Creating a Trauma-Informed Organization

Literature Review for Volunteers of America

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Contents

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Introduction

The experience of trauma is simply not the rare exception we once considered it. It is part and parcel of our social reality (Fallot & Harris, 2009).

Over the past several years, organizations have become increasingly interested in the effects of trauma and providing trauma-informed care to their clients. This is no less true for Volunteers of America, a national, faith-based organization dedicated to helping those in need. Since its founding in 1896, Volunteers of America has supported and empowered America's most vulnerable populations, including men and women returning from prison, at-risk youth and families, people experiencing homelessness, people with disabilities, and those recovering from addictions. Through thousands of programs, it serves more than two million people in over 400 communities in 46 states as well as the District of Columbia and Puerto Rico each year.[1]

While Volunteers of America provides services to those with a broad range of needs, a common thread that runs through these populations is potential exposure to trauma. Over the next five years, with support from the Annie E. Casey Foundation, Volunteers of America intends to build a cross-affiliate system that ensures children, youth, and families served by Volunteers of America receive the necessary supports to successfully cope with trauma. Particular attention will be paid to the approximately 20,000 children and youth served by over 140 Volunteers of America programs.

To begin this work, Volunteers of America asked Wilder Research to find information from two sources:

1) **A review of the existing body of literature on best practices in the area of trauma-informed care:** Specifically, Volunteers of America is interested in learning what evidence-based practices currently exist to better serve its target youth populations – including homeless youth, LGBTQ youth, children in the child welfare system, young children from birth to age 5, and school age children – and how the organization can better implement such practices.

2) **A brief web survey with affiliate staff:** The purpose of the survey was to gauge staff perceptions on how trauma informed their affiliate is, and to learn which trauma-informed practices are currently being used at each affiliate site. A survey was sent to 144 staff in management positions (either program leaders or upper-level executives); 74 people responded for a response rate of 51 percent. Wilder sent the findings from the web survey to Volunteers of America in a separate report.

[1] Volunteers of America. https://www.voa.org/about-us

The following report provides a summary of the literature reviewed on this topic, including a description of the most promising current models of how to build a trauma-informed system. The report also includes a resource list for thought leaders and trainers in the field of trauma-informed services, and concludes with a discussion of findings and proposed next steps for Volunteers of America (VOA) in their work toward building a more trauma-informed system.

Literature review

Background

What is trauma and why should we address it?

> *It is imperative for an organization to have a full understanding of what trauma is…An organization that is trauma informed will have the ability to recognize and plan for situations that may create trauma and use best practice to reduce trauma among the communities, clients, patients, families and employees we serve. – VOA staff member*

Awareness of trauma experienced by vulnerable populations has been increasing steadily in recent years, and is a crucial consideration for organizations that interact with children, youth, and families. As awareness increases, so has the research on trauma-informed and trauma-specific care. In order for an organization to offer such care, the system within it must also adhere to policies or guidelines that encourage the organization as a whole to utilize a trauma-informed approach. This literature review comprises an introduction to the field of trauma-informed care, as well as a description of the most current promising models for building a trauma-informed organization.

Definitions of trauma

Many definitions of trauma exist, but as the field of trauma-informed care grows, practitioners are coming to a consensus on appropriate operationalization. A leader in the field, The National Child Traumatic Stress Network (NCTSN) notes two different types of trauma – acute traumatic events and chronic traumatic situations. Acute traumatic events are one-time occurrences or are short lived, while chronic traumatic situations persist over longer periods causing an array of responses, "including loss of trust in others, guilt, shame, a decreased sense of personal safety, and hopelessness about the future" (Gerrity & Folcarelli, 2008). Further, different kinds of trauma affect children and youth in a variety of ways, and this complexity is compounded by the age of the child, among other factors (Hodas, 2006; NCTSN, 2008).

Several authors and organizations also point to the neurological damage done by trauma (Black, Woodworth, Tremblay, & Carpenter, 2012; Hodas, 2006; NCTSN, 2008; SAMHSA, 2014). In particular, trauma at a young age can significantly hinder neurological development, causing a host of other problems for the child. For this reason, providers and experts in the field recommend treating youth affected by trauma as soon as possible to prevent further neurological damage (Hanson & Lang, 2016). The field of mental health is beginning to focus efforts on the issue of implementing trauma-informed care and prominent organizations continue to promote trauma-informed practice.

Who is affected by trauma?

Trauma can come from a wide range of sources or events: "neglect, physical abuse, psychological abuse, sexual abuse, witnessing of domestic abuse and other violence, community violence, school violence, traumatic loss, medical trauma, natural disasters, war, terrorism, refugee trauma, and others" (Hodas, 2006, p. 7). It is perhaps unsurprising, then, that trauma disproportionately affects youth who are socioeconomically disadvantaged (NCCP, 2007). In particular, there is a significant body of work regarding trauma in child welfare systems as it is estimated that 85 percent of youth involved in the child welfare system have been exposed to at least one traumatic event (Lang, Campbell, Shanley, Crusto, & Connell, 2016). Age and gender also play a role in the way that trauma presents in youth; Hodas (2006) explains that the earlier the trauma is experienced, the more "global and pervasive" the consequences for the child. Gender may also be a factor in a child's behavior following trauma; females are more likely to have an internalized response while males are more likely to have an externalized response.

Studies of racial and ethnic differences in exposure to trauma indicate that African American children may be more likely than any other racial group to experience childhood trauma, although data on racial disparities in overall lifetime exposure to trauma is inconsistent (Roberts, Gilman, Breslau, & Koenen, 2011; Gaillot, 2010). In a national study of childhood victimization, Finkelhor, Ormrod, Turner, and Hamby found that while incidence of certain types of victimization may vary slightly by race, overall rates of victimization were consistent, with 71 percent of children age 2-17 experiencing some form of victimization (2005).

