Behavioral Health Services (BHS)

Guidelines for Trauma-Informed Care Workplace and Practice

2019

Approval	Signature	Date
Director of Operations		12/10/19

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Introduction

Purpose

The purpose of the Trauma-Informed Care Workplace and Practice Guideline is to support all Behavioral Health Services (BHS) programs to be trauma-aware and to make trauma-informed decisions in the services provided to our clients and their families. The Guideline aims to promote work environments that are trauma-aware and safe, foster resilience, and actively mitigate the potential negative impacts of providing services to those who have experienced trauma.

Intended Audience

All staff working in HCA's County or county-contracted BHS programs are the primary audience for these guidelines, including, but not limited to, front desk staff, clinicians, mental health workers, peer specialists, managers, directors, supervisors.

Key Terms

Trauma can refer to a single event, multiple events, or a set of circumstances experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual well-being.[1,2]

Secondary trauma is trauma-related stress reactions and symptoms resulting from exposure to another individual's traumatic experience. [1,2]

Trauma informed approach to the delivery of behavioral health services includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. [1,2]

Trauma-informed care is a strengths-based service delivery approach 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. [1,2]

Trauma specific treatment services are evidence-based and promising practices that facilitate recovery from trauma. [1,2]

Resilience is "the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress, such as family and relationship problems, serious health problems or workplace and financial stressors. It means 'bouncing back' from difficult experiences."[3]

Vicarious Trauma refers to the "cumulative transformation in the inner experience of the therapist that comes about as a result of empathic engagement with the client's traumatic material."[4]

Burnout is a syndrome resulting from chronic workplace stress that has not been managed effectively, and is characterized by three dimensions: "(1) feelings of energy depletion or exhaustion; (2) increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and (3) reduced professional efficacy".[5]

Emotional Exhaustion is an element of burnout and refers to mental fatigue[6].

Documentation of Need

We recognize that trauma is a common and significant issue that many of our BHS recipients have experienced. Epidemiological studies show rates of exposure to any traumatic event as high as 82.7% in the U.S. population[7], 89.7 % in adults[8], and over 60% in youth having experienced at least one traumatic event [9]. Exposure to traumatic events is even higher among subpopulations receiving behavioral health services. For example, 84% of psychiatric inpatients have experienced at least one traumatic event [10], up to 94% of outpatient mental health clients report a trauma history[11], and 60 to 90% of treatment-seeking substance abusers report a history of sexual or physical abuse[11]. The magnitude of this trauma epidemic is large, and although many people exposed to trauma demonstrate few or no lingering symptoms, those who seek behavioral health services are more likely to have multiple or repeated and chronic traumas[1].

We also recognize that the psychological and emotional impacts of trauma can be detrimental, primarily a loss of safety, self, and self-efficacy[1], in addition to an increased risk for a range of negative ramifications compared to individuals without a traumatic history[8]. These impacts can include posttraumatic stress disorder (PTSD), depression, substance use, and other delinquent and health-risk behaviors [8]. The effects of trauma are not limited to the time immediately after a traumatic experience and can lead to long-lasting complications, including shortened lifespan, physical health issues, mental health issues, substance use, changes in neurological functioning and development, self-harm and suicide, and greater exposure to more traumatic events[12,13]. In fact, research shows those who had childhood experiences of trauma are up to 5,000 percent more likely to attempt suicide, use intravenous drugs, or develop an eating disorder[12].

The impacts can extend to staff working directly or indirectly with trauma-exposed clients. In particular, clinicians who provide direct services to traumatized populations are at higher risk of experiencing *secondary traumatic stress*, or stress reactions and symptoms resulting from professional contact with traumatized people [11]. Secondary trauma symptoms mirror those observed in people directly exposed to trauma such as intrusive imagery, avoidant behaviors, or physiological symptoms, and can be more pronounced in individuals with a personal trauma history [11]. A study investigating the prevalence of secondary trauma in a random sample of U.S. practicing social workers found that nearly all clinicians reported working with traumatized populations (97.8%), 70% of which identified experiencing at least one symptom of secondary trauma and 15.2% reported symptoms consistent with PTSD [11]. A related concept, *burnout*, which refers to workplace stress or a state of emotional exhaustion, depersonalization or cynicism, and low professional efficacy not effectively managed [14], has recently been included in the latest 11th International Classification of Diseases (ICD-11) as an official syndrome and has been linked to professionals working with traumatized clients [15]. *Emotional exhaustion* is widely documented among mental health professionals[16] and is more prevalent among clinicians who predominately manage a trauma caseload[17]. Mental health professionals affected by secondary trauma are at higher risk of making poor professional

judgments compared to those unaffected (e.g., clinical documentation, ethical decision-making) [11]. This can understandably pose challenges for clinicians in the provision of high quality and effective care to clients and their families.

Justification

The high rates and impact of trauma clearly suggest that implementing a strengths-based service approach to care that is dually and holistically responsive to survivors and providers of care is a crucial initiative. There are also multiple benefits for our clients and our workforce that justify implementing trauma-informed system of care guidelines that warrant mention. First, there is evidence that trauma-informed services lead to better clinical outcomes, including a reduction in client psychiatric symptoms and substance use[18] and improved psychological resilience[19] (e.g., improved self-esteem, healthy relationships). Trauma-informed care establishes a platform for survivors to rebuild a sense of control and empowerment, as well as recognizes the effects of secondary trauma and supports self-care in the workforce. Providers also report greater collaboration with clients, enhanced skills, and support from agencies [20]. There is also evidence that professional training in trauma-informed care improves *compassion satisfaction* or the perceived self-efficacy related to providing care to others[21]. Additionally the use of evidence-based practices lowers compassion fatigue and burnout among therapists treating trauma[22]. Finally, trauma-informed care is cost-effective, as service costs are commensurate to treatment-as-usual[23] and promotes workforce retention[1].

