

Harnessing the Learning Community Model to Integrate Trauma-Informed Care Principles in Service Organizations

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The McSilver Institute for Poverty Policy and Research at New York University Silver School of Social Work (McSilver Institute) recently partnered with the National Council for Behavioral Health (National Council) to facilitate a yearlong Learning Community (LC), a promising methodology for helping organizations adopt and sustain practices and principles of Trauma-Informed Care (TIC).¹

Based on the Institute for Healthcare Improvement’s collaborative learning model for supporting “breakthrough” change efforts,² a LC provides expert guidance and fosters the exchange of ideas among organizations with a common improvement goal. The support of a resource panel of experts guides LC participants to apply change management, continuous quality improvement, and workforce development strategies to plan, implement, and sustain improvements that align with the mission, readiness, capability, and capacity of each participating organization.³

The National Council and McSilver Institute LC enrolled 32 behavioral health organizations, 92 percent of which reported having implemented trauma-informed care in at least six of the National Council’s seven TIC domains by the end of the LC, and 100 percent of which reported improving some area of their trauma-informed principles and practices.

What is Trauma-Informed Care?

Trauma-Informed Care (TIC) is a holistic approach to providing services, distinct from a clinical treatment model. It has its roots in the Vietnam era, and evolved through the turn of the century, with a particular focus on female survivors of physical and sexual violence.⁴

Principles and guidelines for trauma-informed services were developed and tested in the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration’s (SAMHSA) 1998-2003 Women’s Co-Occurring Disorders and Violence Study.⁵⁻⁷ The term “Trauma-Informed Care” was first explicitly expressed in the literature in Maxine Harris and Roger Fallot’s 2001 book, *Using Trauma Theory to Design Service Systems*.⁸⁻¹⁰

TIC stems from the recognition that trauma frequently underlies and/or co-occurs with the conditions for which individuals present at behavioral health, health, or social services systems. In her 1992 book, *Trauma and Recovery*, Judith Herman explained the devastating impact trauma has on survivors' sense of agency and attachment: "Traumatic events call into question basic human relationships. They breach the attachments of family, friendship, love, and community. They shatter the construction of the self that is formed and sustained in relation to others. They undermine the belief systems that give meaning to human experience. They violate the victim's faith in a natural or divine order and cast the victim into a state of existential crisis."¹¹ As a result, trauma survivors not only struggle to function within societal boundaries, but they are also often slow to trust those who might help them and are particularly vulnerable to unintended re-victimization.

Whether or not a particular service system provides services designed to treat trauma (i.e. trauma-specific services), the framework in which services are delivered must be carefully designed to promote healing.

Core Principles of TIC

- ▶ **Support trauma survivors and ensure they are not inadvertently re-traumatized** in the process of accessing services;
- ▶ Reflect an organization-wide **understanding of trauma and its effects**, including the ways survivors' coping mechanisms manifest in symptoms and behaviors;
- ▶ Provide a **physically and emotionally safe environment** for all consumers, staff, and stakeholders;
- ▶ **Empower consumer survivors** to collaborate in developing their treatment plans, to have authority over when, where, and how those plans are implemented, and to have a say in the evaluation of services delivered; and
- ▶ **Help survivors to harness their strengths** to facilitate recovery and develop resiliency.¹²⁻¹⁵

The need for TIC is now widely recognized in the behavioral health field and is emerging in other service systems as well.¹⁶

However, implementing these principles on the organizational or system level is a massive undertaking. It involves the assessment and adjustment of every aspect of operations and service delivery, and requires tremendous commitment and effort from every level of a direct service workforce that may itself be struggling with individual and organizational stress.¹⁷ Despite the challenges, becoming trauma-informed is worth the significant investment. Creating a safe and supportive environment for trauma survivors enables them to recognize what has happened to them and facilitates their connection to evidence-based interventions so they can heal. It also strengthens staff, who themselves may be trauma survivors, and has the potential to pay off in improved client outcomes.¹⁸⁻²⁰

What is Trauma?

