan for the review of policies and procedures, including who will review, how often and how feedback will be gathered from those not directly involved in the reviewing process.	1 2 3 4 5 6 7 8 9 10
b) 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

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 workgroup/committee/team leading the trauma-informed change process meets regularly to plan and execute implementation steps.	1 2 3 4 5 6 7 8 9 10
b1) Resources (time, money, and workers) are available to support trauma-informed efforts and activities.	1 2 3 4 5 6 7 8 9 10
b2) Organization/system actively engages all individuals in the trauma-informed change process.	1 2 3 4 5 6 7 8 9 10
c) Leadership has strategies for consistent and transparent messaging regarding the trauma-informed change process (e.g., newsletter, email, staff meetings, etc.)	1 2 3 4 5 6 7 8 9 10

2. Hiring and Orientation Practices

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 recruitment, application and interview processes reflect the values and principles of a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
c) 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
d) Organization/system provides new employees their job expectations, rights and responsibilities in writing.	1 2 3 4 5 6 7 8 9 10

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

a) All workers—clinical and non-clinical—receive foundation "trauma 101" education that covers trauma/adversity, 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 on trauma and a trauma-informed approach regularly.	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, 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

3. Training the Workforce (Clinical and Non-Clinical), *Continued*

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 establishes and trains a Champion Team, including mentors, trainers and coaches for overall sustainability.	1 2 3 4 5 6 7 8 9 10

4. Addressing the Impact of the Work

a) All workers—clinical and non-clinical—receive training on secondary trauma, vicarious trauma, burnout and compassion fatigue.	1 2 3 4 5 6 7 8 9 10
b) Workers receive regularly scheduled 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.	1 2 3 4 5 6 7 8 9 10
e) Leadership regularly checks in with the workforce.	1 2 3 4 5 6 7 8 9 10
f) Organization/system helps workers debrief after a crisis/incident.	1 2 3 4 5 6 7 8 9 10

5. Establishing a Safe Environment

a) Areas outside the organization/system, common areas and bathrooms are well lit.	1 2 3 4 5 6 7 8 9 10
b) Workers monitor who enters and exits the building.	1 2 3 4 5 6 7 8 9 10
c) 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
d) Signs use positive, welcoming language, and state the desired or "prosocial" behavior.	1 2 3 4 5 6 7 8 9 10
e) Organization/system has a designated "safe space" for workers to practice self-care.	1 2 3 4 5 6 7 8 9 10
f) Physical environment is culturally responsive.	1 2 3 4 5 6 7 8 9 10
g) Common areas, service areas, bathrooms and bedrooms consider privacy and accessibility.	1 2 3 4 5 6 7 8 9 10
h) Workers welcome individuals and ensure they feel respected and supported in all interactions.	1 2 3 4 5 6 7 8 9 10

5. Establishing a Safe Environment, *Continued*

i) Workers maintain consistent, open and compassionate communication.	1 2 3 4 5 6 7 8 9 10
j) Organization/system elicits feedback about the physical environment from all individuals.	1 2 3 4 5 6 7 8 9 10
k) 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

6. Screening for Trauma

a) Organization/system reviews and uses specific tools to screen and assess for trauma.	1 2 3 4 5 6 7 8 9 10
b) 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) Organization/system screens for trauma only once and shares results across treatment settings with informed consent to avoid re-traumatization from re-screening.	1 2 3 4 5 6 7 8 9 10
d) Screening is followed as appropriate by a more extensive trauma assessment.	1 2 3 4 5 6 7 8 9 10
e) Organization/system has a protocol for both positive and negative screens, including an updated list of referrals if trauma treatment is not offered on-site.	1 2 3 4 5 6 7 8 9 10

7. Treating Trauma

a) Organization/system offers evidence-based, trauma-specific treatment interventions (e.g., EMDR, CPT, Seeking Safety, TF-CBT).	1 2 3 4 5 6 7 8 9 10
a2) If not, there is a system is in place to refer individuals who need trauma treatment to affordable evidence-based services.	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

