Trauma-Informed Approaches to Systems of Care

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In considering ways to respond helpfully to those affected by traumatic experiences, we have made a basic distinction between "trauma-specific" and "trauma-informed" services (Harris and Fallot, 2001). *Trauma-specific* services are those whose primary task is to address the impact of trauma and to facilitate trauma recovery. These services include individual and group therapies designed to ameliorate posttraumatic stress disorder symptoms, such as exposure therapy and cognitive reprocessing therapy, as well as those interventions whose goal is to foster trauma recovery more broadly. By contrast, *trauma-informed* systems and services are those that have thoroughly incorporated an understanding of trauma, including its consequences and the conditions that enhance healing, in *all* aspects of service delivery. *Any* human service program, regardless of its primary task, can become trauma-informed by making specific administrative and service-level modifications in practices, activities, and settings in order to be responsive to the needs and strengths of people with lived experience of trauma.

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Becoming trauma-informed, in this sense, entails a shift in the culture or "paradigm" in human services. It involves changing the ways we *think*—about trauma itself, about the survivor, about services, and about the services' relationship—as a prelude to changing the ways we *act* in structuring and offering services. In such settings, trauma moves from the periphery to the center of the staff's understanding. Rather than asking, "What is your problem?" trauma-informed providers may ask, implicitly or explicitly, "What has happened to you? And how have you tried to deal with it?" Rather than adopting a stance of "Here is what I can do to help you," a trauma-informed approach asks, "How can you and I work together to meet your goals for healing and recovery?" In every aspect of the program's functioning, there is enhanced awareness of the ways in which trauma may have affected people coming for services. There is a corresponding shift in attitude, services, and the physical setting in order to welcome, engage, and sustain helpful relationships with consumer-survivors.

From a large number of conversations discussing trauma-informed changes with program administrators, staff, and consumer-survivors, we have distilled five core principles to guide agency self-assessment and planning: *safety, trustworthiness, choice, collaboration, and empowerment.* The broad assessment questions are straightforward. To what extent do current service delivery policies, practices, and settings: (1) ensure the physical and emotional safety of consumers? Of staff members? (*Safety*); (2) provide clear information about what the consumer may expect? Ensure consistency in practice? Maintain boundaries, especially interpersonal boundaries, appropriate for the program? (*Trustworthiness*); (3) prioritize consumer experiences of choice and control? (*Choice*); (4) maximize collaboration and the sharing of power with consumers? (*Collaboration*); and (5) emphasize consumer empowerment? Recognize consumer strengths? Build skills? (*Empowerment*).

Our approach to facilitating trauma-informed modifications draws on these principles as they are enacted at both the services and administrative levels. First, agencies review the extent to which their day-to-day service procedures and settings are welcoming and hospitable for trauma survivors and the extent to which they minimize the possibility of retraumatization. Program administrators, staff, and consumers consider each step of a prospective service recipient's experience with the program, from initial to final meeting. They ask a variety of questions relevant for their program. What is the usual first point of contact? By telephone or in person? Who is likely to greet the individual? With what information? How engaging and nonthreatening are these initial contacts likely to be, especially for people with histories of abuse and related interpersonal concerns? Are the physical settings responsive to the needs of trauma survivors? Are there private areas for confidential conversations? Questions like these address the full range of service relationships over the course of a person's involvement with the program.

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Agencies have made a very wide variety of changes in response to this exercise. For example, one program found that waiting room "love seats" felt very uncomfortable for abuse survivors, that such seats encouraged unwanted physical contact and left little personal space. The agency enhanced a sense of *safety* by removing these seats and replacing them with single chairs. Another program focused on strengthening its *trustworthiness* by publishing more clearly in advance the schedule for its many group interventions. Group leaders then adhered to that schedule as closely as possible and informed group members well in advance of any anticipated changes. In maximizing experiences of *choice* and *control*, an agency adopted a "person-centered recovery planning" approach that emphasizes consumers' priorities in all aspects of the services they receive, including a formal "statement of consumer preference" for responding to crises. A counselor decided to change her usual intake interview setting and practice so that the prospective consumer had the option to sit beside her and review necessary paperwork with her. She reported that this arrangement fostered a more *collaborative* relationship than her former, traditional question-and-answer approach. A community support specialist offered an anxious consumer she had accompanied to a doctor's office the opportunity to practice relaxation and visualization, key self-soothing skills that would facilitate *empowerment* in

many situations. One program focused on its signs and visual environment. They added encouraging and affirming posters while removing or rewriting unnecessarily "commanding"—and sometimes condescending—informational notices.