Another way of measuring the incidence of trauma among children is to examine data on Adverse Childhood Experiences, or ACEs. ACEs can include things like experiencing economic hardship, living with someone who has an alcohol or drug problem, living in a home with domestic violence, or having an incarcerated parent. According to the National Survey of Children's Health on Adverse Childhood Experiences, American Indian/Alaskan Native children were most likely to have experienced two or more ACEs in their lifetime (40%), followed by non-Hispanic children of multiple races, and non-Hispanic black children (33% and 31% respectively). About one-fifth of non-Hispanic white children, Hispanic children, and non-Hispanic native Hawaiian/Pacific Islander children experienced two or more ACEs in their lifetime. Asian children were least likely to have experienced more than one ACE, with only 5 percent reporting two or more ACEs since birth (U.S. Department of Health and Human Services, 2014).

Trauma-specific vs. trauma-informed

Hummer, Dollard, Robst, and Armstrong (2010) outline two major areas of focus related to trauma: trauma-specific care and trauma-informed care. The former "directly addresses complex trauma and facilitates the child's recovery through individual or group therapy specifically focusing on trauma recovery," while the latter might be used more broadly to deal with "the dynamics and impact of complex trauma on youth through a focus on avoiding inadvertently retraumatizing them when providing assistance within the mental health system" (p. 81-82). Additionally, by focusing on being trauma-informed, organizations are supporting the implementation of trauma-specific programs (Hummer et al., 2010). Trauma-informed care is not specific to types of treatment and is relevant to a variety of settings, not necessarily only to mental health. Like trauma itself, defining trauma-informed care relies on gathering data from a range of sources; Hendricks, Conradi, and Wilson (2011) provide a consensus-based definition:

> *Trauma-informed care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment (p. 189).*

All articles reviewed for this report unanimously claim the importance of implementing trauma-informed care at the organizational level as well as the system level. Lang et al. (2016) suggest that thoughtful implementation of trauma-informed care across youth-serving systems may result in overall cost savings by preventing retraumatization caused by lack of appropriate treatment for youth affected by trauma. Due to the staggering share of youth affected by trauma in the child welfare system, it is crucial to consider the effects of trauma in such settings. In a review of literature on trauma-informed care, Black et al. (2012) state that trauma manifests not only mentally, but can exacerbate or cause the development of additional physical health problems. In addition, evidence suggests that the physical and mental health effects of trauma can persist through adulthood (Hodas, 2006).

The evidence clearly supports the need for a framework to integrate trauma-informed care on a broad scale. The next section of this report outlines a series of current practice models that can guide human services organizations and systems in their development of a trauma-informed approach.

Promising models and tools

The Sanctuary Model

A leader in the field of approaches to trauma-informed organizations, Sandra Bloom developed the Sanctuary Model during the 1980s and 1990s, based on perspectives of therapy, human rights, and her work with adults who were traumatized as children (Bloom, 2011). Using frameworks of attachment and child development, Bloom integrated the concept of parallel processes to describe the feedback loop that exists within the model. She explains:

> *…our systems inadvertently but frequently recapitulate the very experiences that have proved to be so toxic for the people we are supposed to help. Just as the lives of people exposed to repetitive and chronic trauma, abuse and maltreatment become organized around the traumatic experience, so too can entire systems become organized around the recurrent and severe stress of trying to cope…when this happens, it sets up an interactive dynamic that creates what are sometimes uncannily parallel processes (p. 141).*

Bloom set out to develop the Sanctuary Model in order to address these flawed processes and help create trauma-informed systems. The model is intended to function within and alongside programs designed to treat trauma but is not a treatment program itself; rather, it is an approach to organizational change and perspective.

In order to achieve meaningful change, Bloom (2010) proposes seven "commitments" to act as guiding principles that may support this change. These commitments are cited directly (p. 242-243):

1) **Non-violence:** to build safety skills, trust, and inspire a commitment to wider socio-political change

2) **Emotional intelligence:** to teach emotional management skills and expand awareness of problematic cognitive-behavioral patterns and how to change them

3) **Social learning:** to build cognitive skills, improve learning and decisions, and create/sustain a learning organization

4) **Open communication:** to overcome barriers to healthy communication, discuss the undiscussables, increase transparency, develop conflict management skills, and reinforce healthy boundaries

5) **Democracy:** to develop civic skills of self-control and self-discipline, to learn to exercise healthy authority and leadership, to develop participatory skills, overcome helplessness, and honor the voices of self and others

6) **Social responsibility:** to harness the energy of revenge by rebuilding social connection skills, establishing healthy attachment relationships, and transforming vengeance into social justice

7) **Growth and change:** to work through loss in the recognition that all change involves loss, and to envision, skillfully plan, and prepare for and be guided by a different and better future.

Bloom explains that these are critical to determining organizational culture, particularly as they apply to all staff within an organization.

With regard to planning and implementation of system changes, Bloom recommends including representatives from all levels of the organization; their responsibility should be to become "trainers and cheerleaders" for their colleagues and community (2011, p. 248). She further emphasizes the importance of gathering and confirming consensus among staff to ensure the successful implementation of the model, particularly because the Sanctuary Model "views systems as alive and therefore subject to conscious and unconscious dynamics similar to the individuals who work in and are served by those systems." This means that all staff should be on the same page regarding "basic values, beliefs, guiding principles, and philosophical principles" (2013, p. 307) – this is a continuous process that should occur at each stage of model implementation through constant communication.

