Addressing Stress and Trauma in Recovery-oriented Systems And Communities

A Challenge to Leadership

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ATTC Addiction Technology Transfer Center Network
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Acknowledgments

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We wish to acknowledge the dedication and generosity of our principal teacher, mentor, and champion in the realm of recovery-oriented systems of care (ROSC), William L. White, MA, Emeritus Senior Research Consultant, Chestnut Health Systems. We also wish to thank our many other sources of inspiration and knowledge on the subjects of ROSC and trauma-informed care (TIC). Their names are too numerous to mention, but the body of work they have produced has saved lives and transformed our approaches forever. SAMHSA has also been a strong, enthusiastic supporter of both movements, through its Center for Substance Abuse Treatment, Center for Mental Health Services, National Center for Trauma-informed Care, and its many ROSC and TIC projects and initiatives.

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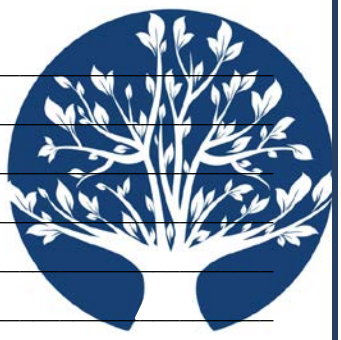
Notes



Section 1: The Role of Leadership

We believe that America is facing a public health crisis of major proportions. The health of our citizens, our economic productivity, the stability of our institutions, and our global leadership are all being undermined by social conditions creating toxic levels of stress, which in turn interact with biological vulnerabilities to affect both individuals and communities.

—Andrea Blanch and David Shern[1]

What if many of the most daunting challenges to human well being had a common center, and you had the tools to reach into that center and begin to heal, not only human lives, but also the families, communities, and service systems that hold those lives?

What if you found a shield that could protect the people you have served, that could turn away many of the forces that erode the strength you have worked so hard to help them build?

What if these and other tools fit together, worked together, made one another stronger by their mutual presence? But there was only one catch: You had to share them—not just share them, but actively engage others in their use, and keep going even when you hit the hard crust of the way things have always been done.

This is where you are right now, as a leader and as a human being. You may think this manual is about trauma-informed care (TIC) within recovery-oriented systems of care (ROSC), but it is really about you—what you are already doing, what you have the opportunity to do, and what you are willing to do.

Trauma-informed Care

"Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization."

National Center for Trauma-Informed Care (NCTIC), Substance Abuse and Mental Health Services

Step One: Understanding

Progress toward effective responses to toxic stress and trauma has often suffered at the hands of widely held misconceptions, including:

[1] Blanch, A.K. and Shern, D.L. (2011). Implementing the new "germ" theory for the public's health: A call to action. Alexandria, VA: Mental Health America.

- Treating the word "trauma" as if it were synonymous with posttraumatic stress disorder (PTSD), one of the many conditions that sometimes arise in the wake of trauma
- Thinking of trauma only as something that occurs in an individual in response to an isolated event or a single type of experience
- Taking a narrow view of the types of experiences that contribute to trauma, and thinking of trauma as a purely psychological phenomenon, and entirely separate from the continuum of human stress exposure and response
- Confusing trauma-informed care with trauma-focused (sometimes called trauma-specific) treatment—therapeutic approaches designed to heal the effects of trauma, in many cases by processing memories of traumatic experiences
- The assumption that an organization can implement trauma-informed care (TIC) by holding a "one-shot" training for clinical staff
- The assumption that TIC and ROSC models are entirely separate constructs, to be addressed separately and supported with separate human and financial resources
- A belief that TIC and ROSC are the concerns of behavioral health organizations and systems alone, with little or no relationship to the many health and human service systems that surround them, and the communities they serve

Recovery

"A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."

SAMHSA, 2011

Recovery-oriented Systems of Care

"…a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems."

William L. White, in

In reality:

- Human experience runs on a continuum that includes mild stress, extreme stress, toxic stress, and the kinds of pain and danger that instill trauma.
- These conditions can come from many types of experiences in the life of an individual, a family, a community, or a culture, and can trigger a wide variety of effects.
- Trauma-informed care and recovery-oriented systems of care are allied and interdependent models, with implications for—and requiring the involvement of—every aspect of organizations, systems, communities, and society as a whole.
- Trauma-informed care nurtures and protects the core of the human being, and recovery-oriented systems nurture and protect the fruits of the healing process, but their roots and branches are intertwined.
- TIC and ROSC resources are meant to protect, not only individuals and families, but also entire organizations, service systems, and communities.
- TIC and ROSC approaches foster long-term healing, not just from substance use disorders or mental health challenges, but from many of the chronic physical, social,

behavioral, educational, economic, and legal problems that join forces to snuff out human hope and potential and destroy individuals, families, and communities.

It is the role and responsibility of every leader to put the resources of trauma-informed care and recovery-oriented systems of care to work.

About This Document

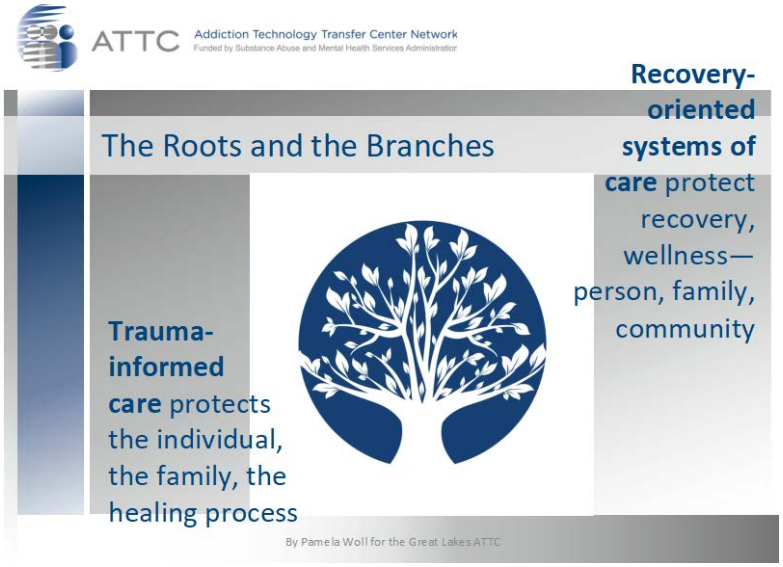
Addressing Stress and Trauma in Recovery-oriented Systems and Communities: A Challenge to Leadership is an exploration of concepts addressed in the Executive Briefing presentation of the same name, developed for the Great Lakes Addiction Technology Center by Pamela Woll, MA, CADP. It is designed to stimulate thought, start conversations, promote understanding, point out resources, and suggest opportunities for collaboration.

Like the Executive Briefing, this manual provides a high-level overview of:

- Two central considerations in building a truly useful vision to guide planning
- Toxic Stress and Trauma and their growing impact on individuals, families, and communities
- Principles and practices of trauma-informed care
- Where trauma-informed care fits within recovery-oriented systems of care, and in relation to other common health and human service conceptual models
- TIC implementation models and resources
- Considerations for trauma training and staff support
- Challenges to be addressed in the planning process

At the end of each Section is a brief "Action Notes" box, inviting you to look at the current cost of toxic stress and trauma in your system, measures already in place, additional measures and resources you might try, and other partners you might be willing to enlist in these efforts.

Using a Team Approach



The most influential person in your system may be the least likely to have time to read this document—and even less likely to have time to complete the Action Notes—but like virtually everything discussed in the Sections that follow, reading and responding to the manual can be a group effort. For example, an organization—or better yet, multiple organizations or departments within an organization—might:

- Divide the Action Notes strategically—perhaps by role, interest, or influence—among the central people involved in the planning process

- Coordinate efforts among multiple partner organizations, departments, or initiatives
- Convene after people have read their sections and started or finished their Action Notes, and discuss what they have learned and what they are willing to do

Ideally, this would take place as part of—or inspire the establishment of—an ongoing TIC/ROSC learning community within the organization. Those who have the time, and those who are willing to carve out the time, can become the resident experts who inform the planning process. Their knowledge must come, not just from books and articles, but also from significant input from staff, volunteers, service participants, family members, and community members.

One note about terminology: When the words "we" and "our" are used in this document, they refer, not to the publishing organization or even to the behavioral health field, but to society as a whole. These words are used deliberately, as a way of emphasizing our collective responsibility, invoking our collective knowledge base, and soliciting our collective efforts. All these are needed—urgently—for the sake of our collective well being.

Action Notes for Section 1

Is there a team in your organization, system, or community that is already studying the kinds of issues and possibilities addressed in this manual, and would you be willing to share this with them? If not, is there a team—or combination of teams—that would be an appropriate body to explore the concepts and suggestions presented in the manual?

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If you were to design a team—or add to an existing team—to study this manual and pull ideas from it, which individuals, organizations, or departments within your organization, system, or community would you invite into the team?

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_____

Who would you like to see in charge of the team?

_____

What would your role be?

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At this point, before you read the rest of the document, what do you think the team's greatest challenges might be?

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What do you think the team's greatest (internal or external) resources might be?

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Section 2: Transforming the Vision

The greatest danger for most of us is not that our aim is too high and we miss it, but that it is too low and we reach it.

—Michaelangelo[2]

A well directed response requires vision, which requires clear and well directed sight. But in the avalanche of information available on toxic stress and trauma, it can be difficult to stay focused on the center of all the problems and possible solutions. So here are two challenges—and opportunities—to consider in transforming our collective vision.

First Challenge: Focusing on Strength, Resilience, and Recovery

Toxic stress and trauma are widespread, often devastating experiences. Their effects wound the body and the mind, rob families of peace and safety, and far too often prove fatal. There are real victims and, in many cases, real perpetrators. These are medical issues, moral issues, social justice issues, and criminal justice issues. When we learn of the many effects of toxic stress and trauma, our natural reactions include shock, sadness, empathy, and anger.