As noted above, a fundamental underpinning of trauma-informed organizations is an understanding by all staff members and stakeholders of trauma and its impact. Thus it is important that there is common understanding of what is meant by “trauma.”

The prevailing psychiatric definition of trauma is rooted in the context of diagnosing Post-Traumatic Stress Disorder (PTSD),²¹ which by its nature pathologizes survivors. It puts the focus on “what is wrong?” with them rather than asking the trauma-informed question, “what has happened?” to them.²²

Recognizing the absence of a universally accepted, trauma-informed definition in the literature, SAMHSA commissioned a panel of experts to develop a concept of trauma that would be pertinent across disciplines and constituencies.²³ SAMHSA’s resulting definition of trauma encompasses its causes and effects as it relates to individuals:

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.

—SAMHSA Trauma and Justice Strategic Initiative

SAMHSA also acknowledges that trauma occurs at the community level, and the agency has identified that as a topic for future work.²⁴ The McSilver Institute is also looking at collective trauma, with a particular focus on the trauma wrought by historical and ongoing structural racial oppression.

Trauma Prevalence and Effects

The Adverse Childhood Experiences (ACE) study conducted by the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente's Health Appraisal Clinic in San Diego, is a multi-year, large-scale research study exploring the associations between childhood adversity and later-life health and wellbeing.²⁵ In two waves, between August 1995 and October 1997, more than 17,000 enrollees in Kaiser Permanente's Health Maintenance Organization, who had recently been given complete health evaluation, answered a follow-up survey that included questions related to categories of adverse childhood experiences including emotional abuse, physical abuse, sexual abuse, household exposure to substance abuse, household exposure to mental health issues, abandonment by a parent, and imprisonment of a household member.²⁶

Almost two-thirds of the predominantly white, well-educated study participants reported at least one adverse childhood experience, and more than one in five reported three or more such experiences.²⁷ Furthermore, the more adverse life events individuals experienced in childhood, the greater their risk of serious physical and behavioral health problems, including chronic disease, depression, alcoholism, drug abuse, smoking, severe obesity, sexual promiscuity, poor anger control and attempted suicide.²⁸⁻³⁰

Studies have also shown that traumatic experiences in early childhood are directly correlated to changes in brain physiology and functioning.³¹ For example, MRIs have revealed a decrease in the volume of the hippocampus and amygdala, which play a role in memory storage and fear responses respectively, among women who had been sexually abused. Risky sexual behaviors and impairment of childhood memories both increase as ACE scores increase.³² Research also indicates that severe life stressors in childhood are associated with long-term disturbances in the hypothalamic-pituitary-adrenal axis, which can lead to depression.³³ Another study found childhood maltreatment associated with changes in



chemical interactions, which results in higher risk of depression and suicidality.³⁴

The ACE study revealed the widespread prevalence of childhood trauma among a relatively homogenous population enrolled in a California health maintenance organization.³⁵ An analysis of data from a more diverse sample of more than 5,877 people age 15 to 54, who participated in a national survey on psychiatric disorders in the United States, found that during their lifetime 60.7 percent of men and 51.2 percent of women had experienced at least one traumatic event, based on *Diagnostic and Statistical Manual of Mental Disorders, Version 3-Revised* criteria.³⁶

Numerous studies have shown even higher rates of trauma, and exposure to multiple traumatic experiences, among people involved in service systems—including health, human services, criminal justice, and child welfare systems.³⁷⁻⁴³ Research also suggests trauma prevalence is higher among urban youth of color than in the general population, which has implications for service providers in poverty-impacted communities.⁴⁴⁻⁴⁵ It is also notable that social workers, who are on the front lines of many of our service systems, are at risk of secondary traumatic stress as a result of their work with trauma survivors.⁴⁶⁻⁴⁹

Implications for Service Systems

Given trauma's prevalence and strong correlation with physical and mental illness, risk behaviors, and functional difficulties, it follows that service delivery systems should adopt a trauma-informed approach. Doing so, however, is a complex, time- and resource-intensive process that presents significant organizational challenges.⁵⁰⁻⁵¹ TIC requires a comprehensive review and redesign of every aspect of an organization's operations with strong commitment from leadership, active engagement of consumer survivors, and buy-in from stakeholders at every level.