Overall, these findings suggest that increasing awareness and training professional staff on effective trauma strategies can be protective and cost-effective. Although there is widespread agreement on the urgency to uphold a trauma informed system of care both externally[1], and internally in our BHS, there is minimal formal guidance and discussion on how this approach applies to our system of care. The Trauma-Informed Care Workplace and Practice Guidelines are a resource applicable BHS-wide for all staff levels and departments in response to this gap in our system.

Consistency with Policies, Regulations, Laws, and Professional Standards

Practice Guidelines are expected to meet the following requirements: be based on valid and reliable clinical evidence or a consensus of health care professionals in the applicable field; consider the needs of the individuals and families served across BHS; are adopted in consultation with contracting health care professionals; and are to be reviewed and updated periodically as appropriate.

A Guideline differs from a Professional Standard, which is mandatory and, thus, may be accompanied by an enforcement mechanism. A Guideline is not mandatory, definitive, or exhaustive. This Practice Guideline is intended to be aspirational, with the intent to facilitate continued development of professional practices and to promote high quality services. This set of guidelines may not apply to every professional or clinical situation within the scope of the Guideline. As a result, the Guideline is not intended to take precedence over professional judgment.

These guidelines are meant to provide consistency with other HCA policies, the Office of Compliance, and any state or federal regulations to which HCA is already adhering. Federal and State laws supersede these Guidelines.

Background

Development of Guideline

This Practice Guideline was developed by the Behavioral Health Services (BHS) Practice Guidelines Workgroup, which is a committee of clinicians, supervisors, psychiatrists, and BHS managers who represent all BHS areas [(i.e., Adult and Older Adult Behavioral Health (AOABH), Children, Youth and Prevention Behavioral Health (CYPBH), and Authority and Quality Improvement Services (AQIS)]. The Practice Guidelines Workgroup was developed to create and standardize clinical practice guidelines within BHS. The Guideline was developed based on a review of the literature and other popular research sources (e.g. internet websites) in the field.

Selection of Evidence

Existing practice guidelines developed by national and international associations were used as resources in the development of this Practice Guideline. Journal articles referencing established guidelines were also included. All resources used were published in the late 1990s to the present.

Guideline

Guideline Statement

To have a trauma-informed workplace and practice means that among staff and throughout all aspects of service provision, there is an integration of trauma awareness. For all staff, there is intentionality to their interactions with one another and with the individuals and families served to prevent re-traumatization and to avoid minimizing trauma experiences. "Trauma-informed practice is an overall way of working, rather than a specific set of techniques or strategies."[1] While this Guideline represents the current principles and research in this area, those working in the behavioral health field are encouraged to stay up to date with current practices and literature. This Guideline outlines the core principles of trauma informed care and describes a continuum for the implementation of trauma informed care.

Applications

Principles of Trauma-Informed Care

Substance Abuse and Mental Health Services Administration (SAMHSA) explains in *A Treatment Improvement Protocol: Trauma-Informed Care in Behavioral Health Services (TIP 57)* that trauma awareness is foundational to the development of trauma informed care. Additionally, SAMHSA has outlined the following core principles of trauma informed care: safety; trustworthiness and transparency; peer support and mutual self-help; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues.

SAMHSA's 4 Rs state that a trauma-informed approach[24]:

1. Realizes the widespread impact of trauma and understands potential paths for recovery
2. Recognizes the signs and symptoms of trauma in individuals and families served, staff, and others involved with the system
3. Responds by fully integrating knowledge about trauma into policies, procedures, and practices
4. Resists re-traumatization

A trauma-informed workplace prioritizes development of trusting relationships, teaches individuals coping skills, and addresses behavior with positive and compassionate approaches. It is a place where an ongoing, inquiry-based process allows for teamwork, coordination, creativity, and sharing of responsibility for all. Using a trauma-informed approach to care can create a safe, accepting, and respectful environment which is often needed to reveal thoughts or behaviors associated with trauma, suicide, or intimate partner violence. It is not always necessary for a person to disclose past painful experiences. Through education about the impact of adverse experiences along with teaching healthy coping skills within a trauma-informed culture, staff can promote positive physical health and behavioral health outcomes. It is important to note that exploring traumatic experiences requires sensitivity, skills, and training. Building resilience is a valuable way to respond to trauma as individuals can be taught skills that assist them to improve coping; manage emotions; connect with others and resources; and find hope, purpose, and meaning.

Staff may also come to this work with histories of trauma that may, at times, impact their ability to explore the traumatic experiences of their patients/consumers. Staff may also be impacted by repeatedly listening to the painful experiences of others. For this reason, a trauma-informed culture considers and responds to the needs of staff as well.[24]

Similarly, the *Trauma-Informed Practice Guide (TIP Guide)*, developed on behalf of the BC Provincial Mental Health and Substance Use Planning Council, outlines the following principles of trauma-informed practice: trauma awareness; emphasis on safety and trustworthiness; opportunity for choice, collaboration, and connection; and strengths and skill building.

