Institutionalized Oppression
Definitions

The following definitions reflect some of concepts used to describe the process of institutionalized oppression:

Institutions are fairly stable social arrangements and practices through which collective actions are taken. Examples of institutions in the U.S. include the legal, educational, health care, social service, government, media and criminal justice systems.

Institutional Oppression is the systematic mistreatment of people within a social identity group, supported and enforced by the society and its institutions, solely based on the person's membership in the social identity group.

Institutional Oppression occurs when established laws, customs, and practices systematically reflect and produce inequities based on one's membership in targeted social identity groups. If oppressive consequences accrue to institutional laws, customs, or practices, the institution is oppressive whether or not the individuals maintaining those practices have oppressive intentions.

Institutional Oppression creates a system of invisible barriers limiting people based on their membership in unfavored social identity groups. The barriers are only invisible to those "seemingly" unaffected by it.

The practice of institutionalized oppression is based on the belief in inherent superiority or inferiority. Institutionalized oppression is a matter of result regardless of intent.

Stereotypes are attitudes, beliefs, feelings and assumptions about a target group that are widespread AND socially sanctioned. Can be positive and negative, but all have negative effects. Stereotypes support the maintenance of institutionalized oppression by seemingly validating misinformation or beliefs.

Prejudice is favorable or unfavorable opinion or feeling about a person or group, usually formed without knowledge, thought or reason. It can be based on a single experience, which is then transferred to or assumed about all potential experiences.

Overt forms of oppression are open and observable, not secret or hidden. The target of overt oppression is very aware of the intention and action of the oppressive act, and of the oppressive person or group.

Adapted from *"Institutional Oppression,"* Tools for Diversity, © TACS.

Covert forms of oppression may be secret, hidden and not openly practiced, or so subtle that they are not readily obvious, even to the intended target. The person targeted with covert oppression may not even realize that an oppressive act has occurred until after the fact, nor be aware of who committed the act. Often, targets of covert forms of oppression may second guess themselves and their reactions to covert oppression.

Adapted from *"Institutional Oppression,"* Tools for Diversity, © TACS.

Tri-County Domestic & Sexual Violence Intervention Network Anti-Oppression Training for Trainers
Created by Carol Cheney, Jeannie LaFrance and Terrie Quinteros, 2006.
503.287.9628 ext. 2. www.actforaction.org

Trauma-Informed Care in Youth Serving Settings: Organizational Self Assessment **

Directions: Please rate the items listed in the various categories. Please write comments about why you rated items in a particular way on the back side of each page.

This list is meant to be comprehensive and the process of implementing trauma-informed care generally takes multiple years. While implementation of these elements is the goal, the list represents an ideal to strive for.

	How much is this value embraced by your organization? **1=Not at all** **2=Slightly** **3=Moderately** **4=Mostly** **5=Very Much**
Trauma-Informed Care Values The following values underlie all the elements of trauma-informed care listed below. These values underlie the relationships between staff and clients, staff and their peers, as well as supervisory staff and their supervisees. Inherent in these values is the belief that all aspects of the organization's functions should be shaped by consumer involvement and input.	
1. **Safety** – physical and emotional safety.	1 2 3 4 5
2. **Trustworthiness** – creation of a feeling of trust and safety via clear and thoughtfully considered frame and boundaries governing all aspects of the organization's work.	1 2 3 4 5
3. **Collaboration** – inviting, whenever possible, the input of those served by the organization and staff of the organization; providing opportunities for decision-making and innovation.	1 2 3 4 5
4. **Empowerment** -- sharing power with, and giving appropriate authority and decision-making power to, those served by the organization and staff of the organization; maximizing choice and control for the organization's consumers and employees; recognizing and highlighting strengths; looking for opportunities to praise and reward positive behavior; viewing mistakes as learning opportunities.	1 2 3 4 5

**** Significant sections of this assessment were adapted from the work of Fallot, R.D. & Harris, M. (2006). *Trauma-informed services: A self-assessment and planning protocol, version 1.4*. Community Connections: Washington, D.C. (202-608-4796).**

