Trauma-Informed Services: A Self-Assessment and Planning Protocol

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March, 2006

Introduction

Over the past fifteen years, there has been growing acknowledgement of several interrelated facts concerning the prevalence and impact of trauma in the lives of people in contact with various human service systems. We advocate for trauma-informed service approaches for a number of reasons.

•**Trauma is pervasive.** 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. The experience of trauma is simply not the rare exception we once considered it. It is part and parcel of our social reality.

•**The impact of trauma is very broad and touches many life domains.** Trauma exposure increases the risk of a tremendous range of vulnerabilities: mental health problems like posttraumatic stress disorder, depression, excessive hostility, and generalized anxiety; substance abuse; physical health problems; interpersonal struggles; eating disorders; and suicidality, among many others. Trauma thus touches many

areas of life not obviously or readily connected with the experience of trauma itself. This broad impact makes it particularly important to understand the less evident links between trauma and its sequelae.

•**The impact of trauma is often deep and life-shaping.** Trauma can be fundamentally life-altering, especially for those individuals who have faced repeated and prolonged abuse and especially when the violence is perpetrated by those who were supposed to be caretakers. Physical, sexual, and emotional violence become a central reality around which profound neurobiological and psychosocial adaptations occur. Survivors may come to see themselves as fundamentally flawed and to perceive the world as a pervasively dangerous place. Trauma may shape a person's way of viewing and being in the world; it can deflate the spirit and trample the soul.

•**Violent trauma is often self-perpetuating.** Individuals who are victims of violence are at increased risk of becoming perpetrators themselves. The intergenerational transmission of violence is well documented. Community violence is often built around cycles of retaliation. Many of our institutions—criminal justice settings, certainly, but also schools and churches and hospitals—are too frequently places where violent trauma is perpetuated rather than eliminated.

•**Trauma is insidious and preys particularly on the more vulnerable among us.** People who are poor, who are homeless, who have been diagnosed with severe mental health problems, who are addicted to drugs, or who have developmental disabilities—all of these groups are at increased risk of violent victimization.

•**Trauma affects the way people approach potentially helpful relationships.** Not surprisingly, those individuals with histories of abuse are often reluctant to engage in, or quickly drop out of, many human services. Being vigilant and suspicious are often important and thoroughly understandable self-protective mechanisms in coping with trauma exposure. But these same ways of coping may make it more difficult for survivors to feel the safety and trust necessary to helpful relationships.

•**Trauma has often occurred in the service context itself.** Involuntary and physically coercive practices, as well as other activities that trigger trauma-related reactions, are still too common in our centers of help and care.

Growing awareness of these facts regarding trauma has led to calls for the development of both trauma-informed and trauma-specific services. Human service systems become **trauma-informed** by thoroughly incorporating, in all aspects of service delivery, an understanding of the prevalence and impact of trauma and the complex paths to healing and recovery. Trauma-informed services are designed specifically to avoid retraumatizing those who come seeking assistance. They seek

"safety first" and commit themselves to "do no harm." The recently completed SAMHSA-funded Women, Co-Occurring Disorders, and Violence Study has provided evidence that trauma-informed approaches can enhance the effectiveness of mental health and substance abuse services. By contrast, **trauma-specific services** have a more focused primary task: to directly address trauma and its impact and to facilitate trauma recovery. An increasing number of promising and evidence-based practices address PTSD and other consequences of trauma, especially for people who often bring other complicating vulnerabilities (e.g., substance use, severe mental health problems, homelessness, contact with the criminal justice system) to the service setting.

This Self-Assessment and Planning Protocol and its accompanying Trauma-Informed Program Self-Assessment Scale attempt to provide clear, consistent guidelines for agencies or programs interested in facilitating trauma-informed modifications in their service systems. It is a tool for administrators, providers, and survivor-consumers to use in the development, implementation, evaluation, and ongoing monitoring of trauma-informed programs.

Overview of the Protocol and Scale

The Self-Assessment and Planning Protocol is divided into six domains; they address both services-level and administrative or systems-level changes. In each domain, there are guiding questions for a collaborative discussion of a program's activities and physical settings, followed by a list of more specific questions and/or possible indicators of a trauma-informed approach. Many of these questions and indicators are drawn from the experiences of human service agencies that have previously engaged in this self-assessment. Discussions of trauma-informed program modifications constitute an opportunity to involve all key groups—administrators, supervisory personnel, direct service and support staff, and consumers—in the review and planning process. In our experience to date, the more inclusive and fully representative these discussions are, the more effective and substantial the resulting changes.