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 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

8. Collaborating with Others (Partners and Referrals), *Continued*

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 from services is thoughtful, gradual and includes referrals to trauma-informed resources.	1 2 3 4 5 6 7 8 9 10

9. Reviewing Policies and Procedures

a) Policies and procedures are clear, consistent and accessible to all individuals in writing as relevant.	1 2 3 4 5 6 7 8 9 10
b) Organization/system regularly reviews policies and procedures for the potential of re-traumatization.	1 2 3 4 5 6 7 8 9 10
c) Policies and procedures are anchored in the values and principles of a trauma-informed approach: safety, trustworthiness, choice, collaboration and empowerment.	1 2 3 4 5 6 7 8 9 10
d) Organization/system has a de-escalation or "code blue" policy to minimize the potential for re-traumatization.	1 2 3 4 5 6 7 8 9 10
e) Written safety/crisis plans are incorporated into treatment plans.	1 2 3 4 5 6 7 8 9 10
f) Individual rights, responsibilities and expectations are clear and easily accessible.	1 2 3 4 5 6 7 8 9 10
g) Policies are written in positive language that depict the desired or "prosocial" behavior.	1 2 3 4 5 6 7 8 9 10

Sustainability

1. Evaluating and Monitoring Progress

a) Organization/system has mechanisms in place for on-going assessment of a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
b) Organization/system incorporates a trauma-informed approach in its quality improvement processes.	1 2 3 4 5 6 7 8 9 10
c) Leadership receive 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 Oregon (2017). The Roadmap to trauma informed care. Retrieved from http://traumainformedoregon.org/roadmap-trauma-informed-care/

Trauma-Informed Organizational Model Planning

USING APPENDIX B

Purpose: The chart in Appendix B 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 C**, 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) Organization/system has a mission/vision statement and strategic plan that reflect a commitment to a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
a1) Leadership team (including administration, board of directors, etc.) has training on trauma and a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
a2) Leadership team allocates some of their own time to the creation and sustainability of a trauma-informed organization.	1 2 3 4 5 6 7 8 9 10
b) Organization/system has a designated workgroup/committee/team to lead the trauma-informed change process.	1 2 3 4 5 6 7 8 9 10
b1) Resources (time, money, and workers) are available to support trauma-informed efforts and activities.	1 2 3 4 5 6 7 8 9 10
b2) Organization/system has strategies for engaging all individuals in the trauma-informed change process.	1 2 3 4 5 6 7 8 9 10
c) Organization completes a trauma-informed organizational self-assessment as a baseline 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

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 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 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 B**, 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) Organization/system has a mission/vision statement and strategic plan that reflect a commitment to a trauma-informed approach.	What is the statement?
a1) Leadership team (including administration, board of directors, etc.) has training on trauma and a trauma-informed approach.	What was it/what is the plan? How will it be sustained?
a2) Leadership team allocates some of their own time to the creation and sustainability of a trauma-informed organization.	What is the plan?

1. Leading and Communicating, *Continued*

b) Organization/system has a designated workgroup/committee/ team to lead the trauma-informed change process.	Who is on it? What is their trauma-informed knowledge?
b1) Resources (time, money, and workers) are available to support trauma-informed efforts and activities.	What are they?
b2) Organization/system has strategies for engaging all individuals in the trauma-informed change process.	What are the strategies? Who will you engage?
c) Organization completes a trauma-informed organizational self-assessment as a baseline evaluation.	What are they?

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 Interview Questions

APPENDIX D

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.**

- Please talk about what it means to be trauma-informed in your work.
- 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 principle of *[principle]* in your work.
- Please talk about your understanding of how trauma 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 and 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 principle of trustworthiness in order to address the situation.
- 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?