SAMHSA's Concept of Trauma

In 2014, The U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) underwent a comprehensive process to develop a framework for understanding trauma and a trauma-informed approach (SAMHSA, 2014). In order to complete this work, SAMHSA integrated information from three sources: current research, practice knowledge from experts in the field, and lessons from trauma survivors who have also been service recipients. Through this process, SAMHSA defined trauma-informed programs, organizations, and systems as those which "realize the widespread impact of trauma and understand the potential paths for recovery; recognize the signs and symptoms of trauma in clients, families, staff and others involved with the system; and respond by fully integrating knowledge about trauma into policies, procedures, and practices and seek to actively resist re-traumatization" (p. 9).

In this review, SAMHSA also identifies six key principles of a trauma-informed approach, as well as ten "implementation domains." While the domains themselves are consistent with existing literature on organizational change, it is the process of integrating the six key trauma-informed principles into each domain that makes this model unique. The key principles and implementation domains are listed below.

Six Key Principles of a Trauma-Informed Approach (SAMHSA, 2014)

1. Safety
2. Trustworthiness and transparency
3. Peer Support
4. Collaboration and mutuality
5. Empowerment, voice and choice
6. Cultural, historical, and gender issues

Ten Implementation Domains for a Trauma-Informed Approach (SAMHSA, 2014)

1. Governance and leadership
2. Policy
3. Physical environment
4. Engagement and involvement
5. Cross sector collaboration
6. Screening, assessment and treatment services
7. Training and workforce development
8. Progress monitoring and quality assurance
9. Financing
10. Evaluation

The SAMHSA report also includes an organizational assessment based on these principles and domains to guide implementation.

Creating Trauma-Informed Care Environments

Through an evaluation of trauma-informed policies and procedures across several Florida mental health programs for youth, Hummer et al. utilized both existing research and theoretical models related to organizational change. They also conducted interviews and observation to support the case study approach used. Based on their study, the authors developed a curriculum: Creating Trauma-Informed Care Environments. This curriculum has three modules (2010):

- **Understanding Trauma and Trauma-Informed Care** (which includes training on cultural competence): This module aims to orient participants to trauma and trauma-informed care through training on components of healing, types of care, and various interventions.
- **Application of the Learning Collaborative Model** to Florida Residential Treatment Settings for Youth: While specific to Florida in this case, the process outlined by Hummer et al. is relevant to other organizations in that it emphasizes the importance of local context for addressing trauma at an organizational level. This module also includes facets of approaches discussed earlier, namely that staff should be involved at all levels and that organizations are dynamic and should be treated as such during systems change interventions.
- **Metrics and Organizational Assessment Tools:** The authors explain that self-assessments are important for a variety of reasons, but that in particular they promote a culture of transparency. Thus, any changes occurring within the organization, regardless of level, should be shared across the organization. They include in their module materials a tool for self-assessment that is designed to assess organizational readiness to implement these changes.

The modules include exercises and discussions designed to encourage participants to gain a deeper understanding of trauma and its effects. The final module wraps up with training on assessment followed by participants conducting an actual assessment on organizational readiness for implementation of these trauma-informed practices.

Creating Cultures of Trauma-Informed Care

Cited in numerous works on trauma-informed environments, Fallot and Harris' protocol emphasizes the role of assessment in the creation of such environments (2009). It should be noted that this protocol is not specific to youth. The Creating Cultures of Trauma-Informed Care approach has five core values: "safety, trustworthiness, choice, collaboration, and empowerment" (Fallot & Harris, 2009). They outline four key steps to creating a trauma-informed culture:

1) **Initial planning:** Encompassing several of the components mentioned earlier in this review, this initial stage recommends organizations to determine representation across various levels or departments within the organization as well as confirm the commitment to and support for the initiative.

2) **Kickoff training event:** This event should include all staff and any interested stakeholders because the information presented stresses the importance of having all staff on board. Additional presentations should include information on the basic tenets of trauma-informed care and cultures as well as the importance of trauma within the context of the agency or organization in question.

3) **Short-term follow-up:** During this phase, an organization applies what they have learned and develops a plan for assessment. Ongoing training and refresher material is also presented to staff to help solidify the organization's culture change.

4) **Long-term follow-up:** Fallot and Harris recommend that longer-term follow-up occur after about six to nine months. External consultants meet with staff, including organization leaders, while conducting a site visit to ensure continued progress towards becoming trauma informed.

The protocol proposed by Fallot and Harris is extensive and involves two overarching pieces – service-level changes and system-level/administrative changes.

The Exploration, Preparation, Implementation, and Sustainment Model

Designed to promote evidence-based practices for organizations working toward becoming trauma informed, the Exploration, Preparation, Implementation, and Sustainment (EPIS) model is comprised of four phases, which are listed below (Goldman, 2015, p. 36):

1) **Exploration:** assessing the degree to which the organization is currently recognizing and responding to trauma.

2) **Preparation:** securing buy-in from key constituents, working with them to determine what tools and practices will be implemented, and developing a plan for implementation.

3) **Implementation:** carrying out and monitoring the plan.

4) **Sustainment:** considering financial and practical implications for long-term implementation of trauma-informed practices.

Developed by researchers at the Child and Adolescent Services Research Center at Rady Children's Hospital, the model intends to fill a gap in implementation support for organizations seeking to improve practices. While the model is not specific to trauma, the authors are especially interested in the role of evidence-based practices in building a more solid foundation among organizations serving youth and adolescents. After reviewing several models recommended by others in the field, they determined a set of themes relevant to implementation and used them to create the conceptual framework which is intended to inform organizations considering an evidence-based practice and help them navigate the process of implementation (Aarons, Hurlburt, & Horwitz, 2010).

Working with vulnerable youth populations

Volunteers of America serves a broad range of young people through its programs for young children, school aged children, children in the child welfare system, and youth experiencing homelessness. While the program models discussed above offer general guidance for organizations seeking to provide trauma-informed services, several promising practices have emerged from the field that are targeted to serve these specific populations. Some of these models and practices are described in more detail below.