Following the questions and indicators are brief notes linking the Self-Assessment and Planning Protocol to the Trauma-Informed Self-Assessment Scale. The structure and format of the Program Self-Assessment Scale are similar to those of "fidelity scales" commonly used to assess the extent to which a service model is actually being implemented as intended (e.g., consistent with a plan or a manual). Both administrative and clinical experience suggests that attributes of the system "as a whole" have a very significant impact on the implementation and potentially the effectiveness of any specific services offered. This instrument reflects current thinking about

those program characteristics—at both the services and systems level—most likely to provide the sort of context in which people with trauma histories may become engaged in chosen services most helpful to their recovery.

The Self-Assessment Scale is intended primarily for the use of programs to assess their own current practices and/or to track their progress in relation to a specific understanding of trauma-informed services (Harris & Fallot, 2001). We recommend that programs beginning this review process complete the Scale at the time of their initial overall self-assessment. Its patterns may be helpful in prioritizing areas for change. Subsequent dates for completion of the Scale may be scheduled based on the key timelines in a trauma-informed program implementation plan. Self-monitoring can therefore be built into the change process. Some programs may choose to have the assessment completed by raters from outside the program. Outside raters would need access to administrative and clinical records and also be able to conduct interviews and/or focus groups as necessary to gain a complete picture of the agency's operation.

Part A: Services-level Changes

Domain 1. Program Procedures and Settings: "To what extent are program activities and settings consistent with five guiding principles of trauma-informed practice: safety, trustworthiness, choice, collaboration, and empowerment?"

This section of the protocol can be used to assess the extent to which formal and informal procedures and the physical environment in a human services program are trauma-informed and to plan corresponding modifications in service delivery practices. Consumer-survivors should be actively involved in the review process as should support staff, direct service staff, supervisors, and administrators.

Step One: Identify Key Formal and Informal Activities and Settings

A. List the sequence of service *activities* in which new consumers are usually involved (e.g., outreach, intake, assessment, service planning). Think broadly to include informal as well as formal contacts. For example, consumers may be greeted and given directions by a number of people prior to formal service delivery.

B. Identify the *staff members* (positions and individuals) who have contact with consumers at each point in this process.

C. Identify the *settings* in which the various activities are likely to take place (e.g., home, waiting room, telephone, office, institution).

Step Two: Ask Key Questions about Each of the Activities and Settings

(See list of questions for Domains 1A-1E following Step Four)

Step Three: Prioritize Goals for Change

After the workgroup has reviewed services and has developed a list of possible trauma-informed changes in service delivery procedures, these goals for change should be prioritized. Among the factors to consider in this prioritizing are the following: (1) feasibility (which goals are most likely to be accomplished because of their scale and the kind of change involved?); (2) resources (which goals are most consistent with the financial, personal, and other resources available?); (3) system support (which goals have the most influential and widespread support?); (4) breadth of impact (which goals are most likely to have a broad impact on services?); (5) quality of impact (which goals will make the most difference in the lives of consumers?); (6) risks and costs of not changing (which practices, if not changed, will have the most negative impact?).

Step Four: Identify Specific Objectives and Responsible Persons

After goals have been prioritized, specific objectives (measurable outcomes with timelines for achievement) can be stated and persons responsible for implementing and monitoring the corresponding tasks can be named.

Domain 1A. <u>Safety</u>—Ensuring Physical and Emotional Safety

♦ *Key Questions: "To what extent do the program's activities and settings ensure the physical and emotional safety of consumers and staff? How can services be modified to ensure this safety more effectively and consistently?"*

Sample Specific Questions:

- Where are services delivered?
- When are they delivered?
- Who is present (other consumers, etc.)? Are security personnel present?   What impact do these others have?
- Are doors locked or open? Are there easily accessible exits?
- How would you describe the reception and waiting areas, interview rooms, etc.? Are they comfortable and inviting?
- Are restrooms easily accessible?
- Are the first contacts with consumers welcoming, respectful, and engaging?
- Do consumers receive clear explanations and information about each task and procedure? Are the rationales made explicit? Is the program mission explained? Are specific goals and objectives made clear? Does each contact conclude with information about what comes next?
- Are staff attentive to signs of consumer discomfort or unease? Do they understand these signs in a trauma-informed way?