- 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?
- What aspects of the trauma-informed approach would you like to know more about?
- 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]*.
- 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 E

Purpose: The chart in Appendix E will invite you to re-visit the Hiring and Orientation Practices 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 F**, 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. Hiring and Orientation Practices

a) Organization/system plans 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 designs trauma-informed interview questions with a focus on hiring employees who are knowledgeable about trauma and a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
c) Organization/system prepares for new-hire orientation to include a foundation Trauma 101 presentation that covers trauma/adversity, re-traumatization and an introduction to a trauma-informed approach.	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

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 F

Purpose: The chart in Appendix F will invite you to re-visit the Hiring and Orientation Practices 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 E**, 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. Hiring and Orientation Practices

a) Organization/system plans 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 designs trauma-informed interview questions with a focus on hiring employees who are knowledgeable about trauma and a trauma-informed approach.	What are the questions?
c) Organization/system prepares for new-hire orientation to include a foundation Trauma 101 presentation that covers trauma/adversity, re-traumatization and an introduction to a trauma-informed approach.	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

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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 G

Purpose: The chart in Appendix G 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 H**, 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 considers aspects of the physical environment that make a difference in individuals feeling comfortable and welcomed when designing or re-designing the physical space.	1 2 3 4 5 6 7 8 9 10
b) Organization/system considers what it has already done with regard to making trauma-informed changes to its physical space.	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 H

Purpose: The chart in Appendix H 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 G**, 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 considers aspects of the physical environment that make a difference in individuals feeling comfortable and welcomed when designing or re-designing the physical space.	How were aspects of the physical environment considered?
b) Organization/system considers what it has already done with regard to making trauma-informed changes to its physical space.	What changes were made?

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 I

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 J

Purpose: The chart in Appendix J 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 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

5. Collaborating with Others (Partners and Referrals)

a) Organization/system identifies opportunities to collaborate with partners, referrals and/or other entities in ways that deliberately incorporate a trauma-informed approach together.	1 2 3 4 5 6 7 8 9 10
b) Organization/system recognizes others' level of a trauma-informed approach (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

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 K

Purpose: The chart in Appendix K 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 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 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

5. Collaborating with Others (Partners and Referrals)

a) Organization/system identifies opportunities to collaborate with partners, referrals and/or other entities in ways that deliberately incorporate a trauma-informed approach together.	Who are your partners, referrals, others regularly interfaced with? What opportunities were identified?
b) Organization/system recognizes others' level of a trauma-informed approach (trauma-informed, trauma-sensitive, and trauma-specific).	How was 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

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Trauma-Informed Organizational Model Planning

USING APPENDIX L

Purpose: The chart in Appendix B 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 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.

Pre-Implementation

9. Reviewing Policies and Procedures

a) Organization/system creates a plan for the review of policies and procedures, including who will review, how often and how feedback will be gathered from those not directly involved in the reviewing process.	1 2 3 4 5 6 7 8 9 10
b) 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

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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 M

Purpose: The chart in Appendix M 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 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 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.

Pre-Implementation

9. Reviewing Policies and Procedures

a) Organization/system creates a plan for the review of policies and procedures, including who will review, how often and how feedback will be gathered from those not directly involved in the reviewing process.	What is the plan? How often?
b) 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

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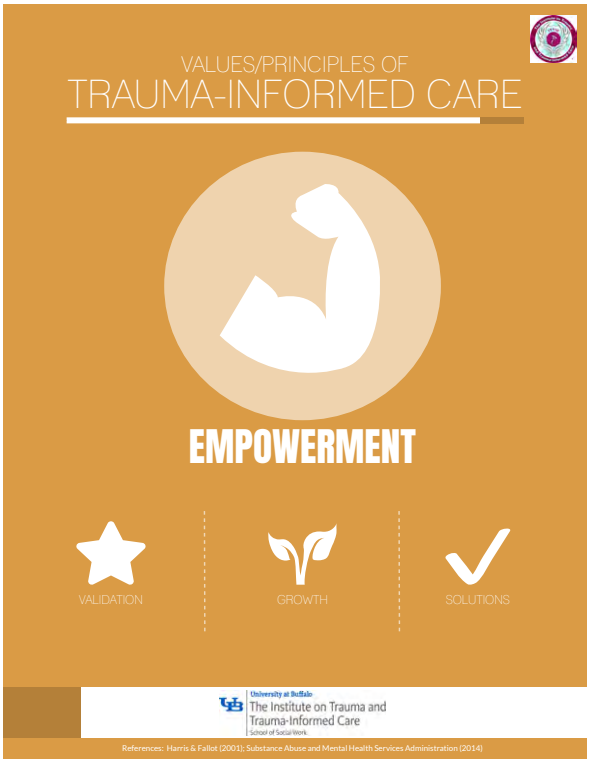
Sample Trauma-Informed Messaging Posters