Under the weight of all these realities, we might find it difficult to take strength-based approaches, yet these approaches are essential to recovery. Strength-based approaches:

- Affirm the dignity and freedom of all people, no matter how many indignities they have suffered, no matter how many challenges they still face
- Walk with "victims" until they understand that they are survivors, and walk with survivors until they take their place as heroes in their own and others' lives
- Generate hope by identifying and believing in the values, aspirations, attributes, and skills that each individual embodies and cultivates in the healing process
- Make it safe for the individual to reclaim—and in some cases claim for the first time—the power of choice and the power of true connection with healthy people
- Make it safe for the story to be told, heard, honored, and eventually transformed
- Protect, nourish, empower, and sustain, not only people who have experienced toxic stress and trauma, but also the friends, family members, neighbors, and service providers who witness their pain and rejoice in their success

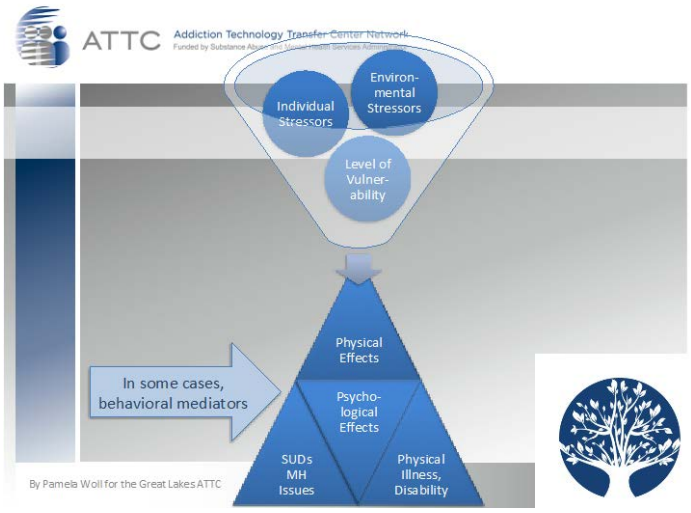
[2] Attributed without citation in Ken Robinson (2009), *The Element*, p. 260, and often attributed to Michelangelo since the late 1990s.

In a field where service plans and service reimbursement are based on diagnoses and symptoms, it may be difficult to move beyond the inclusion of a few strength-based questions in the assessment process, and staff training in pointing out people's positive qualities. In a community that has experienced the negative effects of some community members' post-trauma symptoms, it may be hard not to think in terms of "good citizens" and "bad citizens." In a society where any form of flaw or weakness is stigmatized—often in defense against our own sense of human vulnerability and limitation—it may be difficult to recognize and acknowledge the strength that lives in even the most troubled human being. But we must learn to do all these difficult things, if we want to promote well being, healing, and recovery.

Second Challenge: Looking at the Whole Picture

Toxic stress, trauma, and their effects are most often considered and dealt with on an individual basis—person by person, experience by experience, symptom by symptom, and diagnosis by diagnosis. This response may point to effective ways of addressing specific symptoms and diagnoses, but it fails to address the synergy of all these elements. It can also have only limited impact on the forces—including some elements of our own service delivery systems and approaches—that spread and perpetuate toxic stress and trauma.

Only a look at the big picture can bring all the little pictures into focus. And although our society has often thought of toxic stress as a social issue and trauma as a therapeutic one, it is both logical and useful to consider them together. For example:



- All these experiences meet in the human body, mind, and spirit, where they combine to wield powerful influence over our development, our physical and neurological health and balance, the way we process stress and emotions, the way we perceive and treat ourselves and others, and the sense we make of our experiences and our worlds.
- The way we react to a particular stressor is sometimes influenced primarily by that stressor, but often influenced by the shape that a combination of stressors has taken in our lives.
- We are, after all, human beings. The many layers of stories we carry with us cannot be reduced to the categories that assessment forms, funding streams, and clinical protocols require. These stories may not dictate the terms of policy, treatment, or recovery

support, but they must be honored and must feed the wisdom of all who seek to help. If we know how to listen, each human story becomes a story of strength.

One important implication of all this is that:

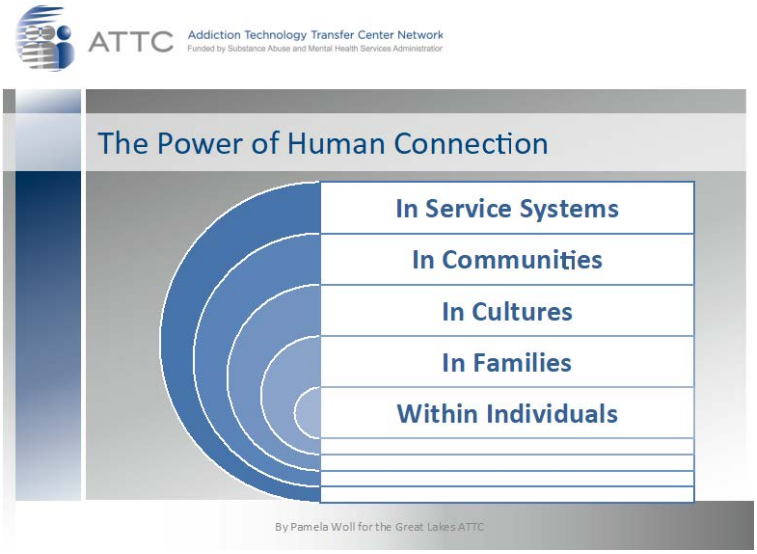
- Psychological trauma is the concern, not only of behavioral health and recovery support, but also of medicine, policy, and the community as a whole.
- Social justice is the concern, not only of policy and community leaders, but also of public health, medicine, prevention, intervention, treatment, and recovery support providers.
- Understanding and prevention of trauma—in this generation and the next—is everyone's concern.

Turning Challenges into Opportunities

Here are a few ways leaders can begin to approach these responsibilities we all share:

- **Use toxic stress and trauma as a lens** through which you can hone your understanding of the many challenges you see in individuals, families, systems, and communities.
- **Use resilience, trauma-informed care, trauma-informed systems, and trauma-informed communities as a lens** through which you can assess potential solutions and guide the development of policies and programs, within and beyond your own system.
- **Incorporate resilience, stress, trauma, and trauma-informed care** into your concepts of recovery-oriented systems of care and other models that guide your vision.
- **Incorporate a long-term recovery focus** and the integration of recovery support services, rooted in the community, into your concept of trauma-informed care.
- **Commit whatever resources you can to implementing strength-based, recovery-oriented, trauma-informed approaches** in all of the processes, personnel, organizations, systems, and communities you influence—and be open to creative ways of leveraging and sharing resources, to reap the greatest benefit in spite of budgetary limitations.
- **Be a vocal and persistent coalition builder and advocate** of integrative, multidisciplinary, multi-system, big-picture approaches toward addressing the problem of toxic stress and trauma—and all its causes and effects—on community and societal levels.

And here is the beginning of a vision that these measures might help us approach:



- **Behavioral health and recovery support providers and systems** that initiate and conduct integrated, multi-system efforts to identify and intervene in the progression of traumagenic circumstances and post-trauma effects
- **Prevention programs** that collaborate with public health entities and with the range of community-based efforts to promote safe, respectful, and supportive communities, schools, youth-serving organizations, social service providers, and medical care
- **Treatment and recovery support systems and providers** that collaborate with schools and medical, child welfare, and social service systems and their providers in the development and implementation of safe, evidence-based screening, brief intervention, and referral efforts in these community-based locations
- **Behavioral health assessment processes** that are overwhelmingly strength-based and include safe, respectful, non-stigmatizing, evidence-based questions to identify the presence of trauma and the need for trauma-specific assessment
- **Strength-based, evidence-based assessment and appropriate referral** to individualized trauma-informed treatment and recovery support for all children, youth, and adults who need behavioral health services, and trauma-focused assessment and referral of those identified as possible trauma survivors or living in currently traumagenic circumstances
- **Safe, effective, evidence-based trauma-focused treatment** available to all who need it and can safely engage in it, no matter where or why they entered the treatment system

- **Referrals that follow "warm referral" principles and practices**, with support, assistance, and follow-up by the referring provider, and trained and effective peer support during the referral and transition process

The remaining sections describe a variety of tools for moving toward this vision, tools that are meant to be shared and adapted to the strengths and challenges of each community.

Action Notes for Section 2

At this point, how would you describe your vision for trauma-informed responses?

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Section 3: Resilience, Stress and Trauma

We have learned, given the numbers of trauma survivors and their often debilitating post-traumatic responses, that this constitutes a public health challenge of the first magnitude.

—Susan Salasin[3]

As we approach the subject of toxic stress and trauma, it is important that we bring with us an enduring vision of resilience, the ground that these weeds invade and the soil that nourishes healing and recovery. In some form, resilience lives even in the most painful circumstances. For the woman or man whose symptoms make getting out of bed and stepping into the shower an almost insurmountable challenge, just showing up at your door and asking for help can be a stunning act of strength and courage.

Resilience

"…the ability to adapt well over time to life-changing situations and stressful conditions."

SAMHSA

Toxic stress and trauma have strong and often direct impact on human vulnerability to a wide variety of physical, developmental, medical, psychiatric, behavioral, social, cultural, spiritual, criminal justice, educational, employment, economic, and human rights challenges—many of them life threatening. A few examples:

- The chronic stress inflicted by poverty or low income, unemployment, poor nutrition, racism/prejudice/stigma and discrimination, life in troubled families and communities, environments that reflect a sense of hopelessness, chronic or terminal illness in oneself or a loved one, and a host of other conditions can cause a sort of "weathering" process that can hinder development, wear down human stress and immune systems, and speed up the aging process.[4]
- Acute and chronic exposure to experiences of extreme stress and threat can destabilize human responses to stress and fundamentally change people's relationship with the memory of traumatic experiences, in some cases leading to conditions such as posttraumatic stress disorder (PTSD).
- The experience of toxic stress and trauma can also raise vulnerability to a variety of other mental health challenges,

Toxic stress

A term often applied to children's experience but relevant to many adults as well, toxic stress is caused by "exposure to excessive adversity," leading to "strong, unrelieved activation of the body's stress management system."

Center for the Developing

Trauma

"Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being."

[3] Salisan, S. (2011). Sine qua non for public health. *National Council Magazine*, 2011, Issue 2.