Early childhood and school aged youth

Young children (birth to age 5) are disproportionately exposed to trauma, particularly interpersonal violence. In addition, young children are at a greater risk of experiencing negative outcomes of trauma compared to adults and even older youth because they have not developed emotionally enough to process events. Young children are also more likely to develop mental health problems later in life because their ability to manage emotions and use coping skills are not developed at the time of the trauma (Chadwick Trauma-Informed Systems Project, 2012). For these reasons, it is particularly important to use trauma-informed service interventions when working with young children.

School aged children may experience trauma differently, as they are more likely to be able to understand the meaning of a traumatic event. Therefore, these children may experience depression, anxiety, and aggressive behavior, among other things (Chadwick Trauma-Informed Systems Project, 2012).

One organization that specializes in training child and youth serving organizations in trauma-informed interventions is the National Institute for Trauma and Loss in Children. This organization provides training and resources on a range of trauma interventions. One such intervention is the Sensory Intervention for Traumatized Children, Adolescents and Parents (SITCAP). This intervention serves children between age 3 and 18, as well as parents and adults. SITCAP programs are listed on the California Evidence-Based Clearinghouse and the SAMHSA National Registry of Evidence-Based Programs and Practices. The intervention provides children and youth the opportunity to address major experiences induced by trauma to help them recover (Steele & Kuban, n.d.).

Children involved in the child welfare system

The National Childhood Traumatic Stress Network describes a trauma-informed child and family service system as one in which "all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system including children, caregivers and service providers" (NCTSN, n.d.a.). To this end, NCTSN developed a toolkit to train child welfare professionals on how to work directly with children affected by trauma and their families. The toolkit defines seven essential elements of a Trauma-Informed Child Welfare System (NCTSN, 2008):

The Essential Elements of Trauma-Informed Child Welfare Practice

1. Maximize Physical and Psychological Safety for Children and Families

2. Identify Trauma-Related Needs of Children and Families

3. Enhance Child Well-Being and Resilience

4. Enhance Family Well-Being and Resilience

5. Enhance the Well-Being and Resilience of Those Working in the System

6. Partner with Youth and Families

7. Partner with Agencies and Systems that Interact with Children and Families

This toolkit is available at no cost and contains a wide range of resources and training materials. Information about how to access the tool-kit is included in the "Resources" section of this report.

Additionally, in 2015 the Child Welfare Information Gateway issued a brief report titled "Developing a Trauma-Informed Child Welfare System." This issue briefly discusses several primary areas of consideration as the child welfare system moves toward becoming trauma-informed, including workforce development, screening and assessment, data system needs, evidence-based and evidence-informed treatments, and funding. According to this report, the following evidence-based practices are effective methods for working with children and youth in the child welfare system who have experienced trauma (Child Welfare Information Gateway, 2015, p. 9).

- **Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT):** A common and well-researched intervention, CBT is used to help reduce negative emotions and behaviors by addressing the child's distorted beliefs around the traumatic event.

- **Parent-Child Interaction Therapy (PCIT):** A family-centered treatment approach for children age 2 through 8 as well as their caregivers, this approach includes parent coaching and children's programming.

- **Eye Movement Desensitization and Reprocessing (EMDR):** A research-based intervention, EMDR uses elements of cognitive-behavioral therapy as well as eye movements to decrease negative responses associated with trauma.

A wide range of other interventions have been identified as evidence-informed, but still lack conclusive evidence to prove effectiveness. The National Child Traumatic Stress Network offers a list of these interventions, including research available to date (NCTSN, n.d.b.)

Homeless youth

Another population of concern for Volunteers of America is youth experiencing homelessness. For this population of older youth, a common theme within trauma-informed care is the emphasis placed on empowerment of the client. This is especially important with youth who may have developed a deep mistrust of professionals from a young age. In one toolkit presented by Ferguson-Colvin and Maccio (2012), the authors discuss the importance of empowering youth in a variety of ways, from involving them in decision-making processes to asking for their help in determining outreach strategies for other homeless youth. Two frameworks that embody these approaches are Positive Youth Development (PYD) and Youth-Driven Space (YDS; Ferguson-Colvin & Maccio, 2012); both advocate for staff to treat clients with respect and develop a collaborative and supportive relationship in which youth are the experts on their own lives.

Additional care may be necessary with youth who are dealing with complex trauma. Studies show that LGBTQ youth are disproportionately represented among homeless populations and are at greater risk of abuse or sexual exploitation (Wayman, 2008; Keuroghlian, Shtasel, & Bassuk, 2014). In many cases, rejection by family members leads to homelessness for LGBTQ youth. The lack of access to health care coupled with increased risk of abuse suggests that service providers should offer access to medical as well as mental health care.

Beyond shelters, these youth need long-term housing options with positive youth development services that allow for gateways to other services (Wayman, 2008). Wayman makes several suggestions regarding interventions with this population including a four-pronged intervention framework (p. 607):

1) Street- and community-based outreach services to build trusting relationships and help youth navigate systems to receive resources and services

2) Prevention services dedicated to stopping child abuse, preventing homelessness, and enhancing family preservation

3) Crisis intervention and shelter geared toward family/kin counseling and reunification

4) Housing models oriented toward positive youth development and mastery of life skills when family reunification is not possible

Developing a method of self-assessment or evaluation

When developing new organizational systems, it is important that changes are accompanied by a plan for recurring evaluation. By making space for the use of evaluation, the organization is helping to ensure accurate and appropriate implementation of its trauma-informed plan or approach. In particular, the use of tracking and evaluation can continue to further the field of trauma-informed care as well as provide positive outcomes for patients and communities.