APPENDIX N



Trauma-Informed Organizational Model Planning

USING APPENDIX O

Purpose: The chart in Appendix O 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 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.

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 workgroup/committee/team leading the trauma-informed change process meets regularly to plan and execute implementation steps.	1 2 3 4 5 6 7 8 9 10
b1) Resources (time, money, and workers) are available to support trauma-informed efforts and activities.	1 2 3 4 5 6 7 8 9 10

1. Leading and Communicating, *Continued*

b2) Organization/system actively engages all individuals in the trauma-informed change process.	1 2 3 4 5 6 7 8 9 10
c) Leadership has strategies for consistent and transparent messaging regarding the trauma-informed change process (e.g., newsletter, email, staff meetings, 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

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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 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 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 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.

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 is the plan?
b) Organization/system's designated workgroup/committee/team leading the trauma-informed change process meets regularly to plan and execute implementation steps.	How often do they meet? What is the plan?

1. Leading and Communicating, *Continued*

b1) Resources (time, money, and workers) are available to support trauma-informed efforts and activities.	What are they?
b2) Organization/system actively engages all individuals in the trauma-informed change process.	What are the strategies? Who is being engaged?
c) Leadership has strategies for consistent and transparent messaging regarding the trauma-informed change process (e.g. newsletter, email, staff meetings, etc.)	What are the 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

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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 Q

Purpose: The chart in Appendix Q 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 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

2. Hiring and Orientation Practices

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 recruitment, application and interview processes reflect the values and principles of a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
c) 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
d) 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

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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 Hiring and Orientation Practices 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 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 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

2. Hiring and Orientation Practices

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 recruitment, application and interview processes reflect the values and principles of a trauma-informed approach.	How are they reflected?

2. Hiring and Orientation Practices, *Continued*

c) Organization/system reviews their employee handbook, employee rights/responsibilities, job descriptions, etc. with a trauma-informed lens.	Who reviewed? What was the process?
d) Organization/system provides new employees their job expectations, rights and responsibilities in writing.	How/when are they provided?

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 S

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 T

Purpose: The chart in Appendix T 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 U**, 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, 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 on trauma and a trauma-informed approach regularly.	1 2 3 4 5 6 7 8 9 10
c) Clinical workers are trained in evidence-based, trauma-specific treatment interventions (i.e. EMDR, CPT, 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

3. Training the Workforce (Clinical and Non-Clinical), *Continued*

e) All workers receive training on supporting, managing and responding to reactivity (i.e. 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 establishes and trains a Champion Team, including mentors, trainers and coaches for overall sustainability.	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 U

Purpose: The chart in Appendix U 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 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 T**, 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, 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 on trauma and a trauma-informed approach regularly.	What is the plan?
c) Clinical workers are trained in evidence-based, trauma-specific treatment interventions (i.e. EMDR, CPT, TF-CBT) when possible.	What treatment interventions?