[4] Geronimus, A.T., Hicken, M., Keene, D. and Bound, J. (2006). *American Journal of Public Health, 96*(5), 826-833.

e.g., anxiety disorders, depressive disorders (including bipolar disorder), personality disorders, conduct disorders, and psychotic disorders.[5]

A Few Clarification Points

Traumagenic Experiences

Events and circumstances with the potential to overwhelm coping abilities

Trauma

The individual's subjective experience at the time

Post-trauma Effects

Physical, psychological, social, and spiritual effects, ranging from mild and/or temporary challenges to increased vulnerability to more serious acute or chronic conditions

- People who experience severe or chronic neglect and/or abuse in childhood are particularly vulnerable to lifelong challenges in attachment and stress and emotion regulation and other symptoms of complex or developmental trauma.[6]
- The use of alcohol or drugs to "medicate" the pain left by toxic stress and trauma can raise the risk of substance use disorders, affect many other areas of functioning, and place people in dangerous situations with high potential for retraumatization.[7]
- Toxic stress and trauma often have lasting physical effects on natural brain chemicals, hormones, muscle tension, heart rate, inflammation, and immune functioning, effects that can raise th e risk of many acute and chronic illnesses.[8] Behavioral reactions to the pain left by trauma (e.g., alcohol and drug use, overeating, lack of self-care, unprotected sex) can further increase this risk.
- Trauma in one generation can affect future generations, often through its effects on parents' behavior, attachment styles, and modeling of responses to stress; family functioning; cultural identity; and levels of resources available to the family, the community and/or the culture, and through "epigenetic"

[5] Heim, C. and Nemeroff, C.B. (2001). The role of childhood trauma in the neurobiology of mood and anxiety disorders: preclinical and clinical studies. *Biological Psychiatry, 49*(12), 1023-1039.

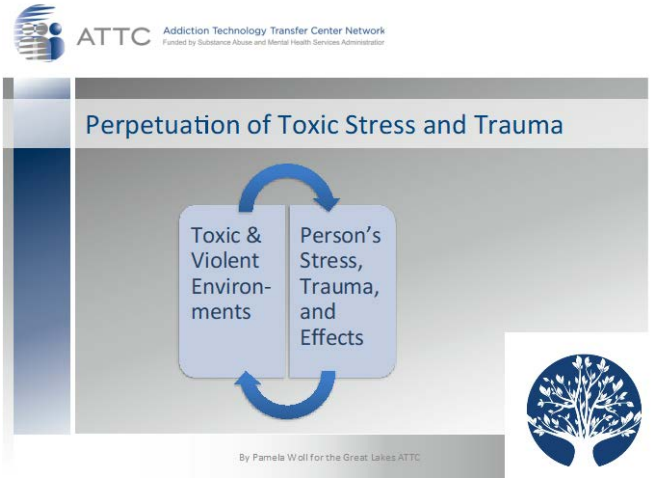
[6] Perry, B.D., Pollard, R.A., Blakley, T.L., Baker, W.L. and Vigilante, D. (1996). Childhood trauma, the neurobiology of adaptation, and use-dependent development of the brain: How states become traits. *Infant Mental Health Journal, 16*(4), 271-291.

[7] Najavits, L.M. (2002). *Seeking Safety: A treatment manual for PTSD and substance abuse.* New York: The Guilford Press.

[8] Scaer, R. (2005). *The trauma spectrum: Hidden wounds and human resiliency.* New York: W.W. Norton & Company.

changes that affect the way our DNA expresses itself.[9]

There are so many pathways (e.g., genetic, biological, behavioral, social, environmental) through which the effects of toxic stress and trauma are passed on—from experience to person, from person to reaction, from reaction to the next person, and from generation to generation—that these conditions might accurately be described as highly contagious and self-perpetuating. Among the strongest factors that can increase individuals', families', and communities' vulnerability are social isolation and lack of access to resources.[10]



At the same time, the impact of trauma is clearly an injury, though it may trigger a number of different injuries, illnesses, and disabilities.

The Scope of the Problem

Toxic stressors and traumagenic circumstances are all around us, particularly in the communities served by public health and treatment systems. Growing economic challenges in these communities, and the erosion of funding for services, foster increases in deprivation, fear, frustration, and hopelessness, sometimes leading to escalating levels of crime and violence and diminishing levels of social support, self-care, and help-seeking.

According to Fallot and Harris (2009), "National community-based surveys find that between 55 and 90% of us have experienced at least one traumatic event. And individuals report, on average, that they have experienced nearly five traumatic events in their lifetimes."[11] However, the problem extends far beyond traumatic "events." Many people—particularly people who find their way to public treatment, child welfare, and criminal justice settings—have lived with multiple forms of prolonged or recurring traumagenic circumstances. The number, intensity, and chronicity of these circumstances often add layers of complexity to people's post-trauma effects and layers of difficulty to the challenge of addressing them.

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[9] Yehuda, R. and Bierer, L.M. (2007). Transgenerational transmission of cortisol and PTSD risk. *Progress in Brain Research, 167*, 121-135. Brave Heart, M.Y.H. (2003). The historical trauma response among Natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs, 35,* 7–13. Danieli, Y., Ed. (1998). *International handbook of multigenerational legacies of trauma.* New York: Plenum Press.

[10] Woll, P., Evans, A.C., Berkowitz, S., Jackson, K., and Achara-Abrahams, I. (2013). Safety, strength, resilience, and recovery: Trauma-informed systems and communities. Philadelphia, PA: Department of Behavioral Health and Intellectual disAbility Services.

[11] Fallot and Harris (2009). Creating Cultures of Trauma-informed Care. Washington, DC: Community Connections, p. 1.

In the Adverse Childhood Experiences (ACE) Study, Kaiser Permanente and the Centers for Disease Control and Prevention interviewed 17,421 respondents from a general, largely affluent HMO adult (average 57 years) population. They looked at the prevalence of ten types of adverse childhood experiences (ACEs), including various forms of abuse, neglect, and family dysfunction. A respondent's "ACE score" indicated the total number of types of ACEs he or she had experienced. More than half reported at least one type of ACE, one fourth reported two or more types of ACEs, and one in 16 reported four types of ACEs.[12]

Studies also indicate that the prevalence of ACEs and their consequences among people served in public health and treatment systems is often much higher. According to the National Center for Trauma-Informed Care, "The majority of people in human service and justice systems have trauma histories. Many have experienced multiple sources of trauma. Many service providers and first responders have also been impacted by trauma."[13]

The earlier in life people experience trauma, the more likely they are to experience significant and lasting effects. The ACE study found strong correlation between ACE scores and challenges later in life. Higher ACE scores were associated with dramatically higher rates of:

- Poor self-rated health
- Mental health conditions and sequelae, e.g., self-defined current depression and self-reported suicide attempts
- Behavioral and behaviorally mediated challenges, e.g., poor job performance, poor occupational health, bone fractures, smoking (particularly early-onset smoking), physical inactivity, severe obesity, alcoholism, intravenous drug use, history of having sex with 50 or more partners, sexually transmitted diseases, unintended pregnancy
- Additional health conditions, e.g., chronic obstructive pulmonary disease and other lung diseases, hepatitis, diabetes, stroke, ischemic heart disease, cancer[14]

Subsequent studies have confirmed many of these findings, and some have found higher rates of additional challenges in adult life, including mental health issues in general, interpersonal and family difficulties, victimization through sexual harassment or assault, and perpetration of rape and other criminal acts.

If you are part of the behavioral health/recovery support response, you probably see many of your service participants in these descriptions. Whether or not your position holds you responsible for addressing the challenges of toxic stress and trauma, it certainly burdens you with their consequences. Of course, responding to a challenge requires the ability, not only to understand the challenge, but also to envision the solution. The next chapter introduces two central challenges that change leaders face in building a truly useful vision of trauma-informed responses.

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12 Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P. and Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14*(4), 245-258.

13 Blanch, A. (2012). SAMHSA's National Center for Trauma-Informed Care: Changing communities, changing lives. Rockville, MD: National Center for Trauma-Informed Care, Substance Abuse and Mental Health Services Administration.

14 Felitti, V.J. et al., loc. cit.

Action Notes for Section 3

Who would be the best people to compile a "ballpark" estimate of the total—and inclusive—human, social, and financial cost of toxic stress and trauma on your organization, your community, your service systems, and the people you serve?

_____

_____

_____

Section 4: Trauma-informed Care

When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization.

—National Center for Trauma-Informed Care[15]

Like human beings, human service fields have been evolving, from primitive approaches that often wounded more than they healed to more careful and effective approaches rooted in an understanding of human strength and vulnerability and a commitment to human dignity. Trauma-informed care has both built on this evolutionary process and provided concrete and conceptual tools and guidelines for further progress.

Unlike trauma-focused or trauma-specific interventions, trauma-informed care is not something to add to an organization's or a system's menu of services, but a new way of thinking about and providing existing services. Elements of systems that must be trauma informed include:

- Practitioners, the services they provide, and their perceptions of the people they serve
- Policies, protocols, and service environments
- Systems, organizations, and organizational cultures
- Partnerships to foster trauma-informed communities

Although it first took hold in behavioral health, trauma-informed care has begun to influence other human service systems as well, including child welfare, criminal justice, and primary medical care. In some areas, community-wide trauma-informed initiatives have also begun to transform communities' approaches to civic services, community support structures, and public education.[16] These efforts counter two of the strongest forces locking stress and trauma in place—isolation and lack of resources—by fostering collaboration and resource sharing.

Traditional Human Service Approaches

[15] National Center for Trauma-Informed Care. Trauma-informed care and trauma services. Retrieved January, 2014 from http://www.samhsa.gov/nctic/trauma.asp

[16] Blanch, A. (2011). Peace4Tarpon knows it takes a village. *National Council Magazine,* 2011, Issue 2.

Most behavioral health providers and organizations have evolved beyond the institutionalization of people with mental health challenges and the "break 'em down so you can build 'em back up" approach to substance use disorders, but those old traditions have left their mark on the field and associated communities of recovery. Many related health, human service, and criminal justice systems may have even more to learn.