This Guideline integrates the core principles identified by SAMHSA and the *TIP Guide* and outlines the following core principles for trauma informed care: (1) Trauma Awareness; (2) Safety and Trustworthiness; (3) Choice and Empowerment; (4) Collaboration, Connection, and Peer Support; and (5) Cultural, Historical, and Gender Issues.

Trauma Awareness

Building an awareness of the commonness of trauma is paramount to trauma informed care. To be trauma aware is not to assume, but rather to anticipate, the possibility of trauma exposure and to recognize the potential impact of trauma on an individual's emotional, behavioral, cognitive, spiritual, and/or physical development. This anticipation of trauma experiences reduces the likelihood of re-traumatization of individuals within the context of the behavioral health services being provided. Additionally, to be trauma aware is to understand the increased risk of secondary trauma for family members, significant others, social networks, and behavioral health providers as a result of frequently experiencing an individual's traumatic stress reactions. When a program or agency is trauma aware, education on coping with and preventing secondary trauma is made widely accessible for staff and use of clinical supervision and peer support are encouraged to process trauma related matters.[1]

Types of Trauma

Trauma can take many forms and may or may not be limited to a single finite event. The following list includes examples of both finite and complex traumas[25]:

- Natural disasters
- Accidents
- Medical trauma
- Sexual abuse
- Bullying
- Refugee experiences
- Community violence
- Intimate partner violence
- Physical abuse
- Neglect
- Terrorism
- Traumatic grief

- Adverse childhood experiences (domestic violence, substance abuse, parental separation, incarcerated parent, emotional/physical/sexual abuse, and emotional/physical neglect, mental illness)[12]

Safety and Trustworthiness

SAMHSA explains that in a trauma informed organization, there is a sense of physical and psychological safety experienced, both among the staff within the organization and the individuals and families they serve[2].

According to SAMHSA, in a trauma informed organization sustaining trust among staff and the individuals and families they serve is critical. In line with this goal, organizational decisions are made and operations are conducted transparently.

Ways that this can be accomplished:

1. Be mindful of personal space when approaching and working with individuals and those of different cultures.
2. Practicing good informed consent by always frontloading whatever the individual is about to experience in order to avoid any surprises and minimize discomfort.
3. Checking in with individuals at regular intervals about their experience.
4. Having your materials and plan prepared prior to meeting with individuals.
5. In terms of physical space, recognizing that the milieu of a work environment can have a significant impact on one's sense of safety. This can include maintaining well-lit workspaces, reducing clutter, work toward making areas free of a confined-feeling, use of lighter colors, and avoiding the placement of artwork or informational flyers/posters that contain potentially triggering images.
6. Organizations can assist in enhancing a sense of external safety by providing educational material, building skills and offering trainings, and linking to outside resources.

Choice and Empowerment

SAMHSA describes a core belief in resilience as foundational in trauma informed practice. Grounded in this belief in resilience, trauma informed organizations take a strengths based approach to supporting staff and the individuals and families served. Trauma informed organizations recognize the unique experience of their staff and the individuals and families served and work to build upon and develop new skills, strengthening their experience of exercising choice in their healing. Some strategies that providers can institute to increase choice and empowerment include[26]:

1. Let them know in advance what they are about to do. (1,2,3)
2. Let them choose the language they are most comfortable with. (1,3)
3. Make sure that you describe what assessments and questionnaires you are about to use. (1,2)
4. Offer to do things at the pace that they are comfortable with while checking in at various times. (1,2)
5. Praise, debrief, and explain next steps. (1,2,3)
6. Always ask for permission. (1,2,3)
7. Offer to create a mutually understood signal for when the individual needs to pause and take a break. (1,2)

8. Focus on asking "what do you need" rather than "what is wrong with you?" (1,2,3)
9. When providing feedback, make sure to highlight and emphasize strengths and resiliency, including protective factors (1,2,3), and how you will use these in their treatment plan for recovery (1) or their performance improvement plan (2).

Stakeholder Key	
1	Individual/Family served
2	Program staff and workplace
3	Community

Strategies that can enhance a sense of choice and empowerment for staff include:

1. Forming employee/management committees for sharing feedback, developing ideas collaboratively, and formulating task forces to address needs at the operational level.
2. Create clear mechanisms for staff to express their need for self-care during the work day to reduce the risk of secondary trauma and compassion fatigue (e.g., open-door policy, suggestion box)
3. Provide opportunities for regular debriefing and reviewing of systems with staff.
4. Educate staff on the signs of compassion fatigue, burnout, and secondary trauma and strategies to mitigate them.
5. Regular staff training and enhanced awareness of program efforts and changes.

Collaboration, Connection, and Staff Peer Support

In trauma informed organizations, collaboration is highly valued and there is a recognition that each staff member has an integral role to play. SAMHSA describes this mutuality as a "true partnering and leveling of power differences between staff and individuals/families served and among organizational staff from direct care staff to administrators"[2].

SAMHSA views staff peer support and mutual self-help as "integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety, and empowerment"[2].

One strategy for increasing connection and collaboration includes forming a service user advisory council that provides advice on service design as well as service users' rights and grievances[1].

Cultural, Historical, and Gender Issues

SAMHSA states that the trauma informed organization "actively moves past cultural stereotypes and biases, offers gender responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma."[2] Behavioral health organizations should remain current on developments, research, and trainings in these areas. Below are some strategies and principles for working in a culturally responsive manner with those who have experienced traumatic events.