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•What events have occurred that indicate a lack of safety—physically or emotionally (e.g., arguments, conflicts, assaults)? What triggered these incidents? What alternatives could be put in place to minimize the likelihood of their recurrence?

•Is there adequate personal space for individual consumers?

•In making contact with consumers, is there sensitivity to potentially unsafe situations (e.g., domestic violence)?

Domain 1B. <u>Trustworthiness</u>—Maximizing Trustworthiness through Task Clarity, Consistency, and Interpersonal Boundaries

♦ *Key Questions: "To what extent do the program's activities and settings maximize trustworthiness by making the tasks involved in service delivery clear, by ensuring consistency in practice, and by maintaining boundaries that are appropriate to the program? How can services be modified to ensure that tasks and boundaries are established and maintained clearly and appropriately?"*

Sample Specific Questions:

•Does the program provide clear information about what will be done, by whom, when, why, under what circumstances, at what cost, with what goals?

•When, if at all, do boundaries veer from those of the respectful professional? Are there pulls toward more friendly (personal information sharing, touching,

exchanging home phone numbers, contacts outside professional appointments, loaning money, etc.) and less professional contacts in this setting?

•How does the program handle dilemmas between role clarity and accomplishing multiple tasks (e.g., especially in residential work and counseling or case management, there are significant possibilities for more personal and less professional relationships)?

•How does the program communicate reasonable expectations regarding the completion of particular tasks or the receipt of services? Is the information realistic about the program's lack of control in certain circumstances (e.g., in housing renovation or time to receive entitlements)? Is unnecessary consumer disappointment avoided?

•What is involved in the informed consent process? Is both the information provided and the consent obtained taken seriously? That is, are the goals, risks, and benefits clearly outlined and does the consumer have a genuine choice to withhold consent or give partial consent?

Domain 1C. <u>Choice</u>—Maximizing Consumer Choice and Control.

♦ *Key Questions: "To what extent do the program's activities and settings maximize consumer experiences of choice and control?   How can services be modified to ensure that consumer experiences of choice and control are maximized?"*

Sample Specific Questions:

•How much choice does each consumer have over what services he or she receives? Over when, where, and by whom the service is provided (e.g., time of day or week, office vs. home vs. other locale, gender of provider)?

•Does the consumer choose how contact is made (e.g., by phone, mail, to home or other address)?

•Does the program build in small choices that make a difference to consumer-survivors (e.g., When would you like me to call? Is this the best number for you? Is there some other way you would like me to reach you or would you prefer to get in touch with me?)

•How much control does the consumer have over starting and stopping services (both overall service involvement and specific service times and dates)?

•Is each consumer informed about the choices and options available?

•To what extent are the individual consumer's priorities given weight in terms of services received and goals established?

•How many services are contingent on participating in other services? Do consumers get the message that they have to "prove" themselves in order to "earn" other services?

•Do consumers get a clear and appropriate message about their rights and responsibilities? Does the program communicate that its services are a privilege over which the consumer has little control?

•Are there negative consequences for exercising particular choices? Are these necessary or arbitrary consequences?

•Does the consumer have choices about who attends various meetings? Are support persons permitted to join planning and other appropriate meetings?

Domain 1D. <u>Collaboration</u>—Maximizing Collaboration and Sharing Power

♦ *Key Questions: "To what extent do the program's activities and settings maximize collaboration and sharing of power between staff and consumers? How can services be modified to ensure that collaboration and power-sharing are maximized?"*

Sample Specific Questions:

•Do consumers have a significant role in planning and evaluating the agency's services? How is this "built in" to the agency's activities? Is there a Consumer Advisory Board? Are there members who identify themselves as trauma survivors? Do these individuals understand part of their role to serve as consumer advocates? As trauma educators?

•Do providers communicate respect for the consumer's life experiences and history, allowing the consumer to place them in context (recognizing consumer strengths and skills)?

•In service planning, goal setting, and the development of priorities, are consumer preferences given substantial weight?

•Are consumers involved as frequently as feasible in service planning meetings? Are their priorities elicited and then validated in formulating the plan?

