Creating Trauma-Informed Provider Organizations

What does a trauma-informed organization look like?

Jane is a 7 year old middle class white child who was recently in a car accident that killed her sister. She has been having trouble eating and sleeping and refuses to go to school. Her mother connects with a mental health agency, despite strong objections from family members, who believe mental health treatment is a bad idea. Jane's mother speaks to an intake coordinator, who provides information about the treatment process. The information is easy to understand and the coordinator is kind. Jane's mother decides to proceed. Jane and her mother arrive at Green County Family Center more than an hour late. They had to take two buses and had trouble finding the office. The Center's office is located in a converted home. The space is welcoming and comfortable. Jane and her mother are warmly greeted by the receptionist, despite the late arrival. The receptionist is understanding about their circumstances and offers both Jane and her mother a snack. Jane is nervous, but is given crayons and a coloring book to entertain her while waiting for the appointment. The waiting room has couches and pictures of children playing. The therapist, Sandy, meets them right away and sits with Jane and her mother in the waiting room. She asks whether Jane is ready to come back, and Jane begins to cry and sits with her mother. The therapist is gentle and patient and asks Jane whether she would like her mother to come. Jane nods, and all move to the office. The office is private, and there is a noise canceling machine placed outside the door to ensure privacy. The session goes well, and another appointment is made. For 2 years, Sandy has been providing therapy to children who have experienced trauma. She still finds herself experiencing anxiety and distress when beginning a new case. Sandy meets with her supervisor immediately following Jane's session to process her own reactions. Sandy's supervisor is supportive and patient. She encourages Sandy to take lunch with a coworker and to leave early if necessary.

Trauma-Informed Care Within Provider Organizations

Traumatic experiences can significantly alter individuals' worldview, as well as how they perceive and react to their environment or relate to other people. As highlighted in the case example of Jane, children may appear anxious or present with behaviors that are seen as challenging, such as aggression, or symptoms mistaken for oppositional defiant disorder, conduct disorder, attention deficit disorder, or other psychiatric conditions as they try to cope with traumatic experiences.[1] These behaviors or symptoms may be adaptations to trauma.

Children who have experienced trauma and require services need responses that are sensitive to what has happened to them and how it has shaped their behaviors.

Because of the high prevalence of trauma within the general population, provider organizations that work with children, youth, and families—whether inpatient, outpatient, or intensive in-home mental health counseling or clinical case management or somatic care—should presume that the clients they serve have experienced some form of trauma. It is recommended that, to effectively serve their clients, organizations implement a trauma-informed care approach, which involves looking at all practices through a trauma lens, constantly keeping in mind how traumatic experiences affect children and families. In the case example, the mental health agency has undergone a cultural shift to become fully trauma informed, providing sensitive and appropriate services and supports for Jane and her family. Trauma-informed practices are distinct from trauma-specific treatments that are designed specifically to help clients work through their experiences and facilitate healing. Trauma-informed practices are not interventions but are approaches that are infused through all levels of the organization.

Trauma-informed practices include, among others, creating a safe, supportive, welcoming, and respectful environment; educating and training all staff including administrators, direct care staff, case managers, and support staff about the impact of trauma; implementing screening and assessment tools and procedures to identify clients who have experienced trauma and determine the impact of that trauma; and training clinical staff in trauma-specific treatments. In addition, it is essential that providers are aware of their own cultural attitudes and beliefs, as well as those of their clients, and provide culturally competent approaches. This awareness, when appropriate, may help clients rebuild their identity and connection to their communities. Being culturally competent requires organizations to adopt and implement behaviors, attitudes, and policies to function effectively within the context of the clients' cultural beliefs, behaviors, and needs.[2] Unless they are both trauma informed and culturally appropriate, organizations run the risk of re-traumatizing their clients and offering inappropriate treatment because they have misunderstood the reasons for behavior. In the case example, had the organization not been trauma informed, Jane and her mother would possibly not have been seen for services because of their late arrival, thus reducing the likelihood of Jane's receiving trauma treatment.

To become trauma informed, organizations need to examine their current practices using self-assessment procedures. Trauma-informed self-assessments tools are available to help organizations identify steps for trauma-informed modifications in their structure and practices.[3] Self-assessments support administrators and providers in identifying areas of strength; pinpointing areas for improving trauma-informed service; and developing implementing, evaluating, and monitoring trauma-informed practices on an ongoing basis. A trauma-informed organization can be viewed on a continuum of readiness to respond to trauma. Understanding where the organization falls on that continuum is essential to increasing appropriate practices.

Models To Create Trauma-Informed Provider Organizations

Becoming fully trauma informed may require organizations to change their culture, fundamental values, and functioning. This change requires an understanding of the organizations' focus, clients, and supportive practices. Several models are available to facilitate cultural change within organizations to assist them in becoming trauma informed, but organizations may also develop their own approaches. Three commonly used models include the **Sanctuary Model,**[4] the **Creating Cultures for Trauma-Informed Care (CCTIC) Model,**[5] and **Risking Connection**.[6]

The **Sanctuary Model** is a participatory trauma-informed operating system that provides organizations with a clinical and organizational structure and common language to promote safety and recovery from trauma.[7] It is based on the premise that trauma is pervasive in children and families seeking services, as well as in those who provide services. Using a set of practice tools (Sanctuary Tool Kit), organizations train staff in the philosophical underpinnings of the model and the overarching domains for trauma-informed care: safety, emotions, loss, and future to create effective trauma-informed provider organizations. For more information about this model, go to http://www.sanctuaryweb.com/index.php.