The traditional human service paradigm can be ineffective and even harmful for people with histories of trauma. A quick synthesis of some of the literature on trauma-informed care reveals a number of potentially counterproductive elements in the old paradigm, e.g.:

- A hierarchical structure and reliance on rule, control, and consequences, with efforts to control and manage participants (e.g., seclusion, restraint) often resulting in destabilization, retraumatization, and triggering of traumatic memories
- Attributing to the individual too much responsibility (e.g., blaming the victim) or too little responsibility (e.g., considering people helpless and "doing for them")
- An overall focus on problems and deficits, with strengths considered as afterthoughts, marginalized within assessment processes, and neglected in planning processes
- Interpretation of behaviors as symptoms, though they may have started as necessary, adaptive ways of surviving traumatic circumstances—and might still provide protection
- Over-medication and inappropriate medication for conditions and crises that would be better addressed through skill building and more effective responses by staff members
- Interpretation of problems as individual problems, rather than seeing them in the context of relationships, systems, communities, cultures, and history—and failure to consider this larger environment's potential to instill resilience, healing, and recovery
- Separate service systems, each with its own view of the individual and approaches that may run counter to those of other systems, resulting in, at best a sense of confusion or cognitive dissonance, and at worst the undermining of one system's efforts by another
- Emphasis on individual diagnoses, considered and treated separately from one another

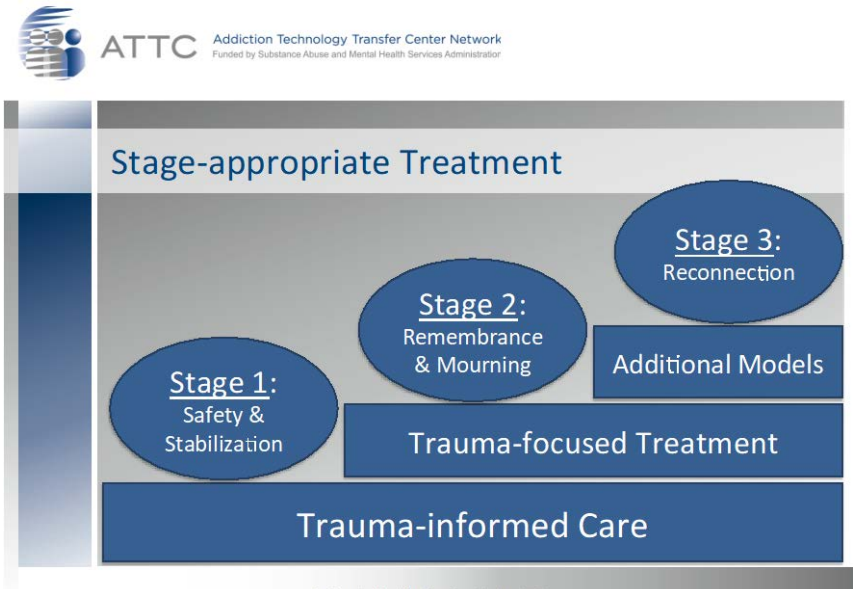
Current knowledge of trauma-informed care comes from the bitter experience of many trauma survivors, and from the creativity and courage of service participants, families, staff, and administrators who have forged safer, more respectful, and more effective approaches. The momentum toward this model is increasing as the research community gathers more and more evidence of the reach and consequences of trauma and the benefits of trauma-informed care.

Essential Elements of Trauma-informed Care

Trauma-informed care is rooted in an understanding of the three stages of trauma recovery documented by Judith Herman, MD in her foundational book, *Trauma and Recovery.*[17] In Stage

[17] Herman, J. (1992). *Trauma and recovery: The aftermath of violence – From domestic abuse to political terror.* New York: Basic Books.

1, "Safety and Stabilization," one of the survivor's primary responsibilities is to learn to identify and manage post-trauma effects and the triggers that might activate them, and—wherever possible—to avoid dangerous and destabilizing circumstances, including treatment processes that trigger post-trauma symptoms (e.g., by invoking strong emotions or memories). Trauma-informed care is essential at each stage, but its first critical task is to protect people in Stage 1.



When people are stable enough to progress to Stage 2, "Remembrance and Mourning," safe trauma-focused services that address traumatic memories may become important facets of the healing process. And in Stage 3, "Reconnection," recovery support also takes on special importance, as people reconnect with others and with their own sense of meaning and purpose.

Many implementation and practice models have been developed to capture and communicate the essential elements of trauma-informed care—and, with some variation, they emphasize many of the same characteristics. In its working definition of trauma-informed care,[18] the Substance Abuse and Mental Health Services Administration (SAMHSA) identifies ten guiding principles for trauma-informed care, principles that reflect many of the predominant TIC models. They are reprinted here verbatim:

1. <u>Safety</u>: *Throughout the organization, staff and the people they serve feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety.*
2. <u>Trustworthiness and transparency</u>: *Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients, and family members of people being served by the organization.*
3. <u>Collaboration and mutuality</u>: *There is true partnering and leveling of power differences between staff and clients and among organizational staff from direct care staff to administrators; there is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making.*
4. <u>Empowerment</u>: *Throughout the organization and among the clients served, individuals' strengths are recognized, built on, and validated and new skills developed as necessary.*
5. <u>Voice and choice</u>: *The organization aims to strengthen the staff's, clients', and family members'*

[18] SAMHSA. Retrieved 9/15/13 from http://www.samhsa.gov/traumajustice/traumadefinition/approach.aspx

experience of choice and recognize that every person's experience is unique and requires an individualized approach.

6. *Peer support and mutual self-help: are integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety, and empowerment.*
7. *Resilience and strengths based: a belief in resilience and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma builds on what clients, staff and communities have to offer rather than responding to their perceived deficits.*
8. *Inclusiveness and shared purpose: The organization recognizes that everyone has a role to play in a trauma-informed approach; one does not have to be a therapist to be therapeutic.*
9. *Cultural, historical, and gender issues: The organization addresses cultural, historical, and gender issues; the organization actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, geography, etc.), offers gender responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.*
10. *Change process: is conscious, intentional and ongoing; the organization strives to become a learning community, constantly responding to new knowledge and developments.*[19]

Along with its leadership in trauma-informed care, SAMHSA has also spearheaded a nationwide movement toward recovery-oriented systems of care (ROSC) and explored a number of other conceptual models and their implications for behavioral health and recovery support services. The next chapter looks at the way trauma-informed care fits into a ROSC, and at the relationships among these constructs a few of the many related conceptual models.

[19] Ibid.

Action Notes for Section 4

This Action Note invites you to spearhead an effort to take inventory of the ways in which trauma-informed approaches are already in place in your organization, system, or community, and elements of trauma-informed approaches that should be added. Who else should be involved in gathering this information?

_____

_____

_____

_____

Off the top of your head, write a few words about some trauma-informed approaches that are already in place in terms of:

Mission and vision: _____

Collaboration with other systems: _____

TIC Initiatives:_____

Policies: _____

Procedures: _____

Safety measures: _____

Atmosphere: _____

Composition of leadership: _____

Management/supervision styles: _____

Roles for service recipients: _____

Staff understanding of TIC: _____

Service provision styles: _____

Section 5: Trauma-informed Care in Context

My paradigms are tired of shifting! My paradigms need stability!

—Anonymous[20]

Like the Executive Director quoted above, many leaders cannot help perceiving each new conceptual model as one more "flavor of the month" and each new page of guidelines as yet another set of demands competing for scarce resources. Trauma-informed care, which plays such an essential role in so many aspects of human services, is still marginalized at times, or assumed to be covered in other models. This section offers a more productive alternative, an exploration of the ways in which TIC and these other models complete and enhance one another, beginning with recovery-oriented systems of care.

ROSC and the Recovery Paradigm

In recent years, concepts and practices of recovery-oriented systems of care (ROSC) have gained steady ascendance in the behavioral health field, because they make human and financial sense: ROSC implementation can improve immediate and long-term outcomes and save money. Many readers of this document will be familiar with the ROSC conceptual model, which is working to replace traditional "acute-care" approaches, instead addressing the complex and chronic nature of substance use disorders and mental health challenges by:

- Taking a whole-system, multi-system approach and using recovery as the central guiding principle in service planning and implementation
- Not replacing treatment, but integrating recovery concepts and peer-based recovery support services into all aspects of pre-treatment, treatment, and post-treatment services
- Empowering service participants, people in recovery, and families to wield true influence on policy, assessment, service planning and delivery, and evaluation
- Preparing and compensating providers of ongoing peer-based recovery support, often rooted in the community, and integrating their efforts with those of treatment providers

For any who are less familiar with the ROSC model, a brief description of it—including the recovery paradigm and collections of principles identified by diverse groups of SAMHSA stakeholders—will show why it has been chosen as the primary context for this exploration of trauma-informed care. Perhaps the best description of the recovery paradigm and definitions of "recovery-oriented systems of care" and "recovery management" appear in William L. White's

[20] From an elevator conversation with the Executive Director of a statewide human service organization.

classic monograph, *Recovery Management and Recovery-oriented Systems of Care: Scientific Rationale and Promising Practices.*[21] Three excerpts from this document are reprinted below.

Toward a Recovery Paradigm

Calls for a "chronic care" model of addiction treatment grew out of and in turn intensified a shift in the organizing paradigm of the addictions field from one of pathology (focus on the etiology and patterns of AOD problems) and intervention (focus on professional-directed addiction treatment) to a focus on the lived solution (focus on long-term addiction recovery). This emerging recovery paradigm is evident in calls to reconnect addiction treatment to the larger and more enduring process of addiction treatment, and to growing scientific interest in AA, other Twelve Step programs, and secular and religious alternatives to Twelve Step programs. At the treatment system level, it is also evident in:

- *the emergence of recovery as an organizing fulcrum for national, state, and urban addiction treatment policy;*
- *efforts to define recovery;*
- *calls for a fully developed recovery research agenda;*
- *federal programs promoting peer-based recovery support services such as CSAT's Access to Recovery and Recovery Community Services Program; and*
- *calls to use recovery as an integrating bridge for the addiction and mental health fields.*

The field seems to be shifting its historical focus toward the processes of recovery initiation to pathways, patterns, stages, and styles of long-term recovery. That transition has opened the door for the concepts of recovery management and recovery-oriented systems of care, which are heard with increasing frequency but are often ill-defined or used interchangeably (p. 17).

Recovery-oriented Systems of Care as a Macrosystem Organizing Philosophy

The phrase recovery-oriented systems of care...refers to the complete network of indigenous and professional services and relationships that can support the long-term recovery of individuals and families and the creation of values and policies in the larger cultural and policy environment that are supportive of these recovery processes. The "system" in this phrase is not a federal, state, or local agency, but a macro-level organization of the larger cultural and community environment in which long-term recovery is nested.

Recovery Management as a Microsystem Organizing Philosophy

Recovery management…is a philosophy of organizing addiction treatment and recovery support services to enhance pre-recovery engagement, recovery initiation, long-term recovery maintenance, and the quality of personal/family life in long-term recovery....

[21] White, W.L. (2008). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices.* Pittsburgh, PA: Northeast Addiction Technology Transfer Center, the Great Lakes Addiction Technology Transfer Center, and the Philadelphia Department of Behavioral Health and Mental Retardation Services.