•Does the program cultivate a model of doing "with" rather than "to" or "for" consumers?

•Does the program and its providers communicate a conviction that the consumer is the ultimate expert on her or his own experience?

•Do providers identify tasks on which both they and consumers can work simultaneously (e.g., information-gathering)?

Domain 1E. <u>Empowerment</u>—Prioritizing Empowerment and Skill-Building

♦ *Key Questions: "To what extent do the program's activities and settings prioritize consumer empowerment and skill-building? How can services be modified to ensure that experiences of empowerment and the development or enhancement of consumer skills are maximized?"*

Sample Specific Questions:

•Do consumer-survivor advocates have significant advisory voice in the planning and evaluation of services?

•In routine service provision, how are each consumer's strengths and skills recognized?

•Does the program communicate a sense of realistic optimism about the capacity of consumers to reach their goals?

•Does the program emphasize consumer growth more than maintenance or stability?

•Does the program foster the involvement of consumers in key roles wherever possible (e.g., in planning, implementation, or evaluation of services)?

•For each contact, how can the consumer feel validated and affirmed?

•How can each contact or service be focused on skill-development or enhancement?

•Does each contact aim at two endpoints whenever possible: (1) accomplishing the given task and (2) skill-building on the part of the consumer?

Domain 2. Formal Services Policies

Key Question: "To what extent do the formal policies of the program reflect an understanding of trauma survivors' needs, strengths, and challenges?"

Some Possible Indicators**:**

◆Policies regarding confidentiality and access to information are clear; provide adequate protection for the privacy of consumers; and are communicated to the consumer.

◆The program avoids involuntary or potentially coercive aspects of treatment—involuntary hospitalization or medication, representative payeeship, outpatient commitment—whenever possible.

♦The program has developed a de-escalation or "code blue" policy that minimizes the possibility of retraumatization.

♦The program has developed ways to respect consumer preferences in responding to crises—via "advance directives" or formal statements of consumer choice.

♦The program has a clearly written, easily accessible statement of consumer rights and grievances.

Domain 3. Trauma Screening, Assessment, and Service Planning

Key Question: "To what extent does the program have a consistent way to identify individuals who have been exposed to trauma and to include trauma-related information in planning services with the consumer?"

Some Possible Indicators**:**

♦Staff members have reviewed existing instruments to see the range of possible screening tools.

♦At least these minimal questions are included in trauma screening:
•Have you experienced sexual abuse at any time in your life?
•Have you experienced physical abuse at any time in your life?

◆Screening avoids overcomplication and unnecessary detail so as to minimize stress for consumers.

◆The program recognizes that the process of trauma screening is usually much more important than the content of the questions. The following have been considered:
- •What will it mean to ask these questions?
- •How can they be addressed most appropriately—for the likely consumers, for the service context, time available, prior relationship, possible future relationship, at various points in the intake/assessment process?

◆The need for standardization of screening across sites is balanced with the unique needs of each program or setting.

◆The screening process avoids unnecessary repetition. While there is no need to ask the same questions at multiple points in the intake or assessment process, there is often a good rationale for returning to the questions after some appropriate time interval.

Part B: Systems-level/Administrative Changes

Domain 4. Administrative Support for Program-Wide Trauma-Informed Services

Key Question: " To what extent do program or agency administrators support the integration of knowledge about violence and abuse into all program practices?"

Some Possible Indicators:

♦ The existence of a policy statement or the adoption of general policy statement from other organizations that refers to the importance of trauma and the need to account for consumer experiences of trauma in service delivery.

♦ The existence of a "trauma initiative" (e.g., workgroup, trauma specialist).

- Designation of a competent person with administrative skills and organizational credibility for this task.
- Chief administrator meets periodically with trauma workgoup or specialist.
- Administrator supports the recommendations of the trauma workgroup or specialist and follows through on these plans.

♦ Administrators work closely with a Consumer Advisory group that includes significant trauma survivor membership. Consumer-survivor members of this group identify themselves

as trauma survivors and understand a part of their role as consumer advocacy. They.play an active role in all aspects of service planning, implementation, and evaluation.

♦ Administrators are willing to attend trauma training themselves (vs. sending designees in their places); they allocate some of their own time to trauma-focused work (e.g., meeting with trauma initiative representatives, keeping abreast of trauma initiatives in similar program areas).