A. **Engagement with the individuals and families served**. Issues of engagement may be problematic for some cultural groups. Making outreach and engagement strategies more culture-specific is an important treatment goal. For example, trust is a sensitive issue when working with refugees. Also, expanding engagement efforts to members of the individual's or family's immediate community can be key in providing treatment more effectively.

B. **Sensitivity to the cultural background when building a strong therapeutic relationship**. When treating an individual who has been exposed to trauma, developing a strong relationship is critical to a successful recovery. Providers need to appreciate the importance of asking questions about the individual's and their family's culture.

C. **Consideration of the impact of culture on symptom expression**. Taking into account the individual's or family's cultural view is important in understanding how symptoms of trauma are expressed for certain cultural groups. Measurements of these trauma symptoms should also be sensitive to these differences.

D. **Careful use of interpreters when necessary**. Being able to communicate with individuals or families during treatment is very important. Language barriers present challenges to providers employing treatment models that require family participation. The use of interpreters should be examined carefully before using a particular treatment intervention.

E. **Understanding that differences in emotional expression exist among cultures**. Teaching individuals and families how to effectively regulate emotional expression in the face of overwhelming feelings associated with their traumatic experiences, is vital to effective treatment. Providers must learn how different cultures dictate the expression of these feelings and the appropriate level of emotional expression within a given culture's norms.

F. **Assessment of the impact of cultural views on cognitive processing or reframing**. Addressing cognitive distortions and misattributions is a core element in many treatments for traumatic stress in individuals and families served. The therapist should be aware of how culture may influence how individuals and their families describe their traumatic experiences to themselves and others. For example, keeping feelings to oneself may be a result of the cultural function rather than a reaction to the traumatic experience.

G. **Using culturally congruent methods to help integrate experiences of trauma into a coherent narrative**. Some therapeutic modalities encourage the construction of a trauma narrative to assist individuals and families in integrating their experiences into a story that focuses on the whole picture. Building the capacity of individuals and families to talk about their traumatic experiences while using coping skills to deal with the emotional reminders that will emerge is critical to many treatment approaches. Including one's cultural view on how life experiences are shared is equally important. The use of storytelling or cultural traditions are examples of how some cultural groups relate their experiences to others.

H. **Highlighting ways in which culture may be a source of resiliency and strength**. Capitalizing on the strengths of the individual or family can help foster feelings of empowerment and confidence that the traumatized individual or family can use in their treatment and post-treatment recovery. Identifying certain aspects of one's culture that provide support and a sense of competence in dealing with adversity can be valuable to any treatment approach.

Implementing Trauma Informed Care

With the core principles of trauma informed care as the foundation, Behavioral Health Services programs and individual staff are encouraged to collaborate in cultivating a trauma informed workplace and practice. A trauma-informed workplace should, in many ways, mirror the way that staff work with individuals and families served.

The *TIP Guide* outlines a continuum for the implementation of trauma informed practice which include: (1) Personal Level – Self-Awareness and Self-Compassion; (2) Practice Level – Our Interactions with individuals and families served; (3) Engaging; (4) Asking About Trauma, (5) Making the Links with Trauma; and (6) Skill-building and Empowerment.

Personal Level – Self-Awareness and Self-Compassion

As described earlier, to be trauma aware is to recognize the commonness of trauma and to anticipate the possibility of trauma exposure. In a trauma informed organization, awareness of the frequency of trauma extends not only to individuals and families served, but to program and agency staff, many of whom have experienced trauma. Moreover, behavioral health providers are often re-exposed to trauma stories and experiences within the provision of services[1].

For behavioral health providers, self-awareness is a critical component of being able to support individuals and families in their healing and recovery. Across all levels of staff this self-awareness is imperative as having an understanding of the traumas one has experienced, as well as one's vulnerabilities, triggers, and beliefs, are essential for effectively working with others and providing treatment services. Trauma informed clinical supervision is an ideal venue for behavioral health providers to develop this self-awareness. Internal program or agency supports and resources are encouraged to be utilized by staff to build this self-awareness.[1]

Vicarious trauma refers to "the cumulative transformative effect on the helper working with the survivors of traumatic life events"[27]. The impact of vicarious trauma can be experienced on both a personal and professional level. On a professional level, the effects of vicarious trauma can be seen behaviorally and interpersonally in one's job performance and morale[28]. Self-care and the utilization and development of protective factors are essential in mitigating the impact of vicarious trauma.

One useful self-assessment tool that individuals or teams can use to assess and track the positive and negative effects of providing help to others who may have a history of trauma or other significant challenges is the ProQOL[41].

Practice Level – Our Interactions with Individuals and Families Served

In a trauma informed organization, the first point of contact with an individual and every subsequent interaction are approached with intention. Regardless of the varying roles each staff member plays in the provision of services at a program or agency, "interactions are respectful, supportive, collaborative, hopeful, and strengths-focused".[1]

Being trauma aware does not mean being a trauma expert, rather, it is the ability to recognize the signs of trauma responses. Trauma responses vary in type, frequency, and intensity among individuals and are

commonly categorized as physical ailments, emotional or cognitive symptoms, spiritual concerns, interpersonal difficulties, and behavioral issues[29–31]. It is important to have an understanding that trauma responses may be expressed differently among varying cultural groups, therefore, staff are encouraged to continuously engage in cultural competency activities[20].