	How much is this element present in your organization? **1=Not at all 2=Slightly 3=Moderately 4=Mostly 5=Very much**
A. Administrative Support for Program-Wide Trauma-Informed Services	
1. Organizational administrators support the integration of knowledge about violence and abuse into all program practices.	1 2 3 4 5
2. The organization has a "trauma-informed care initiative" (e.g., workgroup/task force, trauma specialist) endorsed by and authorized by chief administrator.	1 2 3 4 5
3. A competent person with administrative skills and organizational credibility is designated to lead this task force.	1 2 3 4 5
4. Administration supports the recommendations of the trauma task force and follows through on these plans.	1 2 3 4 5
5. Administration attends at least portion of 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).	1 2 3 4 5
6. The adminstration release staff from their usual duties so that they may attend trainings and deliver trauma services.	1 2 3 4 5
7. Necessary sources of funding for trauma training and education are found.	1 2 3 4 5
8. The administration is able to tolerate certain level of organizationsl disruption in making the transition, including such things as staff confusion, conflict within treatment team, resistance to change, and property destruction.	1 2 3 4 5
9. The administration values and rewards staff efforts to be flexible and to offer choices to the clients, even when the result is that the client is not immediately brought under control.	1 2 3 4 5
10. The administration develops a policy statement that refers to the importance of trauma and the need to acknowledge consumer experiences of trauma in service delivery.	1 2 3 4 5
11. The administration celebrates successes.	1 2 3 4 5

	How much is this element present in your organization? (1=Not at all 2=Slightly 3=Moderately 4=Mostly 5=Very)
B. Organizational Structure	
1. Clinically-trained staff are in leadership positions of multi-disciplinary treatment teams and are integrated into the daily life of programs.	1 2 3 4 5
2. In congregate care, organization has an organizational and supervisory structure where clinical and residential staff are integrated into treatment teams rather than belong to separate clinical and residential "silos."	1 2 3 4 5
3. Intake and discharge process are planful, recognizing the important meaning of relationhip beginnings and endings for traumatized children.	1 2 3 4 5
4. Staff schedules are structured such that staff have time to meet, think about, and talk about the work rather than only doing the work.	1 2 3 4 5
5. Staff have regular clinically-oriented supervision, ideally individual supervision, where they can discuss client issues including their countertransference and vicarious traumatization.	1 2 3 4 5
6. Forums (ie. supervision, treatment team meetings, periodic retreats) aimed at helping staff to acknowledge, address, and transform their vicarious traumatization.	1 2 3 4 5
7. Organization makes use of outside consultants who have expertise in trauma when necessary.	1 2 3 4 5
C. Trauma Screening and Assessment	
1. The program has a consistent way to identify individuals who have been exposed to trauma and to include trauma-related information in planning services with the client.	1 2 3 4 5
2. Trauma screening is relatively brief, not overly complicated, and avoids unnecessary detail that would increase likelihood of triggering traumatic memories.	1 2 3 4 5
3. The screening process avoids unnecessary repetition of same questions at multiple points in the intake or assessment process. It is often important to return to the questions in treatment after some appropriate time interval.	1 2 3 4 5

	How much is this element present in your organization?
	1=Not at all 2=Slightly 3=Moderately 4=Mostly 5=Very
D. Milieu Treatment Practices and Behavior Management (for congregate care settings)	
1. Staff and clinicians routinely think first about the meaning and function of behaviors before deciding how to intervene.	1 2 3 4 5
2. Staff display an attitude of the child "doing the best that they can" rather than assuming intentionality.	1 2 3 4 5
3. Staff use active listening to explore the problem rather than immediately speaking to the child about consequences or solving the problem.	1 2 3 4 5
4. Staff refrain from power struggles with children.	1 2 3 4 5
5. Organization uses of relationship-based behavior management system (such as The Restorative Approach™ *) instead of "point and level" system. Phase system can be used.	1 2 3 4 5
6. During behavioral issues, staff recognize primary goal as helping children to calm down and get back in control of their behavior.	1 2 3 4 5
7. Staff are sensitive to the many ways their interactions with children can trigger shame.	1 2 3 4 5
8. Staff refer to children in descriptive ways and refrain from negative labels (e.g. "manipulative," "resistant," "borderline," etc.)	1 2 3 4 5
9. Staff value flexibility and individualized care in managing behavior rather than strict compliance with rules and treating all children equally.	1 2 3 4 5
10. Multidisciplinary team members function well as a team - manage conflict, care for each other, avoid splits such as therapist/child care worker splits.	1 2 3 4 5
11. Program has thoughtful physical touch policy that recognizes the critical importance of touch for healthy child development and is sensitive to issues of child abuse, allegations of abuse, and re-traumatization.	1 2 3 4 5
12. Staff are willing to talk with their peers and supervisors about their strong positive and negative reactions to clients and doing the work.	1 2 3 4 5
13. Staff feel free to ask their peers for help, or take over for a peer, when there is an impasse in managing a behavioral issue.	1 2 3 4 5