Hendricks et al. (2011) suggest utilizing an assessment on the front end of a new program implementation. They propose several tools for self-assessment, some of which are contained within a model for trauma-informed practices. Trauma-informed assessments briefed by the authors are:

- Developing Trauma-Informed Organizations: A Tool Kit (Institute for Health and Recovery, 2002)
- Trauma-Informed Program Self-Assessment Scale (Harris & Fallot, 2001)
- Creating Cultures of Trauma-Informed Care (Fallot & Harris, 2009)
- Trauma-Informed Organizational Toolkit for Homeless Services (Guarino, Soares, Konnath, Clervil, & Bassuk, 2009)
- Trauma-Informed System Change Instrument (Richardson, Coryn, Henry, Black-Pond, & Unrau, 2012)

These scales and tool kits offer various approaches to gathering information on the degree to which an organization is using trauma-informed practices.

Potential challenges to implementation

As with any program implementation, organizations should expect to encounter barriers during the process of change. While these challenges will vary significantly based on existing organizational framework and institutional context, two themes emerged from the literature regarding common barriers. As is often the case with social programs and nonprofit organizations, lack of resources can act as a significant barrier to change. Without the necessary staff, time, and funding, it may be extremely difficult to implement change. Additionally, without buy-in and support from the community of care – other providers and members of the community – even a well-planned implementation strategy risks failure. The following outlines these potential barriers further.

Time and money to implement training

It is perhaps unsurprising that staff in social service positions experience additional occupational stress as a result of a lack of resources; however, regular attention to training and education is critical to successfully supporting a trauma-informed culture. In fact, through a community assessment of such programs, Hendricks (2011) discovered a lack of time for training. During implementation of a trauma-informed organizational approach, Lang et al. (2016) noticed a similar challenge among participants: "The most common overarching barrier was initiative fatigue and a reluctance among staff at all levels to add 'one more thing' - whether a new training, a new screening measure, or a new meeting with behavioral health providers" (p. 10).

Secondary traumatic stress

Addressing secondary traumatic stress and ensuring that proper training in trauma-informed care are important components in the creation of a trauma-informed organization. However, these components, when not appropriately addressed, can also act as barriers to a successful system. It is worth noting that many individuals serving in a social service role have themselves experienced trauma or have had adverse childhood experiences (Bloom, 2010).

Bloom (2010) describes in particular the parallel processes at work, which can dictate interactions between staff members as well as between staff and clients. These individual interactions play off each other as well as cause an effect on the organizational level: "efforts to create change often appear to confound the very process of change, and as that happens, staff demoralization escalates. It is possible then to see the parallel processes…at a whole-organizational level" (p. 4).

Lack of collaboration across service providers

Because children affected by trauma are often served by many providers and a range of services, much can be lost in translation and information missed. When this happens, services suffer, and the youth do not receive optimal care. Without continuous and consistent services across providers, organizations run the risk of causing retraumatization (Goldman, 2015).

Overcoming this barrier to the provision of appropriate services for youth is a challenge for many organizations, particularly when presented with an already-taxed staff, as noted above. However, Goldman (2015) provides a positive outlook, noting that "collaboration might occur through family team meetings, co-located services, technology or tools which allow for easier and better communication between systems, or multi-disciplinary approaches to treatment" (p. 38). With the increase in trauma-related services as well as tools available to organizations, it may be less challenging than before to facilitate such connections.

Conclusion and recommendations

Existing literature illustrates that the field of trauma-informed care is becoming more prevalent among organizations serving clients with complex and co-occurring issues. Volunteers of America has already begun work to become a more trauma-informed organization by forming an Advisory Committee, conducting a literature review to identify best practices of trauma-informed organizations, and implementing a survey to assess the degree to which their affiliates are currently trauma-informed. As the organization moves forward in this work, Wilder Research recommends the following next steps.

1) **Involve all levels of staff in creating a trauma-informed organization.** Much of the literature on this topic points to the importance of including staff representatives from all levels of an organization in the early stages of this work. In particular, there must be investment in creating a trauma-informed organization from senior leadership.

2) **Create a core set of values and goals related to trauma-informed care.** All staff and stakeholders involved in this work should have a common set of values and goals to ensure that the organization is moving forward together, and that any changes made are successful and inclusive. It is also important to communicate these core values and goals frequently, and to clearly outline any changes (and reasons for changes) as they arise.

3) **Continually train staff on how to recognize the characteristics of trauma and related trauma-informed practices.** One of the central themes of the literature was to involve as many staff as possible in creating a trauma-informed organization, in order to ensure a safe and empowering space for clients who have experienced trauma. For both new and existing staff, this means continually training staff on the agreed-upon core values of the organization around trauma-informed care, and then learning the best practices for working with clients who have experienced trauma.

4) **Approach trauma in a culturally sensitive manner.** Specific populations may experience trauma in unique ways. It is, therefore, important to provide a safe space that meets the cultural and language needs of the population served by a program, in order to prevent further retraumatization, and ultimately lead to positive outcomes.

5) **Develop a stakeholder committee, and continually evaluate the members involved.** As mentioned above, Volunteers of America has already created an Advisory Committee to advance its work in providing more trauma-informed care at its affiliates. This is an important step; however, as the work moves forward, Volunteers of America may consider expanding participation in the group to include more community members, as well as ensuring that a broad range of ethnic and linguistic groups are represented.

7) **Continually assess the organization's work around trauma-informed care to ensure that positive changes are being made.** It is important to conduct an assessment on the front end of a new program or process, and then follow that baseline survey over time to determine if positive changes are being made. Volunteers of America has already completed a survey of its affiliates to determine how trauma-informed they are, and will continue this work over the next several years.