More often than not, the behavioral, emotional, or other responses to trauma that are being experienced by an individual are viewed as deficits. Trauma informed practice requires a shift in thinking and language from deficit-based to strength-based. This shift allows for de-stigmatization, empowerment of individuals, and increased understanding, empathy, and alignment.[1]

Engaging

The process of engagement is an ongoing and critical component of trauma informed practice. Individuals who have experienced trauma often have difficulty establishing initial trust and rapport, which may lead to the discontinuation of services.[1] In order to engage and retain individuals in behavioral health services, all interactions between staff and the individuals and families served should be guided by the principles of safety and trustworthiness and collaboration and choice[32].

In trauma informed practice, there is an understanding that individuals who have experienced trauma may not feel safe in new environments and may have difficulty trusting others. With this understanding, staff recognize that "trust and safety, rather than being assumed from the beginning, must be earned and demonstrated over time"[33]. Some ways behavioral health providers work with individuals to create a sense of physical and emotional safety are by[1]:

- Identifying and attending to all possible barriers, concrete or perceived, to engagement.
- Addressing immediate needs, such as basic needs (e.g., food, housing, transportation), substance intoxication, and suicidality.
- Being transparent, consistent, and predictable.
- Establishing and maintaining healthy boundaries.
- Clearly explaining the provider's role as well as the program expectations.
- Obtaining informed consent and explaining the limits of confidentiality.
- Working with the individual to develop grounding techniques.

Feelings of powerlessness and lack of choice or control are often experienced by individuals who have experienced trauma. In trauma informed practice, empowerment, collaboration, and offering choice whenever possible gives a sense of control back to trauma survivors. Some ways behavioral health providers can create opportunities for collaboration and choice are by[1]:

- Making logistical decisions together (e.g., time/day of appointments, how individual is contacted)
- Problem solving concrete or perceived barriers to participating in treatment.
- Gathering the individual's hopes for treatment.
- Identifying possible support persons to be involved in treatment.
- Using language that makes collaboration and choice apparent.
- Frequently eliciting feedback about the individual's experience in treatment.

Asking About Trauma

Given the prevalence of trauma experiences for individuals accessing behavioral health services, the use of trauma-informed approaches are justified.[1] The literature supports the importance of asking about trauma with clients accessing mental health and substance use services[20,32,34,35]. The following guidelines can assist behavioral health providers in asking about trauma in a trauma-informed way[31,36–38]:

- Remember that engagement and rapport building are critical during screening and assessment.
- Remain present to the purpose of the information that is being gathered and have an understanding as to how the information will support engagement, treatment, and recovery.
- Facilitate a safe and contained discussion while continually tying information to current functioning.
- Offer choice regularly during the assessment process.
- Have trauma-related information accessible and ensure privacy during sessions.
- Explain the reason for asking about trauma and share that trauma reactions are normal and expected.
- Look for trauma responses and provide grounding and containment.
- Elicit strengths, interests, coping skills, support system, and other positive supports.
- Allow for open conversation, where trauma topics can be paused and continued at a later time.
- Utilize OARS – open-ended questions, affirmations, reflective listening, and summaries – a Motivational Interviewing approach to build and maintain engagement.
- Routinely request feedback from the client about how the discussion was for them.
- Use clinical judgement to determine when not to ask trauma related questions (e.g., when a client is in crisis, is under the influence, etc.)

Essential to building therapeutic rapport is first ensuring safety of both the BHS Provider and individual being assessed for suicidality. If a BH Provider is able to establish a safe space in which to interview, then attention can be paid to building therapeutic rapport and trust to increase comfort, openness, and a positive interpersonal experience for the individual being assessed. Establishing a therapeutic rapport allows for a collaborative approach to intervention so the individual can be an active participant in any screening, assessment, or short/long-term treatment plans. Therapeutic rapport will help uphold the respect and rights of the individual being assessed, as well as increase recognition of the individual preferences and needs.

Trauma Screening Tools

Specific instruments to measure trauma and the effects of trauma should be interpreted by qualified staff and should not be used without additional competent clinical assessment. Self-report trauma scales are primarily useful in screening, and caution should be used in administering them with a person who has already been diagnosed with a trauma-related mental health disorder as such scales may require the individual to have to re-disclose information about traumatic experiences unnecessarily.

Brief screening tools and specific instruments to assess trauma do not substitute a clinical assessment, and their tendency is to be oversensitive and under specific, yielding false positives but few false negatives. A person who scores positively on a trauma scale should always be further assessed clinically.

BHS Providers should refer to their individual Program/Division/Agency policies and procedures and/or their supervisors for direction as to what screening tools are recommended for use with the individuals and families you serve.

Screening and Assessment Tools for Children and Adolescents:

A. Pediatric Symptom Checklist (PSC)
    a. The PSC can be obtained for use in all County threshold languages here
B. Children's PTSD Inventory (CPTSD-I)
C. The Connor-Davidson Resilience Scale (CD-RISC)
D. Child and Youth Resilience Measure (CYRM)
E. Child Stress Disorders Checklist (CSDI)
F. Trauma Symptom Checklist for Children (TSCC)
G. Trauma Symptom Checklist for Young Children (TSCYC)
H. Trauma and Attachment Belief Scale (TABS)
I. Clinician-Administered PTSD Scale for DSM-5 – Children/Adolescents (CAPS-CA-5)
J. UCLA PTSD Reaction Index for DSM-5 – Child/Adolescent and Parent/Caregiver Versions (PTSD-RI)

Screening and Assessment Tools for Adults:

A. Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)
B. Dissociative Subtype of PTSD Scale (DSPS)
C. The Connor-Davidson Resilience Scale (CD-RISC)
D. Adult Resilience Measure (ARM)
E. Mississippi Scale for Combat-Related PTSD (M-PTSD)
F. Trauma Symptom Checklist (TSC-40)
G. PTSD Checklist for DSM-5 (PCL-5)
H. Brief Trauma Questionnaire (BTQ)
I. ACE Questionnaire

Making Links with Trauma

Individuals or families often seek treatment when experiencing a crisis or when symptoms are causing significant concern and are increasingly difficult to manage[30]. Trauma is often stored in the brain as unprocessed experiences and responses in the present may be reactions or reenactments of past trauma. Trauma-informed practice can assist individuals in noticing the link between past experiences and current difficulties and can empower clients to practice choice and control in the present[1]. The following guidelines can be used by behavioral health providers to assist clients in making links with trauma[30]:

- Individualize the pacing and timing of when information is shared, ensuring that safety has been established.
- Offer choices regarding if, when, and how much information about the possible connections between past trauma and current experiences is offered.
- Use reflective listening and normalizing often.
- Demonstrating understanding of reactions and making links to their responses to past trauma can support the individual in normalizing their experience.

The following are key messages that may be helpful to behavioral health providers when conveying links with trauma[1]:

- Trauma awareness – define abuse and/or neglect; explain contexts of trauma, which may include social, biological, and psychological contexts; and offer reframes to the individual's interpretation of their experience, which is that something happened to them, rather than something being wrong with them.
- De-stigmatize and normalize responses to trauma experiences.
- Emphasize resiliency and hope.
- Depending upon the type of trauma, when appropriate, convey the message that what happened was not the individual's fault.
- Communicate the types of service and support that can be provided by the program, offer referrals when appropriate and based on the client's readiness, and work on developing supports and connections with people and communities in the individual's life.

Skill-Building and Empowerment

One of the most important aspects of healing from trauma, which also serves as a protective factor for children and adolescents, is learning to manage emotions[34,39]. Behavioral health providers can support the individuals and families they serve in developing grounding and self-care skills. As these skills develop, individuals and families have greater capacity to address trauma issues with behavioral health providers. Staff working in behavioral health programs, likewise, may benefit from their ongoing development of safety, grounding, and self-care skills in order to effectively do trauma work with those they serve[1].

As outlined below, a stepped approach is recommended for supporting individuals in managing trauma responses:

1. Notice one's own internal reactions as the behavioral health provider.
2. Observe the individual's non-verbal (e.g., posture, facial expressions) and verbal (e.g., tone, rate of speech, words) communication.
3. Provide verbal support and grounding.
4. Remain present and strive to not immediately change or "fix" their difficult emotions.
5. Continue to provide grounding and calming until safety appears re-established and the client is present.
6. Strengthen and develop empowerment and collaboration.
7. Seek consultation or support from a peer or supervisor to process.

Special Populations or Settings

There are populations that are highly vulnerable to trauma exposure that warrant mention. These may include children and youth, individuals with intellectual disabilities, older adults, LGBTQIA+ communities (lesbian, gay, bisexual, transgender, queer, intersex, and asexual), individuals with HIV/AIDS, homeless populations, veterans, and immigrant or refugee populations. Additionally, individuals living in urban communities, marked by poverty, crime, and drug-related activities, are often at increased risk for violence exposure and victimization (e.g., physical altercations, assaults)[40]. Behavioral health professionals that work in specialized contexts with groups highly vulnerable to trauma exposure consequently encounter more

trauma stories and are themselves more vulnerable to experiencing secondary trauma, vicarious trauma, emotional exhaustion, and burnout. These settings may include foster care settings, emergency clinics, inpatient and residential settings, and law enforcement contexts, including juvenile halls, jails, and prisons.

Although we forgo providing specific recommendations on each group, we encourage staff to turn to the literature on specific populations with which you are working, seek consultation/supervision, and/or training to learn more about the considerations for special populations.

SAMHSA offers multiple resources, including handbooks and trainings focused on special populations.

Children and Youth:

- Zero to three
- The National Child Traumatic Stress Network (NCTSN)
- The NCTSN – Complex Trauma in Children & Adolescents
- Childhood Trauma, Changing Minds
- Juvenile Justice

Veterans:

- U.S. Department of Veterans Affairs
- African American PTSD Association
- National Alliance on Mental Illness

Individuals with Intellectual Disabilities:

- Developmental Disabilities Administration Health Initiative

Older Adults:

- National Center for PTSD – Symptoms in older adults
- National Center for PTSD – Assessment and treatment in older adults

LGBTQIA+:

- National LGBT Health Education Center
- Fenway Institute

HIV/AIDS:

- Health Resources & Services Administration HIV/AIDS Programs

Homeless:

- Trauma-Informed Organizational Toolkit for Homeless Services

Immigrant or Refugee:

- Administration for Children & Families
- Moving beyond trauma: Child migrants and refugees in the United States

Traumatic Experiences in the Workplace

While a trauma-informed workplace is one that emphasizes and creates a safe working environment[1], it is not always possible to prevent potentially-traumatic experiences from taking place in or near the program, especially in certain settings (e.g., incarcerated settings, hospitals, residential treatment settings, field-based work, and programs located in areas that experience community violence). Administrators should consider establishing policies and procedures that support staff in managing the effects of traumatic events that occur in or near a workplace. Much of what has been discussed in this guide can be applied or adapted to address such situations.