As we shall see, achieving both a recovery-oriented system of care and implementing a recovery management philosophy requires substantial changes in treatment philosophies, purchase of care strategies, regulatory policies and monitoring protocols, clinical and support service menus, service relationships, the roles of the service professional and service consumer, the training and supervision of staff and volunteers, and intra- and inter-organizational relationships (p. 18).[22]

[22] Ibid.

SAMHSA's Principles, Components, and Elements of Recovery and ROSC

In 2005 and 2006, the Substance Abuse and Mental Health Services Administration convened two large and diverse stakeholder groups and invited them to craft definitions and principles related to recovery and recovery-oriented systems of care. The first group defined recovery as: "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential"[23] and developed 12 Principles of Recovery and 17 Essential Elements of Recovery-oriented Systems. The group convened the following year developed 10 Fundamental Components of Recovery from a mental health perspective.[24]

[23] SAMHSA. (2011). SAMHSA News Release: SAMHSA announces a working definition of "recovery" from Mental disorders and substance use disorders. Retrieved September, 2012 from http://www.samhsa.gov/newsroom/advisories/1112223420.aspx.

[24] Stengel, K., Schwartz, E., and Mathai, C. (2012). *Operationalizing recovery-oriented systems: Expert panel meeting report, May 22-23, 2012.* Rockville, MD: Substance Abuse and Mental Health Services Administration.

12 Principles of Recovery

1. There are many pathways to recovery.
2. Recovery is self-directed and empowering.
3. Recovery involves a personal recognition of the need for change and transformation.
4. Recovery is holistic.
5. Recovery has cultural dimensions.
6. Recovery exists on a continuum of improved health and wellness.
7. Recovery emerges from hope and gratitude.
8. Recovery involves a process of healing and self-redefinition.
9. Recovery involves addressing discrimination and transcending shame and stigma.
10. Recovery is supported by peers and allies.
11. Recovery involves (re)joining and (re)building a life in the community.
12. Recovery is a reality.

10 Fundamental Components of Recovery

1. Self directed
2. Individualized and person-centered
3. Empowerment
4. Holistic
5. Non-linear
6. Strength-based

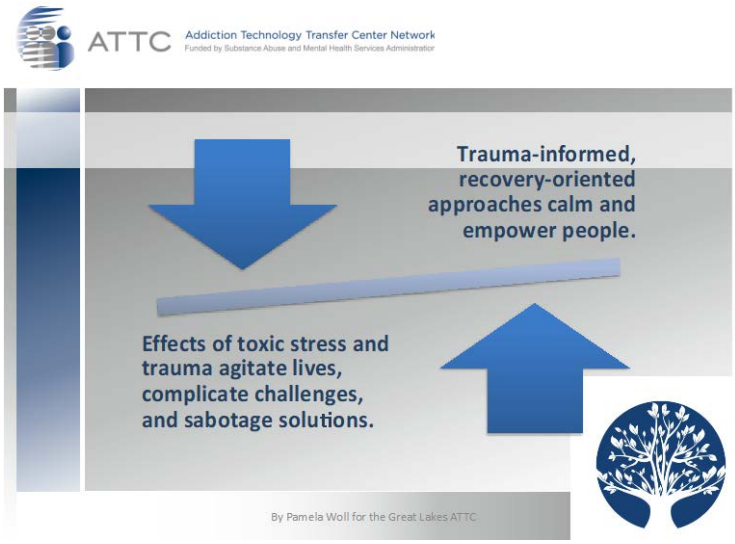
17 Essential Elements of Recovery-oriented Systems of Care

1. Person-centered
2. Family and other ally involvement
3. Individualized and comprehensive services across the lifespan
4. Systems anchored in the community
5. Continuity of care (pretreatment, treatment, continuing care, and recovery support)
6. Partnership/consultant relationship, focusing more on collaboration and less on hierarchy
7. Strength-based (emphasis on individual strengths, assets, and resilience)
8. Culturally responsive
9. Responsive to personal belief systems
10. Commitment to peer recovery support services
11. Inclusion of the voices of individuals in recovery and their families
12. Integrated services
13. System-wide education and training
14. Ongoing monitoring and outreach

Recovery-oriented, Trauma-informed Systems of Care

Recovery-oriented systems of care (ROSC) and trauma-informed care (TIC) are related, interwoven, and interdependent. And yet many organizations and systems have addressed these two models in separate initiatives, with little or no communication, coordination, or collaboration—or have addressed one model and not the other. However:

- Effects of toxic stress and trauma are major contributors to the complexity and intransigence of many disorders and symptoms, circumstances that often necessitate significant recovery support. A thorough grounding of treatment and recovery support leaders, staff, and volunteers in TIC can deepen and enhance their understanding of challenges to recovery and strengthen their responses to those challenges.
- Essential components of TIC (including many of its guiding principles) are also essential components of ROSC. Integrating TIC and ROSC efforts makes it possible to share resources, eliminate duplication of efforts, forge more effective ways of implementing both models, and assume leadership roles in national TIC and ROSC efforts.
- Recovery support services conducted without sufficient grounding in TIC can be ineffective, even harmful. Old traditions within some treatment and recovery cultures embrace or tolerate harsh confrontation and/or shaming—practices that can destabilize vulnerable service participants—as ways of motivating people to change their behaviors.
- Services that are called trauma-informed care but are based on an acute-care model, or conducted without the benefit of long-term peer support, have limited value in the treatment of complex and chronic conditions. Thus far the realms of trauma treatment/research and TIC still experience some challenges in integrating peer support.[25]



ROSC is an essential framework in which trauma-informed care is more likely to take place, and a medium for integrating TIC within multiple systems and in the community as a whole.

Related Models and Frameworks

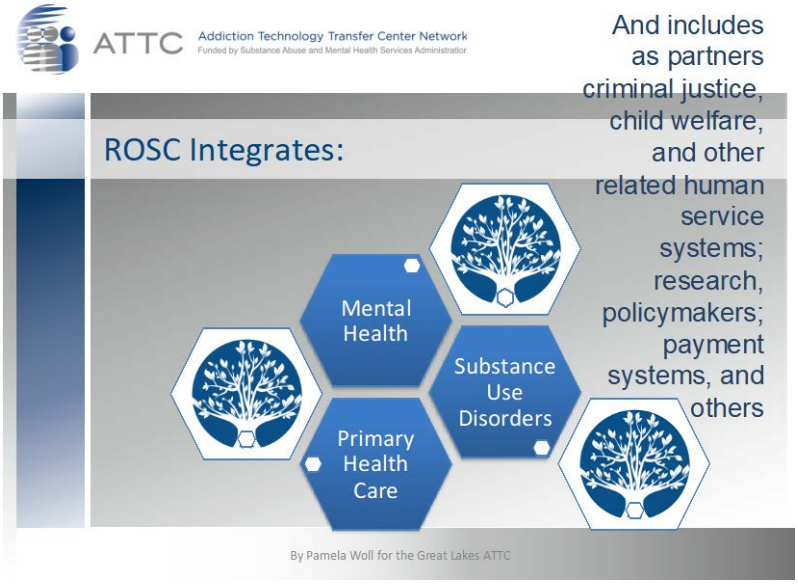
[25] For example, the theme of the 2013 Annual Meeting of the International Society for Traumatic Stress Studies was "Resilience After Trauma: From Surviving to Thriving." Out of hundreds of symposia, there were only three presentations on peer-based services. Two of these were 12-minute talks within four-presentation symposia, and the third was the case study of a program in Rwanda.

Trauma-informed care and recovery-oriented systems of care are also integral to the success of many other models. Consider a few examples, introduced on the following page.

Public Health/Environmental Approaches

As discussed in earlier Sections, environmental factors (e.g., physical, socioeconomic, policy) often interact with genetic/epigenetic, psychological, social, and spiritual factors to lock toxic stress and trauma in place—and to transmit their effects widely—within a family, a community, or a culture. Clearly an understanding of trauma and recovery is incomplete without consideration of the full range of environmental factors, and services for trauma and its sequelae may have only temporary positive effects—in this generation, and certainly in the next—if these environmental factors continue to promote toxic and traumagenic experiences.

TIC and ROSC considerations also play essential roles in public health and prevention—particularly in prevention concerns for children (e.g., fostering long-term recovery among parents, for the safety, development, and physical/behavioral health of their children), but also in the full spectrum of public health concerns. And prevention efforts—particularly those that might disturb the denial and lack of trust that many children need to maintain for their own protection in troubled families—should be conducted in safe and trauma-informed ways.[26]



Models of Cultural Competence

Conceptual and implementation models of cultural competence share much with models of trauma-informed and recovery-oriented services, providers, organizations, systems, and communities. The *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (*National CLAS Standards*) call for "effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs."[27]

SAMHSA's guidelines for trauma-informed care exceed those standards, specifying that "The organization addresses cultural, historical, and gender issues; the organization actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, geography, etc.), offers gender responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma." And one of the principal elements that proponents of culturally competent services have consistently advocated—

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[26] Illinois Prevention Resource Center (1994). *Breaking the Chain: Making prevention programs work for children of addicted families.* Springfield, IL: Illinois Prevention Resource Center.

[27] U.S. Department of Health and Human Services (2001). *The national standards for culturally and linguistically appropriate services in health and health care: Final report.* Washington, DC: U.S. Department of Health and Human Services, Office of Minority Health.

empowerment of individuals, families, cultures, and communities—is both an essential requirement and a natural result of trauma-informed and recovery-oriented organizations, services, systems, and communities.

Healthcare Integration

Defined as "the systematic coordination of general and behavioral healthcare,"[28] healthcare integration is (at the time of this writing) a major topic of thought, discussion, and effort within behavioral health and primary care. Although trauma-informed care and recovery-oriented systems and services are not yet featured prominently in those discussions, it is only a matter of time until necessity places them center stage, for a number of reasons. For example:

- Effects of toxic stress and trauma are major contributors to the existence and complexity of many chronic physical and behavioral health conditions, as evidenced by higher levels of trauma history among people with these conditions. Medical teams often miss opportunities to ask the questions that might help them intervene early in the process.
- Symptoms of, and treatment for, many behavioral health conditions and post-trauma effects can raise vulnerability to many physical illnesses. For example, both the eating disorders that are common among trauma survivors and the use of most psychotropic medications can increase food consumption, blood sugar levels, and weight gain, raising the risk of diabetes, cardiovascular disease, and gastrointestinal problems.[29] And smoking, use of street drugs, and overuse of alcohol or prescription medications—also more common among trauma survivors—all raise a variety of serious health risks.
- Primary medical care is often driven by a sense of urgency—little time to build trusting relationships—and many tests and procedures are painful and invasive. This can raise the risk of triggering traumatic memories and emotions, de-stabilizing behavioral health and trauma recovery, and jeopardizing patients' ability to cooperate with medical staff. Few fields need a strong focus on trauma-informed care more than the medical field.
- Like treatment for post-trauma effects and behavioral health conditions, treatment of chronic physical illness is often followed by neglect of medical regimens and return to behavioral excesses that contributed to the illnesses. Many patients are also bewildered by medical terms and instructions, so they "get lost" in referral and follow-up processes. The long-term perspective and integrated peer support services that have become staples of ROSC are desperately needed within primary care systems.