♦ Administrators make basic resources available in support of trauma-informed service modifications (e.g., time, space, training money).

♦ Administrators support the availability and accessibility of trauma-specific services where appropriate; they are willing to be creative about finding alternative reimbursement strategies for trauma services.

♦ Administrators find necessary sources of funding for trauma training and education (this sometimes requires going outside the usual funding mechanisms in a creative way).

♦ Administrators are willing to release line staff from their usual duties so that they may attend trainings and deliver trauma services. Funding is sought in support of these activities.

♦ Administrators participate actively in identifying objectives for systems change.

♦ Administrators monitor the program's progress by identifying and tracking core objectives of the trauma-informed change process.

♦ Administrators may arrange pilot projects for trauma-informed parts of the system.

Domain 5. Staff Trauma Training and Education

Key Question: "To what extent have all staff members received appropriate training in trauma and its implications for their work?"

Some Possible Indicators:

♦ General education (including basic information about trauma and its impact) has been offered for all employees in the program with a primary goal of sensitization to trauma-related dynamics and the avoidance of retraumatization.

♦ Staff members have received education in a trauma-informed understanding of unusual or difficult behaviors. (One of the emphases in such training is on respect for people's coping attempts and avoiding a rush to negative judgments.)

♦ Staff members have received basic education in the maintenance of personal and professional boundaries (e.g., confidentiality, dual relationships, sexual harassment).

◆Clinical staff members have received trauma education involving specific modifications for trauma survivors in their content area: clinical, residential, case management, substance use, for example.

◆Clinical staff members have received training in trauma-specific techniques for trauma clinicians.

◆Staff members offering trauma-specific services are provided adequate support via supervision and/or consultation (including the topics of vicarious traumatization and clinician self-care).

Domain 6. Human Resources Practices: "To what extent are trauma-related concerns part of the hiring and performance review process?"

Key Question: "To what extent are trauma-related concerns part of the hiring and performance review process?"

Some Possible Indicators:

◆The program seeks to hire (or identify among current staff) trauma "champions," individuals who are knowledgeable about trauma and its effects; who prioritize trauma sensitivity in service provision; who communicate the importance of trauma to others in their work groups; and who support trauma-informed changes in service delivery.

◆Prospective staff interviews include trauma content (What do applicants know about trauma? about domestic violence? about

the impact of childhood sexual abuse? Do they understand the long-term consequences of abuse? What are applicants' initial responses to questions about abuse and violence?)

♦Incentives, bonuses, and promotions for line staff and supervisors take into account the staff member's role in trauma-related activities (specialized training, program development, etc.).

Addendum A: Possible Items for Consumer Satisfaction Surveys

(Items are worded to be consistent with a Likert response scale from "strongly disagree" to "strongly agree;" specific items and wording should be tailored to the program's goals and services)

Safety
• When I come to [program], I feel physically safe.
• When I come to [program], I feel emotionally safe.

Trustworthiness
• I trust the people who work here at [program].
• [Program] provides me good information about what to expect from its staff and services.
• I trust that people here at [program] will do what they say they are going to do, when they say they are going to do it.
• The people who work here at [program] act in a respectful and professional way toward me.

Choice

• [Program] offers me a lot of choices about the services I receive.
• I have a great deal of control over the kinds of services I receive, including when, where, and by whom the services are offered.
• People here at [program] really listen to what I have to say about things.

Collaboration

•At [program], the staff is willing to work <u>with</u> me (rather than doing things <u>for</u> me or <u>to</u> me).

•When decisions about my services or recovery plan are made, I feel like I am a partner with the staff, that they really listen to what I want to accomplish.

•Consumers play a big role in deciding how things are done here at [program].

Empowerment

•[Program] recognizes that I have strengths and skills as well as challenges and difficulties.

•The staff here at [program] are very good at letting me know that they value me as a person.

•The staff here at [program] help me learn new skills that are helpful in reaching my goals.

•I feel stronger as a person because I have been coming to [program].

Trauma Screening Process

•The staff explained to me why they asked about difficult experiences in my life (like violence or abuse).

•The staff are as sensitive as possible when they ask me about difficult or frightening experiences I may have had.

•I feel safe talking with staff here about my experiences with violence or abuse.

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Community Connections
October, 2002; May, 2003; March, 2004;
February, 2005; March, 2006

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