3. Training the Workforce (Clinical and Non-Clinical), *Continued*

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 (i.e. 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?
h) Organization/system establishes and trains a Champion Team, including mentors, trainers and coaches for overall sustainability.	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

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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 secondary trauma, vicarious trauma, burnout and compassion fatigue.	1 2 3 4 5 6 7 8 9 10
b) Workers receive regularly scheduled 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.	1 2 3 4 5 6 7 8 9 10

4. Addressing the Impact of the Work, *Continued*

e) Leadership regularly checks in with the workforce.	1 2 3 4 5 6 7 8 9 10
f) Organization/system helps workers debrief after a crisis/incident.	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

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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 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 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 secondary trauma, vicarious trauma, burnout and compassion fatigue.	What is the training? When does it occur?
b) Workers receive regularly scheduled supervision.	How often?
c) Supervision allows opportunities for workers to explore their own stress reactions, self-care and wellness.	How is this done?

Implementation

4. Addressing the Impact of the Work, *Continued*

d) Leadership actively encourages and promotes workforce wellness and self-care.	Are staff allowed time off Are staff encouraged to take time off for personal reasons?
e) Leadership regularly checks in with the workforce.	Who is leadership? How is this done? How is there communication between leadership and staff and vice versa?
f) Organization/system helps workers debrief after a crisis/ incident.	What is the process? Who does the debriefing? Is the training in how to debrief in a trauma-informed way?

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/

Action Plan

USING APPENDIX X

Purpose: Appendix X will assist in assessing the physical environment of your organization/system. Our walk-through is broken into four main areas—outside, waiting areas, service/common areas and bathrooms.

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 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
• Security measures are in place if necessary	1	2	3	4

Narrative/Comments:

Waiting Area

• Area is clean, free of odor	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:				
- Cultural 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
• Emergency protocols posted	1	2	3	4
• Client rights/expectations posted	1	2	3	4
• Signage:				
- Positive language/images	1	2	3	4
- Clear, visible and updated	1	2	3	4

Narrative/Comments:

Service/Common Areas

- Area is clean, free of odor 1 2 3 4
- Private spaces are used to meet with clients 1 2 3 4
- Designated "safe space" for staff and clients 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
- Area is welcoming and comfortable:
  - Cultural artwork/photos 1 2 3 4
  - Plants 1 2 3 4
  - Soothing colors on walls 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

Narrative/Comments:

Bathrooms

• Easily accessible (for both clients and staff)	1	2	3	4
• Clean, free of odor	1	2	3	4
• Well-lit	1	2	3	4

Narrative/Comments:

Action

NEXT STEPS	TIMEFRAME/PERSON(S) RESPONSIBLE
Outside:	
Waiting Area:	
Service/Common Areas:	
Bathrooms:	

Trauma-Informed Organizational Model Planning

USING APPENDIX Y

Purpose: The chart in Appendix O 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 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.

Implementation

5. Establishing a Safe Environment

a) Areas outside the organization/system, common areas and bathrooms are well lit.	1 2 3 4 5 6 7 8 9 10
b) Workers monitor who enters and exits the building.	1 2 3 4 5 6 7 8 9 10
c) 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
d) Signs use positive, welcoming language, and state the desired or "prosocial" behavior.	1 2 3 4 5 6 7 8 9 10

5. Establishing a Safe Environment, *Continued*

e) Organization/system has a designated "safe space" for workers to practice self-care.	1 2 3 4 5 6 7 8 9 10
f) Physical environment is culturally responsive.	1 2 3 4 5 6 7 8 9 10
g) Common areas, service areas, bathrooms and bedrooms consider privacy and accessibility.	1 2 3 4 5 6 7 8 9 10
h) Workers welcome individuals and ensure they feel respected and supported in all interactions.	1 2 3 4 5 6 7 8 9 10
i) Workers maintain consistent, open and compassionate communication.	1 2 3 4 5 6 7 8 9 10
j) Organization/system elicits feedback about the physical environment from all individuals.	1 2 3 4 5 6 7 8 9 10
k) 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

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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 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.

Implementation

5. Establishing a Safe Environment

a) Areas outside the organization/system, common areas and bathrooms are well lit.	When was this checked? How often will it be revisited?
b) Workers monitor who enters and exits the building.	What is the protocol?
c) Organization/system is welcoming and aesthetically comfortable (e.g., color of walls, presence of artwork/photos, plants, etc.)	How is this done?