8) **Offer multiple outlets for staff, as they may experience secondary traumatic stress.** Working with individuals, children, and families who have experienced trauma often places an additional burden on staff that can lead to secondary trauma, and ultimately high turnover. It is, therefore, important to provide staff with safe spaces to relax and process their work. Examples could include formal counseling for staff, especially those that have client-facing roles; training on how to develop healthy boundaries between professional and personal life; providing a quiet, relaxing place in the office (e.g., prayer or meditation room); and creating an office support network so that staff can connect with each other and share experiences.

Resources

As Volunteers of America moves forward with its work of becoming a more trauma-informed organization, national leadership may wish to consider partnering with one of the following organizations to assist with training and technical assistance. Each organization, its contact information, and descriptions of their work (pulled directly from each website) are listed below.

National Center for Trauma-Informed Care (SAMHSA)
66 Canal Center Plaza | Suite 302 | Alexandria, VA 22314
Office: (866) 254-4819
www.samhsa.gov/nctic/training-technical-assistance

NCTIC provides technical assistance and consultation to support systems and programs that are committed to implementing trauma-informed approaches to service delivery. Technical assistance may help identify and implement some of the following steps that programs, agencies, or institutions can take to begin the transformation to a trauma-informed environment:

- Adopt a trauma-informed care organizational mission and commit resources to support it
- Update policies and procedures to reflect new mission
- Conduct universal trauma screening for all consumers and survivors
- Incorporate values and approaches focused on safety and prevention for consumers, survivors, and staff
- Create strengths-based environments and practices that invite consumer and survivor empowerment
- Provide ongoing staff training and education in trauma-informed care
- Improve and target staff hiring practices

National Child Traumatic Stress Network (NCTSN)
http://www.nctsn.org/resources/training-and-implementation

> *Through linkages to experts, consultation on training and implementation initiatives, and training resources on child trauma, the Training and Implementation Program at the National Center for Child Traumatic Stress guides professionals, agencies, and systems to increase their capacity to treat children and families affected by trauma. One essential function of the National Child Traumatic Stress Network is to increase access to evidence-based child trauma treatments. Several initiatives disseminate knowledge from clinical and system-change experts within the NCTSN, including The Learning Center for Child and Adolescent Trauma, NCTSN-developed resources and products, and a comprehensive Events Calendar.*

National Council for Behavioral Health
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Director of Trauma-Informed Services
1400 K Street NW | Suite 400 | Washington, DC 20005
Office: (202) 684-7457, ext. 275
www.TheNationalCouncil.org

> *The National Council's trauma-informed care initiatives have helped hundreds of organizations across the country map out and operationalize a plan for delivering trauma-informed care. National Council trauma experts can help you devise and implement a complete A-Z trauma-informed care plan for your organization. They help you address board and leadership buy-in, workforce training, practice changes and guidelines, community awareness, and outcomes measurement. Our experts are available for short-term and long-term consulting and training engagements at your site and can work hands on with your core implementation team. https://www.thenationalcouncil.org/areas-of-expertise/trauma-informed-behavioral-healthcare/*

National Institute for Trauma and Loss in Children (TLC) - Starr Commonwealth
Dr. William Steele
Founder
steele@tlcinst.org
https://www.starr.org/training/tlc/about

> *TLC provides training courses, materials and conferences to therapists and other professionals in the United States and around the world. We train and equip professionals and caregivers with the right tools to help guide children, adults, families and communities through the devastating effects of trauma. TLC is one of three programs in the Starr Global Learning Network (SGLN). The other two programs are Reclaiming Youth International (RYI) and Glasswing. All of the programs draw on the Circle of Courage® model of positive youth development based on the universal principle that to be emotionally healthy all youth need to experience Belonging, Mastery, Independence, and Generosity.*

National Technical Assistance Center for Children's Mental Health
Center for Child and Human Development, Georgetown University
Sherry Peters, MSW, ACSW
Senior Policy Associate
slp45@georgetown.edu
http://gucchdtacenter.georgetown.edu/TraumaInformedCare.html

> *A priority for federal, state, and local systems is increasing public awareness of how trauma impacts the lives of children and the importance of helping providers and families be more trauma-informed. The National Technical Assistance Center for Children's Mental Health (TA Center), within the Georgetown University Center for Child and Human Development (GUCCHD), is supporting these efforts in several ways.*

References

Aarons, G. A., Hurlburt, M., & Horwitz, S. M. (2010). Advancing a conceptual model of evidence based practice implementation in public service sectors. *Administration and Policy in Mental Health and Mental Health Services Research*, *38*(1), 4–23.

Barrow, S. (2009). Shelter from the storm: What we know about trauma-informed services. Retrieved from http://homeless.samhsa.gov/Resource/Shelter-from-the-Storm-What-We-Know-about-Trauma-Informed-Services-37603.aspx

Bartlett, J. D., Barto, B., Griffin, J. L., Fraser, J. G., Hodgdon, H., & Bodian, R. (2016). Trauma-informed care in the Massachusetts Child Trauma Project. *Child Maltreatment*, *21*(2), 101–112.

Black, P. J., Woodworth, M., Tremblay, M., & Carpenter, T. (2012). A review of trauma-informed treatment for adolescents. *Canadian Psychology/Psychologie Canadienne*, *53*(3), 192–203.

Bloom, S. (2006). *Organizational Stress as a Barrier to Trauma-Sensitive Change and Systems Transformation*. CommunityWorks. Retrieved from http://www.sanctuaryweb.com/Portals/0/Bloom%20Pubs/2010%20Bloom%20Organizational%20Stress%20as%20a%20Barrier%20to%20Trauma%20Chapter.pdf

Bloom, S. (2013). The sanctuary model: A best-practices approach to organizational change. In V. L. Vandiver (Ed.), *Best practices in community mental health: A pocket guide* (pp. 303–313). Chicago, IL, US: Lyceum Books.