*** The Restorative Approach™ is a trauma-informed behavior management system and an alternative to a "point and level system." For information, contact Klingberg Family Centers, 860-832-5507.**

	How much is this element present in your organization? 1=Not at all 2=Slightly 3=Moderately 4=Mostly 5=Very
E. Physical Environment and Layout of Agency	
1. Space, including waiting and reception area, is welcoming and inviting for clients and families.	1 2 3 4 5
2. Living or program space is nurturing (e.g. colors, plants, music) and affirming (e.g. display of child art/work, culturally competent).	1 2 3 4 5
3. Crisis or "calm down" rooms are safe and soothing places for children to get strong feelings under control.	1 2 3 4 5
F. Clinical Treatment Practices	
1. Utilization of crisis prevention plans (also called safety tools or personal safety plans) written in collaboration with child, family, and possibly previous providers.	1 2 3 4 5
2. Before addressing problem behavior, the team, led by the clinician, considers their understanding of the reasons for the behavior and uses this understanding to determine their interventions.	1 2 3 4 5
3. Treatment planning is built from formulation that considers impact of trauma on client's development and current symptoms/behaviors, and includes goals of developing emotion regulation skills/self capacities as well as healthy attachments.	1 2 3 4 5
4. Family therapy addresses family dynamics, builds parenting skills, and reinforces child's growth and changes.	1 2 3 4 5
5. Staff have an awareness of the role of trauma in the history of parents, and family treatment includes a trauma focus.	1 2 3 4 5
6. Discharge is careful, thoughtful, gradual and includes referral to trauma-informed resources.	1 2 3 4 5
7. Program offers trauma-specific treatments such as: Trauma Focused Cognitive Behavior Therapy (TF-CBT), Dialectical Behavior Therapy (DBT), Eye Movement Desensitization Reprocessing (EMDR), Trauma, Adaptive, Recovery Group Education and Therapy (TARGET), etc.	1 2 3 4 5
8. Treatment utilizes sensory interventions to help children calm down and teach self-soothing.	1 2 3 4 5
9. Psycho-educational groups about trauma are offered to clients and families.	1 2 3 4 5

	How much is this element present in your organization? 1=Not at all 2=Slightly 3=Moderately 4=Mostly 5=Very
G. Restraint and Seclusion Reduction	
1. All levels of staff are aware of propensity for re-traumatization through restraint and seclusion with traumatized clients.	1 2 3 4 5
2. Restraints and seclusion used only when there is threat of imminent danger.	1 2 3 4 5
3. Staff training focuses on de-escalation techniques to avoid restraint and seclusion.	1 2 3 4 5
4. Staff value avoidance of re-traumatization via restraint and seclusion even if it means less adherence to rules, increased property damage, and longer negotiation time.	1 2 3 4 5
5. Each child has an individual plan stating both medical and psychological risks in restraint which includes specific guidelines for staff actions to avoid.	1 2 3 4 5
6. Organization monitors trends in restraint and seclusion. Increased in restraint/seclusion trigger discussions aimed at understanding and addressing the increases.	1 2 3 4 5
H. Workforce Development	
1. Trauma training is required for staff at all levels and of all disciplines (see "Staff Trauma Training" below).	1 2 3 4 5
2. Staff who display mastery of trauma-informed practice are encouraged, celebrated, and promoted.	1 2 3 4 5
3. Organization promotes a culture of performance improvement, one that understands that mistakes will be made but learning will occur.	1 2 3 4 5
4. Trauma-informed values and concepts are integrated into staff orientation.	1 2 3 4 5
5. Hiring practices screen for staff whose values are consonant with a trauma-informed approach.	1 2 3 4 5