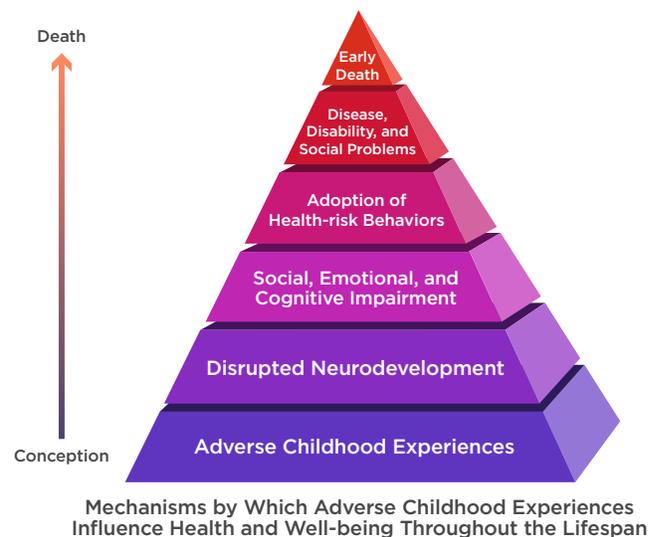


Figure 1. The ACE Pyramid, Centers for Disease Control and Prevention

Harris and Falloot asserted that before an organization can begin to establish a trauma-informed system of care, the following conditions must be met:⁵²

Pre-Conditions for Trauma-Informed Systems of Care

- ▶ **“Administrative Commitment”** to becoming trauma-informed;
- ▶ **“Universal Screening”** of consumers for trauma history;
- ▶ **“Training and Education”** for all staff in introductory trauma dynamics;
- ▶ **“Hiring Practices”** that ensure all new employees have at least a basic knowledge of trauma dynamics and that the organization has at minimum one or two trauma experts to model and promote a trauma-informed approach for colleagues; and
- ▶ **“Review of Policies and Procedures”** by management, clinicians and consumers to identify and revise those that could be directly or indirectly harmful to trauma survivors. At a minimum, organizations should operate with the assumption that all consumers are trauma survivors and adhere to the maxim “above all else, do no harm.”

To guide organizations in making the transformation to trauma-informed, several scholars and agencies have prescribed “domains,” comprised of standards, policies and practices.⁵³⁻⁵⁵ The National Council for Behavioral Health, drawing on common elements in the literature, has set forth seven domains for being a trauma-informed organization:

Seven Domains for Being Trauma-Informed

- ▶ **Early Screening and Comprehensive Assessment of Trauma**
- ▶ **Consumer Driven Care and Services**
- ▶ **Trauma-Informed, Educated and Responsive Workforce**
- ▶ **Provision of Trauma-Informed, Evidence-Based, and Emerging Best Practices**
- ▶ **Create a Safe and Secure Environment**
- ▶ **Engage in Community Outreach and Partnership Building**
- ▶ **Ongoing Performance Improvement and Evaluation**

The Learning Community Model for Implementation

The 32 behavioral health organizations enrolled in the National Council and McSilver Institute LC first completed an extensive application to determine their readiness to achieve the seven TIC domains, and evaluate their commitment to engaging in the LC. Each organization also designated a Core Implementation Team (CIT), generally comprised of senior administration, program supervisors, quality improvement staff, practitioners, and consumers, to participate in the LC, and lead implementation efforts within their organizations.

An expert resource team established by National Council and the McSilver Institute led an initial day-and-a-half-long kickoff meeting designed to assist organizations in developing an implementation process that aligned with their organizational strengths and priorities. Ongoing support was provided through (1) informational webinars across all TIC domains; (2) online technical assistance; (3) quarterly individual or team calls; (4) trauma related webinars; and (5) tools and resources to assist organizations to self-assess their current alignment with TIC, develop implementation plans and monitor progress across all domains. Furthermore, a highly interactive listserv was designed to facilitate the unique characteristic of a LC—i.e. the collective problem solving and information sharing among the participating organizations. Finally, the resource team created a project specific website designed to enable easy access to a range of tools and resources to help organizations assess their strengths and needs across all domains, choose high priority improvement goals, develop practical implementation plans, monitor their progress, and engage their organizational leadership and workforce to support TIC.