Suggestions for accomplishing this can include increasing predictability by defining and providing clear procedures for when such events occur, routine training and reminders for staff of the signs of traumatic stress reactions, encouraging a "buddy system" for regular check-ins amongst colleagues, utilizing employee assistant programs that offer a wide variety of services and resources, including post-event counseling for teams and individuals, and regular debriefing (individually and as a team) shortly after an event occurs to support staff and to assess the response to the event so that any improvements can be identified. Additionally, behavioral health programs should consider normalizing reactions to traumatic events in the workplace and commit to preventing and reducing anything in the workplace that promotes a culture or attitude that such events are just "part of the job" and that one may be weak for not being "up to the job." Expressing genuine empathy and commitment within a program is essential to maintaining trust and engagement that promotes positive coping. Lastly, returning to business as usual is often a positive coping strategy for some, while others may benefit from a temporary shift in workload, work assignment, or even taking time off from work.

Some signs of traumatic stress reactions in the workplace to evaluate include: decreasing productivity, difficulty concentrating, increased tardiness and/or absenteeism, increased concerns about safety, shifts in mood (anger, irritability, sad or tearful), somatic complaints including loss of appetite, decreased employee retention, and feeling uncomfortable or overwhelmed[41].

Quick Guide: Trauma-Informed Care Workplace & Practice

WHAT IS TRAUMA?

Trauma results from an event, series of events, or set of circumstances that are experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being[1].

While responses to experiencing trauma can differ from person to person in type, severity, and frequency the following table is based on the most commonly reported or observed responses to trauma[1]:

Physical	**Emotional or Cognitive**	**Spiritual**	**Interpersonal**	**Behavioral**
• Unexplained chronic pain or numbness	• Depression	• Loss of meaning or faith	• Frequent conflict in relationships	• Substance use
• Stress-related conditions (e.g. chronic fatigue)	• Anxiety	• Loss of connection to: self, family, culture, community, nature, a higher power	• Lack of trust	• Difficulty enjoying time with family and friends
• Headaches	• Anger Management	• Feelings of shame or guilt	• Difficulty establishing and maintaining close relationships	• Avoiding specific places, people, situations (e.g., driving, public places)
• Sleep problems	• Compulsive and obsessive behaviors	• Self-blame	• Experiences of victimization	• Shoplifting
• Digestive problems	• Being over-whelmed with memories of the trauma	• Self-hate	• Difficulty setting boundaries	• Disordered eating
	• Difficulty concentrating, feeling distracted	• Feel completely different from others		• Self-harm
	• Fearfulness	• No sense of connection		• High-risk sexual behaviors
	• Loss of time and memory problems	• Feeling like a "bad" person		• Suicidal impulses
	• Suicidal thoughts			• Gambling
				• Isolation
				• Justice system involved

*Children may also respond in the following ways: separation anxiety, fear of the dark, nightmares, and regressive behaviors (e.g., bedwetting, thumb sucking).

*Cultural Consideration: trauma may have different meanings in different cultures and responses to trauma may also be expressed differently.

WORKING WITH INDIVIDUALS WITH TRAUMA

Possible Signs of Trauma to Watch for When Interacting or Working with Others

- Sweating
- Change in breathing
- Muscle stiffness, difficulty in relaxing
- Inability to concentrate or respond
- Shaking
- Staring into the distance
- Becoming disconnected, losing focus
- Startle response, flinching
- Flood of strong emotions
- Rapid heart rate
- Inability to speak
- Avoidance

Developing Safety and Trustworthiness

1. Consider possible barriers to engagement (visible/invisible, concrete/perceived) and address them collaboratively

2. Attend to immediate needs (e.g., safety, shelter, medical concerns), including providing linkages

3. Be transparent, consistent, and predictable

4. Establish healthy working boundaries and expectations by clarifying roles

5. Clearly outline program and treatment expectations of what the individual can expect and what is expected of them

6. Review informed consent, how information will be shared, and the limits to confidentiality and ensure their understanding

7. Collaboratively develop an understanding of helpful grounding strategies that the individual already utilizes, ways the provider can offer support, and specific strategies that can be learned and utilized in session to promote grounding

See: The Centre for Addiction and Mental Health (CAMH) Client Bill of Rights

Collaboration and Choice

1. Working through the details together (e.g., contact preference, preferred gender of practitioner, timing of appointments)

2. Exploring and problem solving barriers to participation and attendance collaboratively with the individual

3. Striving to understand and make central the individual's priorities and hopes for treatment

4. Inquiring about others who may be helpful to include in some aspect of their care

5. Identifying adjunctive providers and/or those who close to and supportive of the individual and developing a plan with the individual for how they want their supports included in their care

6. Emphasizing importance of individual's preferences and choices (e.g., "I am curious what your thoughts are about this plan." "Please let me know if you need me to pause or if you become uncomfortable at any point.")

7. Eliciting feedback often to inform your work and the program

Asking About Trauma

1. Assessment is also a crucial time for developing the relationship and enhancing engagement

2. Be considerate that information gathered is predominantly in the individual's best interest and course of treatment – generally, specific details of traumatic experiences are not required to provide trauma-informed care

3. Keep the conversation safe, contained, and connected to present functioning and health

4. Offer choice to individuals in answering questions about trauma

5. Ensure that the physical space promotes a sense of safety – provide as much privacy as possible and consider the physical layout, spacing between you and the individual, lighting, proximity to an exit, etc.