	How much is this element present in your organization? 1=Not at all 2=Slightly 3=Moderately 4=Mostly 5=Very
I. Staff Trauma Training	
1. All staff members receive foundational trauma training with a primary goal of sensitization to trauma-related dynamics and the avoidance of re-traumatization.	1 2 3 4 5
2. Staff members receive training in a trauma-informed understanding of unusual or difficult behaviors. Training stresses concept of symptoms as adaptations.	1 2 3 4 5
3. Staff trauma training also includes topics of: frame and boundaries; relationship building with traumatized children; how to use their responses to particular clients (countertransference); impact of, and how to address, secondary trauma such as vicarious traumatization (VT).	1 2 3 4 5
J. Monitoring Trauma-Informed Initiatives	
1. Organization monitors the progress of trauma-informed care initiative in ongoing way.	1 2 3 4 5
2. Data related to implementation of a trauma-informed approach is collected, monitored, and used for quality improvement.	1 2 3 4 5
3. Organization develops a debriefing process to analyze incidents characterized by conflict, violence, and aggression to inform policy, procedures, and practices in order to avoid such incidents in the future.	1 2 3 4 5

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Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol

Community Connections; Washington, D.C.
Roger D. Fallot, Ph.D. and Maxine Harris, Ph.D.

April, 2009

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.

•**Trauma affects staff members as well as consumers in human services programs.** Stressors deeply affect administrators, clinicians, and support staff working in human services. Not only is "secondary" or "vicarious" traumatization common but direct threats to physical and emotional safety are also frequent concerns. Being asked to do "more and more with less and less" becomes a pervasive theme underlying work experiences that may threaten to overwhelm coping abilities.

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 as well as staff working in service settings. These services seek "safety first" and commit themselves to "do no harm." The SAMHSA-funded Women, Co-Occurring Disorders, and Violence Study (1998-2003) 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 CCTIC 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 Change Process, Protocol, and Scale

Culture Change in Human Service Programs

The Creating Cultures of Trauma-Informed Care approach to organizational change is built on five core values of **safety, trustworthiness, choice, collaboration, and empowerment**. If a program can say that its **culture** reflects each of these values in each contact, physical setting, relationship, and activity and that this culture is evident in the experiences of staff as well as consumers, then the program's culture is trauma-informed.

We emphasize organizational culture because it represents the most inclusive and general level of an agency or program's fundamental approach to its work. Organizational culture reflects what a program considers important and unimportant, what warrants attention, how it understands the people it serves and the people who serve them, and how it puts these understandings into daily practice. In short, culture expresses the basic values of a program. Culture thus extends well beyond the introduction of new services or the training of a particular subset of staff members; it is pervasive, including all aspects of an agency's functioning.

In order to accomplish this culture change, we strongly recommend several steps:

1) Initial Planning. In this phase, the program considers the importance of, and weighs its commitment to, a trauma-informed change process. The following elements are key to the successful planning of organizational trauma-informed change: a) administrative commitment to and support of the initiative (see Domain 4 below); b) the formation of a trauma initiative workgroup to lead and oversee the change process; c) the full representation of each significant stakeholder group on the workgroup—administrators, supervisors, direct service staff, support staff, and consumers; d) identification of trauma "champions" to keep the initiative alive and "on the front burner;" e) programmatic awareness of the scope (the entire agency and its culture) and timeline (one to two years) of the culture shift.

Discussions of trauma-informed program modifications constitute an opportunity to involve <u>all</u> key groups in the review and planning process. In our experience, the more inclusive and fully representative these discussions are, the more effective and substantial the resulting changes.

2) A Kickoff Training Event. Usually two days long, the kickoff training is attended by as many of the staff as practical and includes significant consumer representation; it certainly includes all members of the trauma initiative workgroup. During this event, there are at least three presentations. In the first, central ideas of trauma-informed cultures are presented, emphasizing shifts in both understanding and in practice. In addition, the importance of staff support and care is emphasized. Finally, a third presentation addresses the importance of trauma in the work of the specific agency (e.g., trauma and substance use, trauma and children or youth, trauma and mental health problems). There is also a great deal of time for the workgroup members and other attendees to discuss the planning process in more detail and to conduct preliminary conversations that will mirror those to be held in the larger agency after the kickoff.

providing a beginning sense of direction. The kickoff ends with discussion of next steps in the implementation of this change initiative.