Armed with these and many other relevant considerations, formal and informal leadership can play critical roles in promoting shared ideas, shared resources, and truly integrated approaches.

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[28] SAMHSA-HRSA Center for Integrated Health Services. What is integrated care? Retrieved January, 2014 from http://www.integration.samhsa.gov/about-us/what-is-integrated-care.

[29] Newcomer, J.W. (2007). Metabolic syndrome and mental illness. *American Journal of Managed Care, 13*, S170-S177.

Action Notes for Section 5

For a picture of where your organization, system, or community is in terms of your use and integration of related conceptual models and initiatives, you might:

1. Convene a multidisciplinary group of people who would know what kinds of initiatives and processes are taking place.
2. Together, draw a chart with a square for each initiative, and write inside that square the major tasks of the initiative.
3. Draw arrows among them, showing collaborative projects, relationships, resource sharing, etc., and dotted arrows showing potential projects, relationships, and resource sharing.

Section 6: Implementing Trauma-informed Care

There are a hundred stages of change, the first 96 being precontemplation.

– Stuart Duckworth[30]

Broad conceptual models such as trauma-informed care and ROSC resonate deeply with individuals' and organizations' experiences and inspire commitment and creativity. But large-scale change processes require concrete, step-by-step approaches, taken with care and respect for the existing organizational culture, the values that drive it, and the people who depend on it.

Several implementation models have been developed to guide organizations and systems toward trauma-informed policies, practices, and personnel. This section very briefly introduces three of the best-known national models. Developers of these and other approaches provide information on their web sites, offer written materials, and can provide training and technical assistance to organizations and systems that choose to implement them.

After a look at 12 priorities defined for trauma-informed mental health service systems, the final portions of this Section offer a brief description of Technology Transfer, the study of diffusion of innovative practice, and a few thoughts on effective, human-centered implementation of new models in organizations and systems.

Risking Connection®

Risking Connection® (RC), a model for understanding and responding to the needs of people who have been wounded in interpersonal relationships, was developed in 1999 out of a partnership between the Sidran Institute (www.sidran.org) and the Trauma Research, Education and Training Institute (TREATI), under a commission from the state mental health authorities of Maine and New York.

As described at www.sidran.org, "Risking Connection® teaches a relational framework and skills for working with survivors of traumatic experiences. The focus is on relationship as healing, and on self-care for service providers." A few points about this model:

- Risking Connection® identifies four primary components of the therapeutic relationship:

[30] This quote is attributed to Stuart Duckworth. The 2009 document in which it is supposed to have appeared remains elusive, but the quote is too good not to include.

Respect, Information, Connection, and Hope (RICH).

- This model is based on a clinical theory called Constructivist Self Development Theory (CSDT, developed by Lisa McCann, PhD and Laurie Anne Pearlman, PhD), which looks at individuals' responses to trauma as meaningful adaptations to their experience.
- The 20-hour training curriculum based on this model emphasizes the role of therapeutic relationship, empowerment of service participants and providers, collaboration, psychoeducation, understanding symptoms as adaptation, and meaning making. The model also addresses the effects of this work on service providers.

The Sanctuary Model®

Another model that is receiving growing recognition is The Sanctuary Model®, developed by Sandra Bloom, MD, Joseph Foderaro, LCSW, Ruth Ann Ryan, MSN, CS, Brian Farragher, LCSW, MBA, Sarah Yanosky, LCSW and Linda Harrison, MEd, LPC. The Sanctuary Model® (www.sanctuaryweb.com) provides a framework for understanding the universal impact of toxic stress and trauma and engaging members of an organization, a system, or a community, including ways of keeping people active and interested and tools for working through conflicts.

One central theme of The Sanctuary Model® is that the process of change and healing is essentially the same whether it is taking place in someone receiving services, the service provider, the organization, the family, or the community. Like recovery, The Sanctuary Model® begins the healing process at the center, in this case, the service provider. Healthy individuals, organizations, and systems are far more likely to heal—and far less likely to wound—and people who have benefitted from a process are better prepared to bring that process to others.

This model relies on four key domains of healing: Safety (in self, relationships, environment), Emotions (identifying/modulating emotions), Loss (feeling grief and recognizing that change includes loss) and Future (new roles, ways of relating, identity as a "survivor"). The model is passed on through the S.E.L.F Curriculum and the group training program by the same name. Its guiding principles are the Seven Sanctuary Commitments, to be embraced at all levels of the organization: 1) commitment to nonviolence, 2) emotional intelligence, 3) social learning, 4) open communication, 5) democracy, 6) social responsibility, and 7) growth and change.

Creating Cultures of Trauma Informed Care

Maxine Harris, PhD and Roger D. Fallot, PhD of Community Connections (www.communityconnectionsdc.org) have written extensively of cultures of trauma-informed care, and address implementation of trauma-informed care as a process of culture change. They outline the four-stage system-change process that they use to guide TIC implementation:[31]

1. *Initial planning:* This stage involves considering the importance of, and weighing commitment to, a trauma-informed change process. Important elements include administrative support and commitment, a trauma initiative workgroup, representation of each stakeholder group, identification of "champions," and an understanding that this shift will take one to two years and will involve the entire agency and its culture.
2. *Two-day kickoff training:* This stage includes all workgroup members, as many staff as possible, and significant representation of service participants. There are at least three presentations: 1) Central ideas of trauma-informed cultures, 2) Importance of staff support and care, and 3) Importance of trauma in the work of the agency.
3. *Short-term follow-up:* This stage involves application of ideas from the training, using a Self-Assessment and Planning Protocol that addresses both service-level and administrative or systems-level changes, assisted by outside consultants with implementation experience. Stage 3 also includes development and review (by administration, staff, service participants, consultants) of an Implementation Plan, followed by educational events (e.g., "Understanding Trauma 101" and "Staff Support and Care").
4. *Longer-term follow-up:* The final stage includes progress review meetings with consultants, the workgroup, and selected others, followed by ongoing processes to sustain the initiative to its conclusion and to maintain the momentum until culture change has spread throughout the agency.

Priorities for Trauma-informed Mental Health Service Systems

Treatment organizations do not operate in a vacuum, and support at the service system level is necessary, not just for the organizations within the system, but also for the integration of these services in a multi-system, whole community approach. The National Association of State Mental Health Program Directors and the National Technical Assistance Center for State Mental Health Planning have identified twelve priorities for trauma-informed mental health systems:

1. Designated trauma function and focus in the department
2. State trauma policy or position paper
3. Workforce orientation, training, support, competencies, job standards

[31] Fallot, R.D. and Harris, M. (2009). *Creating cultures of trauma informed care.* Washington, DC: Community Connections.

4. Linkages with higher education to promote education of professionals in trauma
5. Consumer/survivor/recovering person involvement and trauma-informed rights
6. Trauma policies/services that respect culture, race, ethnicity, gender, age, sexual orientation, disability, and socioeconomic status
7. Integration/coordination among systems serving persons with trauma histories
8. Trauma-informed disaster planning and terrorism response
9. Financing criteria and mechanisms to pay for best practice treatment models/services
10. Clinical practice guidelines for working with people with trauma histories
11. Procedures to avoid retraumatization and reduce the impact of trauma
12. Rules, regulations, and standards to support access to evidence-based/best practices[32]

The ATTC Model of Technology Transfer

As a field, and as a larger society, we have no shortage of innovative models and practices, but we do sometimes have a hard time persuading individuals, organizations, and systems to adopt new approaches. Meeting these challenges is one of the major missions of the National Addiction Technology Transfer Center (ATTC) Network.

With 10 Regional Centers, four National Focus Centers, and a Network Coordinating Office, the ATTC Network is a nationwide, multidisciplinary resource for professionals in the addictions treatment and recovery services field, dedicated to raising awareness of evidence-based and promising treatment and recovery practices, building workforce skills for state-of-the-art service delivery, and changing practice and improving outcomes by helping people incorporate these skills into everyday use.

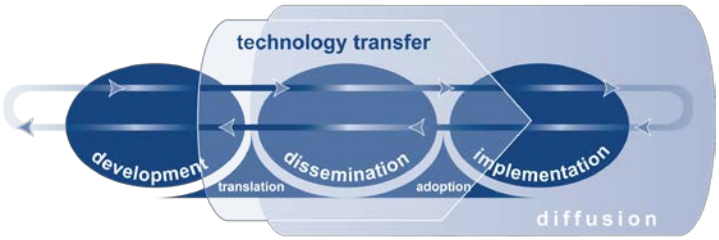
One of the ATTC Network's most fundamental tools is Technology Transfer, a conceptual model and system of strategies designed to make it more likely that a particular model or practice will be adopted and its practices implemented. In adapting the basic concept of technology transfer to its work in the substance use disorder field, the Network has blended a number of relevant models, including stages-of-change and motivational theories, to overcome the many challenges to the adoption of new ideas and practices.

The following excerpt from "ATTC Network Model of Technology Transfer in the Innovation Process" gives a basic introduction to these stages and the processes they foster and assist:

> *The conceptual model in the figure below, developed by the Addiction Technology Transfer Center Network, illustrates the continuum of diffusion of an innovation (an idea, technology, treatment or method) from creation through implementation.*
>
> *Highlighted within the conceptual model is technology transfer, a multidimensional process that intentionally promotes the use of an innovation. Technology transfer begins during development, continues through dissemination, and extends into early implementation. This process requires*

[32] Jennings, A. (2004). *Blueprint for action: Building trauma-informed mental health service systems.* Alexandria, VA: National Association of State Mental Health Program Directors and National Technical Assistance Center for State Mental Health Planning.

multiple stakeholders and resources, and involves activities related to translation and adoption. Technology transfer is designed to accelerate the diffusion of an innovation.