6. Utilize OARS: Ask Open-ended questions, offer Affirmations, use Reflective listening, and provide Summaries

7. Discuss the reason for asking questions about trauma and normalize reactions to trauma

8. Stay aware and respond to the signs of a trauma response – consider pausing the conversation, using grounding skills to connect the individual to the present moment, and provide the a choice to continue or return to the topic at a later time

9. Highlight when possible their strengths, protective factors, goals, coping skills, community supports, spirituality, etc.

10. Remember that topics can be revisited while developing a sense of trust and safety with the individual

11. Break-up the number of questions asked in a row by using more reflections in conversation(see OARS)

12. Elicit feedback often (e.g., "How was this for you today?", "Is there something that you would like to let me know about how I can ask you questions going forward?")

13. Utilize your clinical judgment to decide when to not inquire about trauma, for example, during a crisis, if the individual is experiencing a high level of emotion(s), during substance withdrawal/intoxication, or during active psychosis

14. Gather information from collateral sources to minimize re-telling of events

SELF CARE FOR STAFF[1, 41]

Some Signs of Secondary Trauma

- Having a sense of needing to fix things for the individuals you work with or acting as the expert and not collaborating
- Feeling overwhelmed
- Rushing tasks and assignments
- Dreading appointments or work
- Intrusive thoughts and/or disrupted sleep related to information about others' trauma experiences
- Feeling emotionally exhausted in your work with individuals seeking services
- Feeling "trapped" by your job or "bogged down" by the system
- Easily fatigued, startled, or irritated
- Disruption in self-care
- Feeling depressed, numb, or indifferent
- Avoiding people, places, or activities because they remind you of those you who you work with
- Trouble remembering what you did during the day
- Difficultly separating personal and professional life
- Increasing tardiness/absences

Short-term Self Care Strategies

Physical:
- Feel your feet on the floor
- Focus on your breath
- Stretch
- Run water over your hands
- Progressive muscle relaxation

Mental:
- Scan your office and name what you see
- Read something out loud to yourself
- Imagine changing the channel in your head

Soothing:
- Imagine something that gives you strength
- Put inspirational quotes on your wall and read them as you need
- Develop a mantra (e.g., "No feeling is final", "I can do anything for a day")

Longer-term Self Care Strategies

- Have variety in your day and role overall - research, training, different types of conversation
- Attend continuing education
- Take scheduled breaks in the day
- Develop a personal debriefing plan, with peers or a supervisor
- Set realistic goals for yourself
- Explore spiritual beliefs
- Actively use body therapies (e.g., yoga, stretching, mindful movement)
- Listen to how you "speak" to yourself - practice words of self-respect and recognition

Strategies for Outside of Work

- Eat regular, healthy and balanced meals
- Get adequate sleep
- Meditation/Mindfulness practice
- Practice daily gratitude
- Yoga or stretching
- Rhythmic physical activities and movements
- Journal
- Have a ritual for when you come home to symbolize your transition from work (e.g., unplug from phones/social media, change clothes, eat a snack, call a friend)
- Therapy and/or spiritual guidance

Ideas for Grounding

- Breathing: counting breaths, belly breathing, noticing physical changes with the breath
- Pressing your feet into the floor - either seated or standing
- Notice your weight in your chair and the stability the chair and ground beneath you provides
- 5-4-3-2-1: Name 5 things that you see, 4 things that you hear, 3 things that you feel through touch, 2 things that you smell, and 1 thing that you taste
- Repeat an affirmation mantra
- Clap your hands together and feel all of the movements of your hands, the air between them, the sound they make, and the slight sting of your skin when they make contact
- Go to a safe and calm place
- Click HERE and go to page 85 to see "33 Quick Ways to Ground"

Most people are aware of the need to practice a variety of these strategies, but it can be important to explore your obstacles or hesitancy if you have stopped doing any of them or have yet to start to do them. Sometimes one small action or gesture of self-care can lead to bigger change.

THE TRAUMA-INFORMED WORKPLACE[2]

Ideas that promote care, longevity, and growth that can support staff who work with those with trauma include:

- Structured and strength-based supervision is provided to all staff from someone trained in trauma-informed care
- Conduct regular staff meetings that include sharing of information and ideas for working with trauma, discussion of ethical issues associated with defining personal and professional boundaries, model/teach strategies for self-care, safety, choice, and empowerment, and assess/address issues of safety
- Provide and facilitate opportunities for peer support and consultation
- In supervision, help staff understand their own stress reactions
- Supervisors should provide appropriate support to staff who report experiencing vicarious trauma

The following *Personal Preparation Plan* can be individualized as you prepare for trauma-informed practice:

Personal Preparation Plan[2]

In preparation for engaging with someone coming for mental health and/or substance use support, I will ground myself by…

_____

_____

I will remind myself that…

_____

_____

I will know the work is starting to have a negative effect on me when…

_____

_____

If that starts to happen, I will ground myself by…

_____

_____

Someone who can offer me support

1) At work: _____
2) Outside of work: _____

Two self-care strategies that help me manage are…

_____

_____

Resources

A Treatment Improvement Protocol: Trauma-Informed Care in Behavioral Health Services (TIP 57)

Trauma-Informed Practice Guide (TIP Guide)

Vicarious Trauma Toolkit

Adverse Childhood Experiences (ACEs)

Traumatic Events in the Workplace

SAMHSA offers multiple resources, including handbooks and trainings focused on special populations

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