5. Establishing a Safe Environment, *Continued*

d) 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?
e) Organization/system has a designated "safe space" for workers to practice self-care.	What does this look like?
f) Physical environment is culturally responsive.	When was this checked? How often will it be revisited?
g) Common areas, service areas, bathrooms and bedrooms consider privacy and accessibility.	How is privacy and accessibility considered?
h) Workers welcome individuals and ensure they feel respected and supported in all interactions.	How is this done?
i) Workers maintain consistent, open and compassionate communication.	How is this done?
j) Organization/system elicits feedback about the physical environment from all individuals.	How often is feedback elicited? What is done with the feedback?

5. Establishing a Safe Environment, *Continued*

k) 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 messaged conveyed?

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 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 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

6. Screening for Trauma

a) Organization/system reviews and uses specific tools to screen and assess for trauma.	1 2 3 4 5 6 7 8 9 10
b) 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) Organization/system screens for trauma only once and shares results across treatment settings with informed consent to avoid re-traumatization from re-screening.	1 2 3 4 5 6 7 8 9 10

6. Screening for Trauma

d) Screening is followed as appropriate by a more extensive trauma assessment.	1 2 3 4 5 6 7 8 9 10
e) Organization/system has a protocol for both positive and negative screens, including an updated list of referrals if trauma 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

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 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 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

6. Screening for Trauma

a) Organization/system reviews and uses specific tools to screen and assess for trauma.	What tool(s) are used?
b) Workers are trained in trauma screening and conducting appropriate follow-up discussions with individuals.	How are workers trained?
c) Organization/system screens for trauma only once and shares results across treatment settings with informed consent to avoid re-traumatization from re-screening.	When in the process is the screening implemented?

6. Screening for Trauma

d) Screening is followed as appropriate by a more extensive trauma assessment.	Does the organization/system provide trauma assessment in-house? If not, what referrals are in place?
e) Organization/system has a protocol for both positive and negative screens, including an updated list of referrals if trauma treatment is not offered on-site.	What is the protocol? What options are available for trauma treatment on-site? Referrals?

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 CC

Purpose: The chart in Appendix CC 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 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.

Implementation

7. Treating Trauma

a) Organization/system offers evidence-based, trauma-specific treatment interventions (e.g., EMDR, CPT, Seeking Safety, TF-CBT).	1 2 3 4 5 6 7 8 9 10
a2) If not, there is a system is in place to refer individuals who need trauma treatment to affordable evidence-based services.	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

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 DD

Purpose: The chart in Appendix CC 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 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 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.

Implementation

7. Treating Trauma

a) Organization/system offers evidence-based, trauma-specific treatment interventions (e.g. EMDR, CPT, Seeking Safety, TF-CBT).	What treatment interventions?
a2) If not, there is a system is in place to refer individuals who need trauma treatment to affordable evidence-based services.	What is the system?
b) Organization/system has some form of supervision or consultation available to workers who provide trauma-specific treatment.	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

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 EE

Purpose: The chart in Appendix EE 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 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

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 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 from services is thoughtful, gradual and includes referrals to trauma-informed resources.	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 FF

Purpose: The chart in Appendix FF 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 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 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

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 entities to create a trauma-informed network/community.	How are you aware of others' level of being trauma-informed, sensitive & specific?

8. Collaborating with Others (Partners and Referrals), *Continued*

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 from services is thoughtful, gradual and includes referrals to trauma-informed resources.	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

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 Policy Review Checklist

APPENDIX GG

The following checklist can be used to review any identified policy or procedure with a trauma-informed lens. 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 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 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.				