3) Short-term Follow-up. Over the next several months, the agency takes the ideas from the training and applies them in more detail, using this Self-Assessment and Planning Protocol. First, the workgroup develops an Implementation Plan for review by the rest of the administration, staff, and consumers, as well as by outside consultants with experience in facilitating agency change. Community Connections consultants, for example, provide detailed feedback on Implementation Plans; discuss any barriers as they arise; and assist in developing strategies to overcome these obstacles. Simultaneously, two educational events are scheduled for all staff. The first is on Understanding Trauma or Trauma 101. This training is designed to discuss the prevalence and impact of trauma as well as some of the multiple paths to recovery, emphasizing the ways in which trauma may be seen in the lives of consumers and in the work experience of staff. The second training focuses more directly on Staff Support and Care, emphasizing that a culture shift toward a trauma-informed system of care rests on staff members' experiences of safety, trustworthiness, choice, collaboration, and empowerment. Ideally, these training events are offered by experienced trainers who are also able and willing to encourage and teach staff members to become trainers themselves. In this way, as the program is able, its own trainers become equipped to pass along the important information about trauma to newer or untrained staff.

4) Longer-term Follow-up. After about six months, Community Connections consultants revisit the program site to meet with the workgroup and selected others, in order to review and discuss progress to date. At that time, ongoing processes may be put in place to sustain the initiative to its conclusion. For example, many agencies build trauma-informed questions into their Consumer Satisfaction Survey. Many add the Implementation Plans to the quality assurance or improvement process. Still others, in larger systems, discuss ways to build in consultation to their own and other agencies through a "train the consultant" approach. /The most important goal at this phase is to maintain the momentum established after the kickoff training until the culture change is thoroughgoing.

The CCTIC Self-Assessment and Planning Protocol

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 by a comprehensive workgroup 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.

The CCTIC Self-Assessment Scale

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, surveys, and/or focus groups as necessary to gain a complete picture of the agency's culture.

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

The goal of Step One is to gain a comprehensive sense of the experiences of both consumers and staff members as they come to the setting and participate in its activities, relationships, and physical settings. The goal of this review is to capture for each of these groups—consumer and staff—their experiences *in detail* from their very first to their very last contact with the program or agency. Though some programs accomplish this effectively by forming a representative workgroup to review the full range of contacts, others have found it very helpful to engage in a "walk-through." A walk-through is a process in which staff members come to the setting "as if" they are new consumers and thus enter the setting with a consumer-oriented perspective. For more details about one way to conduct such a walk-through, see the NIATx website: www.niatx.net. Sites routinely begin by focusing on the experiences of consumers and then repeat the process for staff members.

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. These objectives are incorporated into the program's Implementation Plan.

Domain 1A. Safety—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? 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?
- What signs are there? Are they welcoming? Clear? Legible?
- 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?
- 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. Trustworthiness—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? How can the program maximize honesty and transparency?"***

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. Choice—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. Empowerment—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 1F. Safety for Staff—Ensuring Physical and Emotional Safety

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

Sample Specific Questions:

- Do staff members feel physically safe?
- Do staff members feel emotionally safe?
- Is the physical environment safe--with accessible exits, readily contacted assistance if it is needed, enough space for people to be comfortable, and adequate privacy?
- Do staff members feel comfortable bringing their clinical concerns, vulnerabilities, and emotional responses to client care to team meetings, supervision sessions or a supervisor?
- Does the program attend to the emotional safety needs of support staff as well as those of clinicians?

Domain 1G. Trustworthiness for Staff—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 and work tasks be modified to ensure that tasks and boundaries are established and maintained clearly and appropriately? How can the program maximize honesty and transparency?"

Sample Specific Questions:

- Do program directors and clinical supervisors have an understanding of the work of direct care staff? Is there an understanding of the emotional impact (burnout, vicarious trauma, compassion fatigue) of direct care? How is this understanding communicated?
- Is self-care encouraged and supported with policy and practice?
- Do all staff members receive clinical supervision that attends to both consumer and clinician concerns in the context of the clinical relationship? Is this supervision clearly separated from administrative supervision that focuses on such issues as paperwork and billing?
- Do program directors and supervisors make their expectations of staff clear? Are these consistent and fair for all staff positions, including support staff?
- Do program directors and supervisors make the program's mission, goals, and objectives clear?
- Do program directors and supervisors make specific plans for program implementation and changes clear? Is there consistent follow through on announced plans? Or, in the event of changed plans, are these announced and reasons for changes explained?
- Can supervisors and administrators be trusted to listen respectfully to supervisees' concerns—even if they don't agree with some of the possible implications?