Bloom, S. (n.d.). The Sanctuary Model® of Trauma- Informed Organizational Change. Retrieved from http://www.sanctuaryweb.com/Portals/0/Bloom%20Pubs/2007%20Bloom%20The%20Sanctuary%20Model%20The%20Source%20Articles%20Sanctuary.pdf

Bloom, S. L. (2010). Sanctuary: An operating system for living organizations. In N. Tehrani (Ed.), *Managing trauma in the workplace – supporting workers and the organisation.* London: Routledge (pp. 235-251).

Bloom, S. L. (2013). The sanctuary model. In J. D. Ford & C. A. Courtois (Eds.), *Treating complex traumatic stress disorders in children and adolescents: Scientific foundations and therapeutic models* (pp. 277–294). New York, NY, US: Guilford Press.

Bloom, S. L., & Farragher, B. (2011). *Destroying sanctuary: The crisis in human service delivery systems* (Vol. xxvii). New York, NY, US: Oxford University Press.

Bloom, S. L., & Farragher, B. (2013). *Restoring sanctuary: A new operating system for trauma-informed sytems of care.* New York, NY, US: Oxford University Press.

Bride, B. E. (2007). Prevalence of secondary traumatic stress among social workers. *Social Work, 52*(1), 63-70.

Conradi, L., Agosti, J., Tullberg, E., Richardson, L., Langan, H., Ko, S., & Wilson, C. (2011). Promising practices and strategies for using trauma-informed child welfare practice to improve foster care placement stability: A breakthrough series collaborative. *Child Welfare*, *90*(6), 207–225.

Creating Trauma-Informed Services Tipsheet Series. (n.d.). Retrieved from http://www.nationalcenterdvtraumamh.org/publications-products/creating-trauma-informed-services-tipsheet-series-for-advocates/

Chadwick Center for Children & Families. (n.d.). Chadwick Trauma-Informed Systems Project (CTISP). Retrieved from http://www.chadwickcenter.org/CTISP/ctisp.htm

Chadwick Trauma-Informed Systems Project. (2012). Creating trauma-informed child welfare systems: A guide for administrators (1st ed.). San Diego, CA: Chadwick Center for Children and Families.

Child Welfare Information Gateway. (2015). *Developing a trauma-informed child welfare system.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from https://www.childwelfare.gov/pubPDFs/trauma_informed.pdf

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved from https://www.healthcare.uiowa.edu/icmh/documents/CCTICSelf-AssessmentandPlanningProtocol0709.pdf

Ferguson-Colvin, K.M., & Maccio, E.M. (2012). Toolkit for practitioners/researchers working with lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) runaway and homeless youth (RHY). Retrieved from http://www.hunter.cuny.edu/socwork/nrcfcpp/info_services/download/LGBTQ%20HRY%20Toolkit%20September%202012.pdf

Finkelhor, D., Ormrod, R., Turner, H., & Hamby, S. (2005). The victimization of children and youth: A comprehensive, national survey. *Child Maltreatment, 10*(1), 5-25.

Gaillot, S. (2010). *Disparities in trauma and mental health service use.* (Doctoral dissertation). Retrieved from http://www.rand.org/pubs/rgs_dissertations/RGSD272.html

Gerrity, E. & Folcarelli, C. (2008). Child traumatic stress: What every policymaker should know. Durham, NC and Los Angeles, CA: National Center for Child Traumatic Stress. Retrieved from http://www.nctsn.org/nctsn_assets/pdfs/PolicyGuide_CTS2008.pdf

Goldman, J. (2015). Creating organizations that address the needs of youth, families, and staff who have experienced trauma. *Focal Point*, 29, 36-39.

Guarino, K., Soares, P., Konnath, K., Clervil, R., & Bassuk, E. (2009). *Trauma-informed organizational toolkit for homeless services*. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, Daniels Fund, National Child Traumatic Stress Network, W.K. Kellogg Foundation. Retrieved from http://www.air.org/resource/trauma-informed-organizational-toolkit

Hanson, R. F., & Lang, J. (2016). A critical look at trauma-informed care among agencies and systems serving maltreated youth and their families. *Child Maltreatment*, *21*(2), 95–100.

Harris, M. and Fallot, R. (Eds.) (2001). Using trauma theory to design service systems: New directions for mental health services. San Francisco: Jossey-Bass.

Hendricks, A., Conradi, L., & Wilson, C. (2011). Creating trauma-informed child welfare systems using a community assessment process. *Child Welfare*, *90*(6), 187–205.

Hodas, G. R. (2006). Responding to childhood trauma: The promise and practice of trauma informed care. Pennsylvania Office of Mental Health and Substance Abuse Services. Retrieved from http://www.childrescuebill.org/VictimsOfAbuse/RespondingHodas.pdf

Holm-Hansen, C. (2014). Trauma and resilience: How can we promote resilience and recovery for people who have experienced traumatic events? Wilder Research. Retrieved from http://www.wilder.org/Wilder-Research/Publications/Studies/Trauma%20and%20Resilience/Trauma%20and%20Resilience%20-%20How%20Can%20We%20Promote%20Resilience%20and%20Recovery%20for%20People%20Who%20Have%20Experienced%20Traumatic%20Events.pdf

Hummer, V. L., Dollard, N., Robst, J., & Armstrong, M. I. (2010). Innovations in implementation of trauma-informed care practices in youth residential treatment: A curriculum for organizational change. *Child Welfare*, *89*(2), 79–95.

Igelman, R., Conradi, L., & Ryan, B. (2007). Creating a trauma-informed child welfare system. *Focal Point*, *21*(1), 23–26.

Keuroghlian, A. S., Shtasel, D., & Bassuk, E. L. (2014). Out on the street: A public health and policy agenda for lesbian, gay, bisexual, and transgender youth who are homeless. *The American Journal of Orthopsychiatry*, *84*(1), 66–72.