First, during development, the innovation is designed and initially evaluated. Next, during translation, the essential elements and relevance of the innovation are explained and the innovation is packaged to facilitate its spread. In dissemination, awareness about the innovation is promoted with the goal of encouraging its adoption. Adoption is not a single decision but a process of deciding to use the innovation. Finally, during implementation, the innovation is incorporated into routine practice in "real world" settings. Across the continuum, bidirectional communication is a critical component and is represented by a continuous feedback loop.

An organization, system, or community interested in adopting an innovation such as ROSC or trauma-informed care—or any new practice or approach—might find the ATTC technology transfer model a useful tool. It can help change agents:

- Provide a standard language that stakeholders can use to describe their tasks and the process as a whole
- Place the stages of diffusion in context, so key partners can prepare for a multi-tiered change process
- Promote adoption of evidence-based practices with high fidelity
- Create a common understanding that increases partners' satisfaction with the process
- Focus the organization's, system's, or community's purchasing power by providing a realistic look at what activities in the various stages are likely to accomplish

The Human Side of Innovation

Like the individuals they are made of, organizations often balk at the prospect of change, accept it in stages, and find ways of undoing approaches that seem to have been forced on them. People who have made the process of change their life's work have much to offer systems and organizations about to engage in this process. Few of these experts offer better suggestions for this than Michael A. Diamond, PhD, in his seminal 1996 article on the human side of innovation. A few examples:[33]

[33] Diamond, M. (1996). Innovation and diffusion of technology: A human process. *Consulting Psychology Journal: Practice and*

- No matter how much they admire expertise, members of an organization, system, or community tend to resent experts who "descend from on high" to tell them what their problems are and offer solutions. Rather than taking an "expert authority" stance, it is better to approach stakeholders in an attitude of openness and humility and let them, not only help solve the challenges at hand, but first help define the challenges and plan the solutions. Much of the success of a change process depends on whether or not the people who are supposed to implement the solution buy into the definition of the problem and the nature of the solution.
- Understand that the "resistance" that change processes often inspire is a natural expression of the anxiety people feel when they perceive that change is being imposed on them. No matter how much they want to learn and improve, people tend to feel powerless, uncertain, and inferior if they get the impression that the way they have been doing things is now considered wrong or inadequate. However, if they have been part of the planning process from the beginning, participating in empowered and meaningful ways, they can become the ones who have chosen change, a position of dignity.
- Understand and respect the fact that adoption of the new also means the loss of the old, including the sense of certainty that long-time routines and rituals carry, and all the ways in which traditional responses have been woven into the organizational culture. It is helpful to give each individual opportunities for, and support in, identifying and grieving these losses and building a new vision that works for both the individual and the process as a whole.
- Diamond presents the concept of a "transitional space," not so much a physical but a psychological space in which people can work through their thoughts and feelings about the change process, explore the implications of change, make mistakes without dire consequences, and work toward taking responsibility for changing.
- He also emphasizes the fundamental importance of building and maintaining organizational resilience. If leaders promote collaboration and trust through their own respectful and collaborative approaches, the organization is more likely to respond effectively to change.[34]

With all these options and resources in mind, it is time to think—at least in hypothetical terms—about the human, conceptual, material, and financial resources you might use to foster and sustain the change process. Whether your goal is trauma-informed care, a recovery-oriented system of care, or an integrated combination of the two, the Action Notes below give you a space to begin listing some of the resources you have, and some of the resources you need.

Research, 48(4), 221-229.

[34] Ibid.

The next Section will hone in on one important aspect of implementation: staff training in trauma-informed care and the support that staff and volunteers will need—and no doubt already need—to work safely and effectively with people who have been deeply affected by toxic stress and trauma.

Action Notes for Section 6

An important early step in a major implementation process is an inventory of resources that can be mobilized in that effort, including:

- The human, conceptual, and material resources already in place that might aid in the implementation of trauma-informed care
- The resources that are not yet in place but would be free, or be within your organization's, community's, or system's means to engage or acquire
- The resources that are beyond your current means but would be worth engaging, acquiring (alone or shared with allied initiatives), or borrowing if that became possible.

Who might be the key people to involve in taking this inventory_____

_____

At a minimum, your inventory should consider each of these categories and types of resources:

- *Human:* These might include leadership, management, line staff, consultants, volunteers, community members, members of allied systems, representatives of funding bodies, and other stakeholders.
- *Conceptual:* These might include models (conceptual, implementation, or practice), policies, procedures or protocols related to any facets of your implementation process.
- *Material:* This category might include financial assets, funding opportunities, collateral, written documents, audiovisuals, work space, furniture, office products, etc.

Section 7: Trauma Training and Staff Support

Working with trauma survivors can be stressful, and sometimes even vicariously traumatizing. It often exposes us to the pain and suffering that comes from observing the worst that human beings can do to each other.

—John Briere and Catherine Scott[35]

One of the most challenging tasks of human service leadership is to foster in staff, colleagues, and partners an understanding of deep and complex subjects—and to do this as quickly and as economically as possible. When it comes to toxic stress, trauma, and trauma-informed care:

- The depth and complexity of the subject—and the lure of simplistic approaches—can both be significant. In this balancing act, financial realities can tip the scale, and this can be risky. People who understand the complexities should help make these decisions.
- It is clear that all staff and volunteers have the potential to harm people who are experiencing vulnerabilities, but the prospect of training all personnel can be daunting.
- Common misconceptions about trauma, its effects, and stage-appropriate responses can make it difficult for providers to hear and apply accurate information on these subjects.
- The learner's own experience of toxic stress and trauma can deepen understanding, but it can also complicate the learning process and the application of lessons learned.
- If this information is not integrated with the other conceptual models embraced by the system (e.g., recovery-oriented services, cultural competence, integrated healthcare), it might be—at best—implemented in costlier and less effective ways and—at worst—dismissed as just another flavor of the month, to be endured and then ignored.

Most models for implementing trauma-informed care (including those described briefly in the previous Section) include staff and leadership training and technical assistance components. However, when a comprehensive approach is not an option—and a half-hearted approach would be ineffective and even dangerous—it comes down to finding the best compromise. This section presents some suggestions for training and staff support.

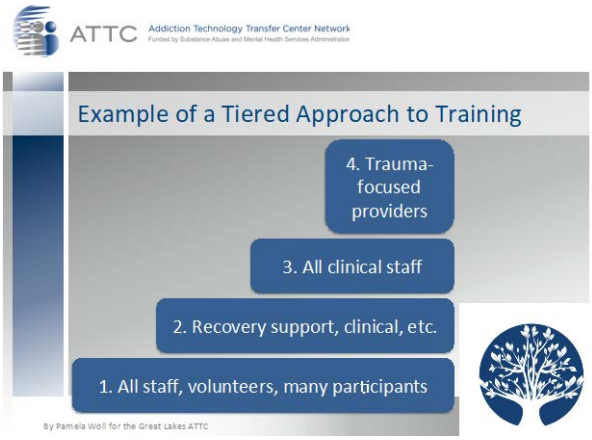
When it is time to map out a training program for staff in trauma and trauma-informed care, many leaders choose a tiered approach—for example, providing:

- *First Tier: For all staff, volunteers, and/or community members, at all levels of the organization or system—with significant participation by service participants in both planning and delivery:*
    - General, accessible, de-stigmatizing information about toxic stress and trauma

[35] Briere, J. and Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluations, education, and treatment.* Thousand Oaks, CA: Sage Publications, Inc.

- Basic tips for safe, respectful, and effective responses to all service participants and people in recovery, given the high prevalence of trauma history and the ever-present possibility that a tough veneer might hide significant vulnerabilities
- Ways of identifying and eliminating safety issues and triggers for post-trauma reactions within the organization, family, community, or service system

- *Second Tier: For recovery support, clinical, case management, and other service-provision staff:*
  - More in-depth discussion of the nature of toxic stress and trauma, their effects, and their implications for therapeutic and support relationships, with special emphasis on the prevalence and implications of complex and developmental trauma in treatment and recovery support service participants

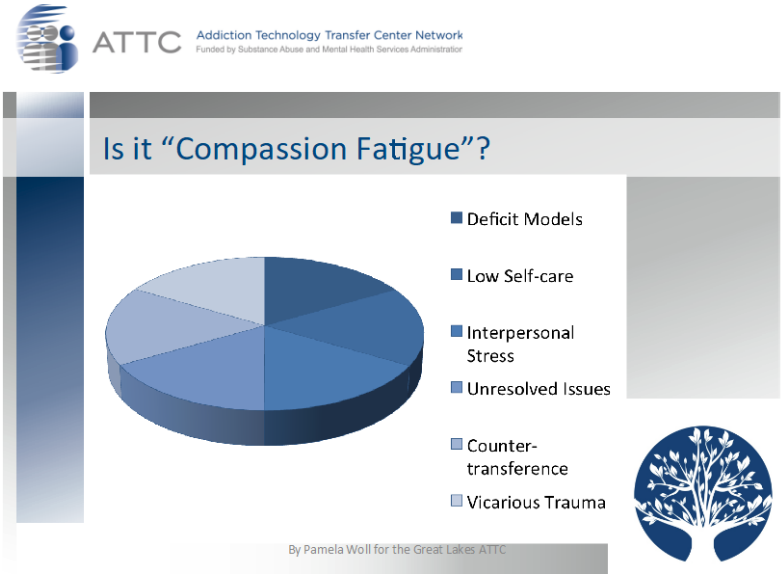


  - The relationship between toxic stress/trauma and co-occurring conditions (e.g., substance use disorders, mental health challenges, chronic physical illnesses)
  - Basic principles and practices of trauma-informed care
  - Brief screening and supported referral to assessment processes
  - The stages of trauma recovery, their implications for service provision, and appropriate treatment and recovery support approaches at each stage—with an emphasis on present-focused safety/stabilization-stage approaches, and careful clarification of any misunderstanding that might arise from that discussion (e.g., when trainers warn not to draw traumatic memories out of people in Stage 1, emphasize that this does not mean they should discourage people from talking about or seeking help for the memories that are triggered or arise unsolicited)
  - Strength-based, normalizing, non-stigmatizing, non-"pathologizing" ways of discussing trauma and its effects
  - Ways of modeling and describing basic skills in self-care, modulation of emotions and stress responses, and management of post-trauma effects
  - Safe and effective ways of responding to and de-escalating post-trauma reactions (e.g., collaborating with service participants in developing individualized plans for safe de-escalation), and seeking assistance from other staff in proactive, non-triggering forms of de-escalation, whenever assistance is need
  - The importance of and opportunities for self-care, ongoing growth, mutual support, supervision, and appropriate help-seeking among service providers
  - Basic information about recognizing and addressing stress and vicarious traumatization among service providers, family members, and support networks