Domain 1H. Choice for Staff—Maximizing Staff Choice and Control.

♦ Key Questions: "To what extent do the program's activities and settings maximize staff experiences of choice and control? How can services and work tasks be modified to ensure that staff experiences of choice and control are maximized, especially in the way that staff members' work goals are met?"

Sample Specific Questions:

- Is there a balance of autonomy and clear guidelines in performing job duties? Is there attention paid to ways in which staff members can make choices in how they meet job requirements?
- When possible, are staff members given the opportunity to have meaningful input into factors affecting their work: size and diversity of caseload, hours and flex-time, when to take vacation or other leave, kinds of training that are offered, approaches to clinical care, location and décor of office space?

Domain 1I. Collaboration for Staff—Maximizing Collaboration and Sharing Power

♦ Key Questions: "To what extent do the program's activities and settings maximize collaboration and sharing of power among staff, supervisors, and administrators (as

well as consumers)? How can services be modified to ensure that collaboration and power-sharing are maximized?"

Sample Specific Questions:

- Does the agency have a thoughtful and planned response to implementing change that encourages collaboration among staff at all levels, including support staff?
- Are staff members encouraged to provide suggestions, feedback, and ideas to their team and the larger agency? Is there a formal and structured way that program administrators solicit staff members' input?
- Do program directors and supervisors communicate that staff members' opinions are valued even if they are not always implemented?

Domain 1J. <u>Empowerment for Staff</u>—Prioritizing Empowerment and Skill-Building

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

Sample Specific Questions:

- Are each staff member's strengths and skills utilized to provide the best quality care to consumers/clients and a high degree of job satisfaction to that staff member?
- Are staff members offered development, training, or other support opportunities to assist with work-related challenges and difficulties? To build on staff skills and abilities? To further their career goals?
- Do all staff members receive annual training in areas related to trauma, including the impact of workplace stressors?
- Do program directors and supervisors adopt a positive, affirming attitude in encouraging staff, both clinicians and support staff, to fulfill work tasks?
- Is there appropriate attention to staff accountability and shared responsibility or is there a "blame the person with the least power" approach? Is supervisory feedback constructive, even when critical?

<u>Domain 2. Formal Services Policies</u>

Key Questions: "To what extent do the formal policies of the program reflect an understanding of trauma survivors' needs, strengths, and challenges? Of staff needs? Are these policies monitored and implemented consistently?"

<u>Some Possible Indicators</u>**:**

♦Policies regarding confidentiality and access to information are clear; provide adequate protection for the privacy of both consumers and staff members; and are communicated to the consumer and staff in an appropriate way.

♦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 consumers' and staff members' rights and responsibilities as well as a grievance policy.

♦The program's policies address issues related to staff safety. For example:

- Policies address if and when a staff member may be alone in the building or on duty.
- Policies govern specific ways for staff to offer home or community based services.
- Incident reviews follow verbal or physical confrontations and lead to effective plans to reduce staff vulnerability.

Domain 3. Trauma Screening, Assessment, Service Planning and Trauma-Specific Services

Key Question: "To what extent does the program have a consistent way to identify individuals who have been exposed to trauma, to conduct appropriate follow-up assessments, to include trauma-related information in planning services with the consumer, and to provide access to effective and affordable trauma-specific services?"

Some Possible Indicators**:**

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

♦At least minimal questions addressing physical and sexual abuse are included in trauma screening:

♦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.

♦Screening is followed as appropriate (given the nature and goals of the program, the length of time consumers are involved, and the specific relationships established with staff members) by a more extensive assessment of trauma history (type, duration, and timing of trauma) and of trauma-related sequelae (addressing resilience-related strengths and coping skills as well as vulnerabilities and problems).

♦In service planning, clinicians and consumers discuss ways in which trauma may be taken into account in clinicians' work with the consumer to achieve the consumer's goals (e.g., the place of trauma and trauma-related strengths and problems in giving shape to the recovery plan, its priorities, and the services and other supports that may be useful).

♦The program either offers or makes referrals to accessible, affordable, and effective trauma-specific services. Group and individual approaches to trauma recovery and healing are both available.

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 with me (rather than doing things for me or to 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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Communication & Collaboration: How Do We Share the Space?

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