Klain, E. J. & White, A. R. (2013). *Implementing trauma-informed practices in child welfare.* Retrieved from State Policy Advocacy and Reform Center website: http://childwelfaresparc.org/wp-content/uploads/2013/11/Implementing-Trauma-Informed-Practices.pdf

Klingberg Family Centers (n.d.). Traumatic Stress Institute. Retrieved from http://klingberg.org/programs-services/traumatic-stress-institute/

Ko, S. J., & Kassam-Adams, N. (2008). Creating trauma-informed systems: Child welfare, education, first responders, health care, juvenile justice. *Professional Psychology: Research and Practice*, *39*(4), 396–404.

Lang, J. M., Campbell, K., Shanley, P., Crusto, C. A., & Connell, C. M. (2016). Building capacity for trauma-informed care in the child welfare system: Initial results of a statewide implementation. *Child Maltreatment*, *21*(2), 113–124.

Lockert, L. (2015). Building a trauma-informed mindset: Lessons from CareOregon's Health Resilience Program. Retrieved from http://www.chcs.org/building-trauma-informed-mindset-lessons-careoregons-health-resilience-program/

McManus, H. H., & Thompson, S. J. (2008). Trauma among unaccompanied homeless youth: The integration of street culture into a model of intervention. *Journal of Aggression, Maltreatment & Trauma*, *16*(1), 92–109.

Menschner, C., & Maul, A. (2016) *Key ingredients for successful trauma-informed care implementation.* Retrieved from Center for Health Care Strategies, Inc. website: http://www.chcs.org/media/ATC-whitepaper-040616-rev.pdf

National Center for Children in Poverty (NCCP). (2007). *Facts about trauma for policymakers: Children's Mental Health.* Retrieved from http://www.nccp.org/publications/pub_746.html

National Child Traumatic Stress Network (NCTSN). (2007). *Creating trauma-informed child-serving systems.* Retrieved from http://www.nctsn.org/sites/default/files/assets/pdfs/Service_Systems_Brief_v1_v1.pdf

National Child Traumatic Stress Network (NCTSN). (n.d.a). Creating trauma-informed systems. Retrieved from http://www.nctsn.org/resources/topics/creating-trauma-informed-systems

National Child Traumatic Stress Network (NCTSN). (n.d.b). National Child Traumatic Stress Network Empirically Supported Treatments and Promising Practices. Retrieved from http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices

National Child Traumatic Stress Network (Child Welfare Committee). (2008). Child welfare trauma training toolkit: Comprehensive guide (2nd ed.). Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress. Retrieved at http://www.nctsn.org/nctsn_assets/pdfs/CWT3_CompGuide.pdf

Newell, J. and MacNeil, G. (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue: A review of theoretical terms, risk factors, and preventive methods for clinicians and researchers. *Best Practices in Mental Health*, *6*(2), 57-68.

Ngo, V., Langley, A., Kataoka, S. H., Nadeem, E., Escudero, P., & Stein, B. D. (2008). Providing evidence based practice to ethnically diverse youth: Examples from the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) Program. *Journal of the American Academy of Child and Adolescent Psychiatry*, *47*(8), 858.

Pittman, B., Gerrard, M., Nelson-Dusek, S., & Shelton, E. (2016). 2015 Minnesota Homeless Study fact sheet. Initial findings: Characteristics and trends. Retrieved from: http://mnhomeless.org/pdfs/2015-homeless-study-initial-findings-fact-sheet.pdf

Richardson, M. M., S, L., Henry, J., Black-Pond, C., & Unrau, Y. (2012). Development and evaluation of the trauma-informed system change instrument: Factorial validity and implications for use. *Child & Adolescent Social Work Journal*, *29*(3), 167–184.

Roberts, A. L., Gilman, S. E., Breslau, N., & Koenen, K. C. (2011). Race/ethnic differences in exposure to traumatic events, development of post-traumatic stress disorder, and treatment seeking for post-traumatic stress disorder in the United States. *Psychological Medicine, 41*(4), 71-83.

Steele, W. & Kuban, C. (2013). *Advancing Trauma Informed Practices: Bringing trauma-informed, resilience-focused care to children, adolescents, families, schools and communities* [White paper]. Retrieved from http://assets1.mytrainsite.com/500051/tlcwhitepaper.pdf

Steele, W., & Malchiodi, C. A. (2012). *Trauma-informed Practices with Children and Adolescents*. New York, NY: Routledge.

Substance Abuse and Mental Health Services Administration (SAMHSA), Trauma and Justice Strategic Initiative. (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach* (HHS Publication No. (SMA) 14-4884). Retrieved from http://store.samhsa.gov/shin/content//SMA14-4884/SMA14-4884.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA). (2015). Trauma-informed approach and trauma-specific interventions. Retrieved from http://www.samhsa.gov/nctic/trauma-interventions

The THRIVE Initiative. (2010). *Guide to trauma-informed organizational development*. Retrieved from http://thriveinitiative.org/thrivetraining/wp-content/plugins/rasGroupManager/rgm_uploads/THRIVE%20Guide%20to%20Trauma-Informed%20Organizational%20Development.pdf

Trauma-informed agency or organizational assessment tools. (n.d.). Retrieved from http://www.t2bayarea.org/resource/grid/index.html

Trauma-Informed Systems of Care – Models/Training (n.d.). Retrieved October 1, 2013, http://www.acesconnection.com/blog/models-training-for-developing-trauma-informed-systems-of-care-tisc-1

U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. (2014). *Child Health USA 2014.* Retrieved from https://mchb.hrsa.gov/chusa14/

Wayman, R. A. H. (2008). Homeless queer youth: National perspectives on research, best practices, and evidence-based interventions. *Seattle Journal for Social Justice, 7*(2), 587-634.