Like the Sanctuary Model, the **CCTIC Model** is not an intervention but a systems change model designed to facilitate cultural change. Its data-driven approach helps organizations assess their progress toward becoming trauma informed with respect to five core organization-based values: safety, trustworthiness, choice, collaboration, and empowerment.[5] As with the Sanctuary Model, CCTIC's culture-based change requires active participation by administrators, supervisors, support staff, and frontline workers. For more information about this model, go to http://www.communityconnectionsdc.org/web/page/673/interior.html.

Risking Connection is a training program for organizations and individuals that provides a framework for developing trauma-informed responses and building trauma-informed skills. The five-module curriculum teaches staff to build relationships that are based on respect, information sharing, connection, hope, and help. In addition, it supports staff in reframing behavior, developing self-capacity, and integrating trauma-informed thinking into action.[8] For more information about this model, go to http://www.riskingconnection.com/.

Using these or other models, provider organizations examine all practices through a trauma lens to help clients heal and build resiliency. It is important to realize that for implemented trauma-informed practices to be sustainable, policies need to be developed, implemented, and continuously reviewed and updated to ensure that all aspects of the organization and all staff members adhere to these practices. Organizations must also continuously review their policies to determine what works and what needs improvement and make modifications as needed. It is essential for organizations to realize that being trauma informed is not an end state but

rather a philosophy that requires continuous evaluation and improvement of policies, structures, and practices. Similar strategies apply to the creation of culturally and linguistically competent organizations. For more information, go to http://nccc.georgetown.edu/.

Secondary Trauma in Providers

An integral part of being a trauma-informed provider organization is awareness that providers such as therapists, clinical social workers, case managers, and other helping professionals working with traumatized children may experience secondary trauma. Working with people who have survived harrowing experiences and listening to their stories may take an emotional toll on providers that compromises their functioning and diminishes their quality of life if it is not addressed. Secondary trauma can result in staff burnout and high turnover rates for organizations. Helping professionals may also come to this work with their own trauma histories and emotional reactions that may be triggered on hearing stories from their clients.

Secondary trauma is also referred to as compassion fatigue or vicarious traumatization. Even though these terms are often used interchangeably, they are by definition distinct but overlapping. **Secondary trauma** is a common reaction to working with clients who have experienced trauma and mirrors the symptoms of post-traumatic stress disorder (PTSD).[9] These symptoms may include, among others, an increase in arousal and avoidance reactions, re-experiencing personal trauma, sleeplessness, guilt, anger, and fearfulness. **Compassion fatigue** is defined as "a state of exhaustion and dysfunction—biologically, psychologically, and socially—as a result of prolonged exposure to compassion stress,"[10] often resulting in secondary traumatic stress reactions. **Vicarious traumatization** is defined as the negative transformation in the self of the provider that results from the empathic engagement with clients' trauma and a sense of responsibility to help.[11]

In addition to being aware of secondary trauma, trauma-informed provider organizations need to implement practices and policies for preventing the development of secondary traumatic stress and support providers in balancing their own needs with those of their vulnerable clients. Strategies and actions must occur at the organizational, professional, and personal levels. Organizational strategies include having sufficient time off and use of flex-time scheduling, providing safe physical space, and use of formal assessments to determine whether providers are experiencing secondary traumatic stress symptoms. Strategies focused on the professional include keeping caseloads small, routine reflective supervision provided in a safe space without fear of administrative repercussions, and psychoeducation about secondary trauma. It is also helpful to offer skill training to address symptoms resulting from trauma, along with support around nutrition, exercise, and stress-reduction activities. Individual providers may benefit from strategies that are introspective and individualized. These strategies include learning to respect one's own limits, maintaining time for self-care activities and routine rituals like taking walks or lunch breaks during which work is not discussed. Although these strategies address

three distinct levels, i.e. organizational, professional, and personal, within a provider organization, the strategies can be integrated with the goal of ensuring service providers have a safe and productive work environment.

Awareness of the impact of indirect trauma exposure or secondary traumatic stress is essential to protecting the health of providers and ensuring that children receive the best possible services and supports. Direct care workers can assess their functioning and stress response using a variety of scales. As with any traumatic event, recognizing the problem is an important first step. It is essential that organizations provide leadership, commitment, and follow through by implementing practices and policies to prevent and reduce secondary trauma in provider staff members. The organization is responsible for not only creating and implementing a policy or practice, but for sustaining changes and remaining committed. Protecting staff and providing a safe work environment are organizational responsibilities.

Conclusion

Becoming a trauma-informed organization can be a lengthy, gradual process and one that requires ongoing effort. Support is required at every level in an organization, from the administration to the direct service workers to the support staff. The results are fully worth the investment because a culturally competent, trauma-informed organization benefits everyone. It contributes to satisfied, productive, and confident staff, supported clients and a strong organizational community and culture.

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