Safety

CONSIDERATION	YES	NO	N/A	NOTES
The policy/procedure considers emotional safety of individuals.				
The policy/procedure considers physical safety of individuals.				
The policy/procedure is reviewed for 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 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 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 individuals within the organization/system.				
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 promotes 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 HH

Purpose: The chart in Appendix HH 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 II**, 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) Policies and procedures are clear, consistent and accessible to all individuals in writing as relevant.	1 2 3 4 5 6 7 8 9 10
b) Organization/system regularly reviews policies and procedures for the potential of re-traumatization.	1 2 3 4 5 6 7 8 9 10
c) Policies and procedures are anchored in the values and principles of a trauma-informed approach: safety, trustworthiness, choice, collaboration and empowerment.	1 2 3 4 5 6 7 8 9 10
d) Organization/system has a de-escalation or "code blue" policy to minimize the potential for re-traumatization.	1 2 3 4 5 6 7 8 9 10

9. Reviewing Policies and Procedures, *Continued*

e) Written safety/crisis plans are incorporated into treatment plans	1 2 3 4 5 6 7 8 9 10
f) Individual rights, responsibilities and expectations are clear and easily accessible.	1 2 3 4 5 6 7 8 9 10
g) Policies are written in positive language that depict the desired or "prosocial" behavior.	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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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 II

Purpose: The chart in Appendix C 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 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 HH**, 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) Policies and procedures are clear, consistent and accessible to all individuals in writing as relevant.	Where are they posted/kept/reviewed?
b) Organization/system regularly reviews policies and procedures for the potential of re-traumatization.	Who reviews policies? How often? How are the voices of all individuals in the organization/system incorporated into the review process?

9. Reviewing Policies and Procedures, *Continued*

c) Policies and procedures are anchored in the values and principles of a trauma-informed approach: safety, trustworthiness, choice, collaboration and empowerment.	How was this ensured?
d) Organization/system has a de-escalation or "code blue" policy to minimize the potential for re-traumatization.	What is the policy?
e) Written safety/crisis plans are incorporated into treatment plans.	How is this done?
f) Individual rights, responsibilities and expectations are clear and easily accessible.	Where are they posted/kept/received?
g) Policies are written in positive language that depict the desired or "prosocial" behavior.	How was this ensured?

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Trauma-Informed Organizational Model Planning

USING APPENDIX JJ

Purpose: The chart in Appendix JJ can be used in combination with any of the previous key development area appendices that asked you to rate your organization/system on a scale from 1-10 (listed in the blue box below). The purpose of this chart is to help you begin action planning by determining what the next small step needed for improvement is.

Pre-Implementation

Appendix B – Leading and Communicating
Appendix E – Hiring and Orientation Practices
Appendix G – Establishing a Safe Environment
Appendix J – Collaborating with Others
Appendix L – Review Policies and Procedures

Sustainability

Appendix LL – Evaluating and Monitoring Progress

Implementation

Appendix O – Leading and Communicating
Appendix Q – Hiring and Orientation Practices
Appendix T – Training the Workforce
Appendix V – Addressing the Impact of the Work
Appendix Y – Establishing a Safe Environment
Appendix AA – Screening for Trauma
Appendix CC – Treating Trauma
Appendix EE – Collaborating with Others
Appendix GG – Reviewing Policies and Procedures

Directions:

1. Record the key development area and specific consideration (from the chart in one of the appendices listed above) you would like to plan for improvement within on the "identified area" line.

2. Transfer the number (1-10) you rated you organization/system at to the "current scaling (1-10)" line.

3. Fill in the chart and remaining questions to begin formulating the next small step for improvement, timeline for completion and who will be responsible for the task.

Identified Area: _____

Current Scaling (1-10): _____

What's helping you be there?	What will be different 1 number higher?	What is the next small step to get there?

Planning for the Next Small Step:

1. Timeframe for Completion:

2. Lead Staff Member:

3. Who Takes it From Here:

Trauma-Informed Organizational Model Planning

USING APPENDIX KK

Purpose: The chart in Appendix KK can be used to create action planning goals that are specific, measurable, attainable and time-bound, relevant to a particular priority item within any of the key development areas.