In the TIC LC, organizations were engaged and supported as partners who could exercise a great deal of autonomy and self-directed decision making for selecting the areas of TIC and number of domains that they would address over the course of the year, and the pace at which they would implement change. They could begin with a single program or implement changes across numerous programs within their organization. This approach acknowledges that significant and planned change is implemented in the context of the day-to-day realities of the organization.

Results of the Learning Community

Post-test quantitative and qualitative data were collected from the CIT at each organization to measure progress made in becoming more trauma-informed, and gauge the effectiveness of the LC. By the end of the LC, 92 percent of the organizations had implemented TIC in at least six of the seven domains and 100 percent of organizations reported progress in Early Screening and Comprehensive Assessment of Trauma as well as Trauma-Informed, Educated and Responsive Workforce. Furthermore, over 90 percent of organizations reported making improvements in Create a Safe and Secure Environment; Provision of Trauma-Informed, Evidence-Based and Emerging Best Practices; and Engage in Community Outreach and Partnership Building. While only 75 percent of organizations reported improvement in Consumer Driven Care and Services, those that did not tended to be child-serving organizations whose young patients were difficult to engage as volunteers, or organizations that only provided services on a short-term basis. At the end of the LC, half of the organizations reported currently evaluating their performance, with most citing administrative challenges, including the functionality of the electronic health record system and the capacity of the quality assurance department, as the reason for their lack of progress in that domain.

Participants who felt their organizations had made great progress attributed that to their CITs and dividing up responsibilities among subgroups. They also reported autonomy in making changes within the organization's policies and procedures as well as the screening and assessment process. A workforce receptive to implementation of TIC, as well as the ability to increase staff training around trauma-specific treatment and trauma-informed care, was also identified as allowing for progress. Beginning with a focus on domains in which the organization could change without outside or upper level administrative assistance was also found to allow for greater progress.

Not having strong buy-in from senior leadership and staff reluctance to adopt TIC principles were among the most common challenges participants reported. Some organizations struggled with administration or staff who believed implementing TIC would create additional work or feared that asking trauma-focused

questions during screening and assessment would “open a can of worms.” With the support of the LC, CITs worked to embed TIC into the culture of their organizations so that it did not appear to be something “extra” that staff needed to do. One participant reported, “staff were reluctant to become trained in TIC at first because of the time commitment, but once they began to learn about it, they loved it.”

Participants reported that the TIC LC provided resources and support to promote effective organizational change. They said that the Organizational Self-Assessment and the coaching calls were the most useful resources from the LC as they helped keep focus. The listserv was reported useful because it showed that other organizations were struggling with similar issues and had a variety of information which was reported as helpful to all organizations. One participant explained, “the calls, conversations, emails...the constant contact has really made a difference and through this process has allowed us to think differently to see where we are on TIC practices and how we have been doing.”

Conclusion

There is a growing recognition that TIC should be a standard practice among service organizations. The fact that it is not more widely implemented speaks to the challenges of adopting a paradigm shift that requires sweeping organizational change.

To help service organizations make the transition to being trauma-informed, there is a need for executive will and access to evidence-based technical assistance, like the Learning Community described above.



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About the McSilver Institute

The McSilver Institute for Poverty Policy and Research conducts and disseminates interdisciplinary, community-based research and advances policy and program solutions to address the root causes and consequences of poverty. Drawing on the intellectual and scholarly strengths of New York University and located within the Silver School of Social Work, the McSilver Institute partners with agencies and communities in New York City, across the nation, and around the world to develop research projects; evidence-informed services and technical assistance; educational programs; and policy recommendations that have short- and long-term social impact. Founded in 2007 through the generosity of Constance and Martin Silver, the McSilver Institute recognizes the significant link between individuals, families, communities, and their external environments, as well as the interrelatedness of race and poverty.