- *Third Tier: For all clinical staff:*
    - More in-depth coverage of the nature and effects of trauma, including the physiology and neurobiology; psychological, social, and spiritual implications; and medical, behavioral, psychiatric, cognitive, parenting, and legal sequelae
    - More in-depth information about trauma-informed care and its implementation within the organization, system, and community
    - The use of assessment tools/techniques and referral to stage-appropriate trauma-focused care
    - Conducting effective, normalizing, strength-based psychoeducation on the nature and effects of toxic stress and trauma (including its physiological roots) and the power of resilience and recovery
    - Training service participants in safety skills and considerations and ways of recognizing and managing the effects of toxic stress and trauma in everyday life
    - More in-depth information about secondary and vicarious traumatization, provision of careful ongoing supervision and mentorship, and development of individual and service provider group plans for self-care and mutual support
- *Fourth Tier: For providers of trauma-focused services:*
    - In-depth training, role-play, and skill rehearsal in the trauma-focused service models to be adopted
    - Wherever available, certification or licensure of staff who will deliver services
    - Ongoing technical assistance, supervision (including videotaping/analysis of sessions), mentorship, and continuing education in these practice models
    - Ongoing learning communities, discussion groups, and peer support groups or dyads among staff delivering these services

Helping Staff Stay Afloat

"Compassion fatigue" has become a popular catch-all phrase for a range of natural reactions to the sometimes overwhelming burden of exposure to others' extremely painful and frightening experiences. Compassion is a significant strength, and identifying it as part of the problem leaves many human service providers wondering just how to work the magic spigot and have *just the right amount* of compassion. It may be more helpful to break "compassion fatigue" down into its component elements and address each element as it arises. For example:



- Immersion in deficit-based models, with their primary focus on problems, symptoms, and diagnoses, can erode important resources for weathering traumatic material. Implementing strength-based approaches can improve outcomes and fortify hope, optimism, empowerment, and faith in one's ability to make a difference.
- Human service providers are notorious for neglecting self-care in order to meet others' needs. Never underestimate the power of stress and fatigue, with all their physical and neurochemical effects on mood, perspective, and energy levels. Policy, supervision, and mentorship can address these challenges effectively, but only if leadership is willing and able to discourage overwork; refrain from making overtaxing demands; and provide training and support in time management, stress modulation, and stress reduction.
- Some post-trauma effects—particularly the effects of complex or developmental trauma—can add layers of confusion and turbulence to relationships, including service relationships. In these cases, providers' sense of interpersonal stress and frustration might add to any challenges related to the traumatic material itself.
- Some of what is thought of as "secondary trauma" may actually be unresolved primary trauma, grief, guilt, shame, and/or anger triggered by exposure to others' traumatic material and ensuing emotions. Service providers are responsible for monitoring and pursuing their own growth and healing—and abstaining from any roles that take them beyond their levels of recovery. Supervisors and managers are responsible for knowing their staff well enough to recognize the signs and intervene within the boundaries of their professional roles—and for creating environments that make it safe to ask for help.
- Sometimes what seems like compassion fatigue might be an old fashioned case of countertransference, overidentification, or seeing the people they serve through the lens of their own needs and challenges. Ongoing employee development must work to instill a sense of responsibility for maintaining clear delineation and boundaries.

- And there is such a thing as "vicarious traumatization," the effect of taking in so much traumatic material—often on a chronic basis—that it overwhelms one's coping abilities and alters one's world view. The leader's job is to ensure that there are many accessible options for guidance and support, and to create an atmosphere in which it is understood that sometimes there simply is too much pain, and people need the grace and the space to rest, reset, recover, and reconnect with their many sources of strength and spirit.

After this brief look at several aspects of trauma, trauma-informed care, recovery-oriented systems, allied models, and considerations for implementation, it is time to step back and look at the implications of all these thoughts and suggestions. The next and final Section reviews the tasks suggested in the Action Notes at the end of each Section and offers some thoughts on hope.

Action Notes for Section 7

It might be helpful to have a picture of where your staff and stakeholders are in terms of their need for training and support in trauma and trauma-informed care. To onduct a survey in your organization, system, or community—one that allows respondents to remain anonymous—to find out:

- How much staff and volunteers at all levels seem to know and understand about toxic stress, trauma, and trauma-informed care
- How staff, volunteers, service participants, and community members are being affected by exposure to other individuals' traumatic material and reactions
- What levels of resources (e.g., peer support, supervision, mentorship, social networks, employee assistance programs, counseling or therapy) people in each of these groups have for coping with and resolving these effects
- What additional resources they would be willing to use if those resources were available

Section 8: Accepting the Challenge

Three frogs are sitting on a log. One of them decides to jump. Now how many frogs are sitting on the log?

(Answer: Three. Just making a decision doesn't get the frog off the log!)

—Popular Riddle in Recovery Circles

Like the frog in the old riddle, most of us have learned over and over again that not even inspiration, vision, conviction, motivation, resolution, determination—not even all those qualities put together—will be enough to make things happen. It takes action. But unlike that contemplative frog, change leaders often find that it takes, not one leap, but a series of leaps, plus the persistence to lure the other two frogs off the log.

If you have read through this document, and perhaps begun to address the Action Notes at the end of each section, you might have something close to the bare bones of a place to start.

The most important tasks are the ones that involve reaching out to potential collaborators: people with answers, people with more questions, people whose input will make things easier, people whose input will make things harder—but better—people who can help you do the things you cannot do alone.

To sum up those Action Notes, here are some interesting projects for leaders who know that the growing impact of toxic stress and trauma is a serious threat that requires careful effort, integrated with recovery-oriented systems and the full spectrum of related efforts.

From Section 1: The Role of Leadership

Identify one or more teams in your organization, system, or community that are studying the kinds of issues and possibilities addressed in this manual—or start a new team. Consider sharing this manual with them, and think about the role you should play in these efforts and the challenges and resources you expect to find in the process.

From Section 2: Transforming the Vision

Clarify (or update) your own vision regarding trauma-informed responses, and look for opportunities to participate in any collective vision- and mission-building processes within your organization, system, or community.

From Section 3: Toxic Stress and Trauma

Catalyze a collaborative effort to compile a "ballpark" estimate of the total—and inclusive—human, social, and financial cost of toxic stress and trauma on your organization, your community, your system, and the people you serve.

From Section 4: Trauma-informed Care

Spearhead a collaborative effort to take inventory of the ways in which trauma-informed approaches are already in place in your organization, system, or community, and the elements of trauma-informed approaches that should be added.

From Section 5: Trauma-informed Care in Context

Gather a multidisciplinary group that can take inventory, within your organization, system, or community, of ways in which efforts toward trauma-informed care, recovery-oriented systems of care, and any other conceptual models are working together, and the extent to which information, resources, and collaborative efforts are being shared among these efforts.

From Section 6: Implementing Trauma-informed Care

With help, make lists of the human, conceptual, and material resources that are being, might be, or should be mobilized for these efforts in your organization, system, or community

From Section 7: Trauma Training and Staff Support

Conduct a survey in your organization, system, or community—one that allows respondents to remain anonymous—to find out:

- How much staff and volunteers at all levels seem to know and understand about toxic stress, trauma, and trauma-informed care
- How staff, volunteers, and service participants are being affected by exposure to other individuals' traumatic material and reactions
- What levels of resources each of these groups has for coping with and resolving those effects
- What additional resources they would be willing to use if those resources were available

Evidence of Hope

When people have lived with the effects of toxic stress and trauma for a long time—a year, a lifetime, many generations—the capacity to trust may be the first casualty, with hope and determination falling not far behind.

As a society, we have watched our human and financial resources erode as the progressive effects of toxic stress and trauma have compromised our collective physical, psychological, behavioral, social, cultural, financial, spiritual, and moral health. All this has increased the senses of isolation and scarcity that wear at the fabric of human health, resilience, and recovery. Given all the ideas in this and thousands of other documents, it might not be too hard to envision collaborative solutions, but believing those solutions can happen is another matter.

Remember: Resilience is real. Most people not only survive but thrive, in spite of pain or poverty or grinding stress.

Recovery is real. Overwhelming numbers of people with chronic, once-debilitating substance use disorders and/or mental health challenges are living full lives, transformed lives. Most did not do it alone, though, and many have become that strength for others.

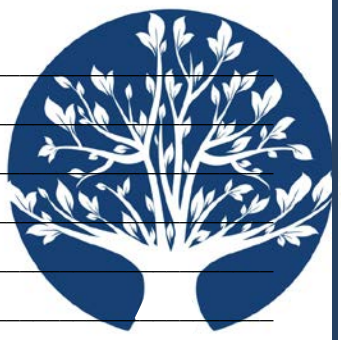
And for anyone who doubts that trauma-informed care can overcome the silos and the scarcity and expand to the scale we need, there is the best possible precedent: recovery-oriented systems of care. In a growing number of organizations, systems, and communities—even large cities and states—diverse groups of stakeholders have pooled their ideas and resources in service of

recovery.[36] This movement is a sign of hope; a source of ideas; and a sound partner in efforts to empower individuals, families, and communities.

The architects and advocates of trauma-informed care and recovery-oriented systems of care need one another. One nourishes and protects the roots, and the other tends the branches, but it is the same tree. It is all of us, and each one of us is responsible. This is our challenge, and our hope.

[36] White, W.L., Clark, H.W., Kirk, T.A., Evans, A.C., Boyle, M., Valentine, P., and Albright, L. (2007). *Perspectives on systems transformation: How visionary leaders are shifting addiction treatment toward a recovery-oriented system of care.* Chicago, IL: Great Lakes Addiction Technology Transfer Center. Lambert, C. (2008). Trails of tears, and hope. *Harvard Magazine,* March-April, 2008. White (2008), loc. cit. Achara, I., Ali, O., Davidson, L., Evans, A.C., King, J.K., Poplawski, P., and White, W.L. (2011). *Philadelphia Behavioral Health Services Transformation Practice Guidelines for recovery and resilience oriented treatment.* Philadelphia, PA: Philadelphia Department of Behavioral Health and Intellectual disAbility Services. Blanch, A. (2011), loc. cit.

Notes



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