Directions:

1. Identify which key development area you would like to create a goal/objective for and indicate it on the "key development area" line.

2. Within that key development area, pick a priority item and indicate it on the "priority item" line.

- For example, perhaps within Establishing a Safe Environment, your organization/system may pick something like "waiting room appearance."

3. Fill out the remaining chart to turn your priority area into a goal/objective that is measurable, anchored in the values and principles and levels of a trauma-informed approach, has specific action steps and person(s) responsible, as well as a timeframe for each step.

- **Note:** There may be more boxes for steps to achieve than you need—feel free to delete or add to the chart as needed depending on your goal/objective.

Key Development Area: _____

Priority Item: _____

GOAL/OBJECTIVE (what you want to see):

HOW WILL YOU KNOW IT HAS BEEN ACHIEVED?:

STEPS TO ACHIEVE GOAL/OBJECTIVE	VALUES/PRINICPLES OF TIC	LEVEL OF TRAUMA PRACTICE	PERSONS RESPONSIBLE	TIMELINE
	☐ Safety ☐ Trustworthiness ☐ Choice ☐ Collaboration ☐ Empowerment	☐ Trauma-Informed ☐ Trauma-Sensitive ☐ Trauma-Specific		
	☐ Safety ☐ Trustworthiness ☐ Choice ☐ Collaboration ☐ Empowerment	☐ Trauma-Informed ☐ Trauma-Sensitive ☐ Trauma-Specific		
	☐ Safety ☐ Trustworthiness ☐ Choice ☐ Collaboration ☐ Empowerment	☐ Trauma-Informed ☐ Trauma-Sensitive ☐ Trauma-Specific		
	☐ Safety ☐ Trustworthiness ☐ Choice ☐ Collaboration ☐ Empowerment	☐ Trauma-Informed ☐ Trauma-Sensitive ☐ Trauma-Specific		
	☐ Safety ☐ Trustworthiness ☐ Choice ☐ Collaboration ☐ Empowerment	☐ 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 Evaluating and Monitoring Progress Key Development Area within the **Sustainability 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.

Sustainability

1. Evaluating and Monitoring Progress

a) Organization/system has mechanisms in place for on-going assessment of a trauma-informed approach.	1 2 3 4 5 6 7 8 9 10
b) Organization/system incorporates a trauma-informed approach in its quality improvement processes.	1 2 3 4 5 6 7 8 9 10
c) Leadership receive 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 MM

Purpose: The chart in Appendix MM will invite you to re-visit the Evaluating and Monitoring Progress Key Development Area within the **Sustainability 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 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.

Sustainability

1. Evaluating and Monitoring Progress

a) Organization/system has mechanisms in place for on-going assessment of a trauma-informed approach.	How often does assessment occur? What is the process?
b) Organization/system incorporates a trauma-informed approach in its quality improvement processes.	How is it incorporated?

1. Evaluating and Monitoring Progress, *Continued*

c) Leadership receive 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?
e) Organization/system is transparent in sharing evaluation data and regularly responds to feedback/evaluation.	How does the organization/system report out on evaluation results? 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 Climate Scale-10 (TICS-10)

APPENDIX NN

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.

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

_____ 2. There are opportunities for me to gain additional skills through workshops and trainings.

_____ 3. The leadership listens only to their favorite employees.

_____ 4. I don't have many choices when it comes to doing my job.

_____ 5. I may disagree with administration, but at least I always know where they stand.

_____ 6. Areas within the building sometimes make me feel trapped or unsafe.

_____ 7. Staff is not supported when they try and find new and better ways to do things.

_____ 8. This organization doesn't seem to care whether staff gets what they need to do their jobs well.

_____ 9. Supervisors and administrators recognize my strengths and skills.

_____ 10. I am uncomfortable with a co-worker at work.

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. _____ = _____

** 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.

Interpreting your score

TICS-10 Total	Interpretation
40-50	High T-I Environment
35-39	Moderate T-I Environment
< 35	Low T-I Environment

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