In addition to this review of basic activities and settings, program assessment and planning involves a detailed look at two other services-level domains: formal, usually written, policies and trauma screening/assessment/referral. Agencies, for example, have addressed both written policies requiring informed consent and the processes (timing, pacing, etc.) by which informed consent is discussed. In this way, time and effort are invested in ensuring that the "routine" obtaining of consent is both meaningful and valid. Similarly, programs have re-examined their policies about how to de-escalate interpersonal conflicts in ways that maximize safety for consumers and staff; they have also instituted careful reviews to be certain that the policies are implemented as written. Universal trauma screening is normative in trauma-informed agencies and is followed, as appropriate, by more in-depth assessment of trauma and its impact. Deciding on the content of this screening and assessment process has afforded opportunities for many agencies to consider the kinds of trauma prospective consumers are most likely to have experienced. Programs then frequently highlight the importance of this assessment by monitoring the extent to which the information is incorporated in service planning and in referrals to needed trauma-specific services.

A similar review of three domains at the administrative level follows: administrative support; trauma training and education; and human resources practices. Because becoming trauma-informed involves significant shifts in both the "culture" and the "system" of a program, administrative support for, and active participation in, such initiatives is a necessity. Engaging all stakeholders or constituencies is also essential, including, perhaps most importantly, those people who are receiving, or have formerly received, services at the agency. Many programs that have developed a consumer advisory group as part of a trauma-informed initiative have found that consumer participation expanded naturally into major roles in planning, implementing, and evaluating services. No other single shift has had such major impact as this enhanced role of consumers. Those programs most successful in developing significant and lasting trauma-informed approaches have engaged frequently underrepresented groups—administrators, support staff, and consumers, especially—in all aspects of the change process.

Education about trauma and its impact has proven, not surprisingly, to be central in virtually all change efforts. All staff, including support and administrative staff, can benefit from an understanding of trauma-related concerns and the factors that facilitate recovery. For example, many programs have decided to prioritize education and consultation for its reception staff in how to handle calls and face-to-face visits with distressed or angry people. When staff learn how to respond helpfully to those who are distraught, they not only avoid escalating conflicts but also contribute to their own safety and sense of competence. There is an additional factor in favor of such education: because trauma-informed changes address program-wide issues, there is an emphasis on *staff members'* experiences of safety, trustworthiness, choice, collaboration, and empowerment alongside that of consumers. Attention to staff support and care has become increasingly important in a time of "do more with less" resource allocation.

Addressing trauma in staff hiring, orientation, retention, and promotion is a final avenue to systemic change. Programs have developed trauma-centered vignettes for use in interviewing prospective staff to gauge both knowledge of, and responsiveness to, trauma experiences. They have incorporated basic information about trauma in orientation, emphasizing trauma's importance in shaping their approach to services. They have put in place incentives for staff who pursue and use additional education in trauma-related areas.

Quantitative studies of the effectiveness of trauma-informed approaches to service delivery have recently been published (Morrissey et al., 2005). Qualitative findings from our consultations have been promising. In programs that have implemented this process, each of the major constituency groups—administrators, direct service staff, and consumers—have reported positive responses to trauma-informed changes in the system of care. The most common theme, one that is echoed across various groups, is an experience of greater collaboration and trust. As one consumer stated, whereas she had previously felt it necessary to leave part of herself outside the agency door, the trauma-informed initiative made it possible for her to "bring her whole self" to the program. A trauma-informed culture ideally expresses just this kind of openness to, and engagement with, the full experiences of trauma survivors.

References

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Spring/Summer 2008 Issue

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