Addressing Stress and Trauma in Recovery-oriented Systems and Communities

A Challenge to Leadership

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February, 2015

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At the time of this publication, Pamela Hyde, JD served as SAMSHA Administrator. Daryl Kade, MA, served as CSAT Acting Director and Kimberly Jeffries Leonard, PhD served as CSAT Acting Director; Andrea Kopstein, PhD, MP served as Director of CSAT’s Division of Services Improvement; and Walker Reed Forman, MSW served as the CSAT Project Officer for the ATTC Network.

The opinion expressed herein are the view of the authors and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA, or CSAT. No official support or endorsement of DHHS, SAMHSA, or CSAT for the opinions described in this document is intended or should be inferred.

# Table of Contents

**Acknowledgments** *(Lonnette M. Albright, BSEd, CPEC)* .......................................................... iii

**Preface** ........................................................................................................................................ v

**Executive Summary** ......................................................................................................................... 1
  - Addressing Stress and Trauma ................................................................................................. 1
  - A Challenge to Leadership .................................................................................................... 1

**About This Manual** ......................................................................................................................... 3
  - The Action Notes .................................................................................................................. 4
  - Using a Team Approach ....................................................................................................... 4
  - Who are “We”? ....................................................................................................................... 4

**Section 1:**
**The Role of Leadership** ............................................................................................................. 5
  - Understanding ....................................................................................................................... 5
  - Action Notes for Section 1 .................................................................................................... 8

**Section 2:**
**Transforming the Vision** .......................................................................................................... 9
  - First Challenge: Focusing on Strength, Resilience, and Recovery ...................................... 9
  - Second Challenge: Looking at the Whole Picture ................................................................. 10
  - Turning Challenges into Opportunities .............................................................................. 11
  - Action Notes for Section 2 .................................................................................................... 12

**Section 3:**
**Resilience, Stress, and Trauma** .................................................................................................. 13
  - A Few Clarification Points .................................................................................................... 14
  - The Scope of the Problem ...................................................................................................... 15
    - The ACE Study ................................................................................................................ 15
    - Beyond the ACEs: Toxic Stress in the Larger Environment ........................................... 16
  - Action Notes for Section 3 (Part 1) ..................................................................................... 17
  - Action Notes for Section 3 (Part 2) ..................................................................................... 18

**Section 4:**
**Trauma-informed Approaches** ................................................................................................... 19
  - Traditional Human Service Approaches ............................................................................ 19
  - Essential Elements of Trauma-informed Approaches ........................................................ 20
  - Action Notes for Section 4 .................................................................................................... 22
Acknowledgments

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Executive Director
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If these acknowledgements are expressions of gratitude, we at the Great Lakes Addiction Technology Transfer Center (Great Lakes ATTC) must first acknowledge that we are grateful to be here, doing this work, at this particular point in history. After centuries’ worth of “top-down,” acute-care approaches to addictive disorders and mental health conditions, we have finally seen the birth and early steps of the recovery-oriented systems of care (ROSC) framework. We hope through this manual to help trauma-informed approaches assume their critically important place in that framework.

We owe a special debt of gratitude to our two principal consultants, mentors and friends in our work toward recovery management and recovery-oriented systems of care, and in the development of leadership capable of ROSC systems transformation:

• William L. White, MA, one of the principal architects and the historian of the recovery movement and the realm of recovery management, first envisioned elements of these approaches back in the early 1990s, when Project SAFE began to mold a multi-systemic, recovery-oriented, trauma-informed approach around the needs of addicted women and families involved in the public treatment and child welfare systems in Illinois. Bill’s tireless efforts and prolific writings have educated and inspired us all, and they still lead us forward.

• Ijeoma Achara, PsyD continues to serve as our best regional and national resource in making recovery-oriented systems of care come alive, preparing leadership for ROSC transformation and providing both conceptual and practical tools that meet the complex needs of large and small systems. Ijeoma played a central role in early transformation efforts in Connecticut and Philadelphia, and she continues to lend her wisdom and expertise to a growing number of systems nationwide. Her ability to lead gently from vision to concrete action is amazing, and we are proud to have her as our colleague.

At the center of our national leadership is our principal funding body, the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT). We thank SAMSHA Administrator Pamela Hyde, JD; CSAT Acting Director Daryl W. Kade, MA, Deputy Director Kimberly Jeffries Leonard, PhD and former Director H. Westley Clark, MD, JD, MPH; Andrea Kopstein, PhD, MPH, Director of CSAT’s Division of Services Improvement; and Reed Forman, MSW, SAMHSA/CSAT’s Lead Public Health Advisor and Interim Project Officer for the Addiction Technology Transfer Center (ATTC) Network, for their support and their belief in the power and importance of recovery. SAMHSA has been a strong, enthusiastic supporter of both recovery-oriented systems of care and trauma-informed care, through its Center for Substance Abuse Treatment, Center for Mental Health Services, and National Center for Trauma-informed Care, and through their many ROSC and TIC projects and initiatives.

At the time of this writing, we also have special gratitude for the leadership and support of the late Suzan Swanton, LCSW-C, CSAT, who served as ATTC Project Officer from September, 2012 to January, 2015, earning the love and respect of a grateful network.
We also thank the ATTC Network as a whole for consistent mutual support as we have worked together to strengthen all facets of recovery by assisting in the transformation of systems, organizations, practices, and the addictions treatment and recovery workforce. We are very grateful as well for the partnership of our colleagues at the Jane Addams College of Social Work, University of Illinois at Chicago, our academic home for the past 16 years. Special thanks to Dean Creasie Finney Hairston, PhD, whose guidance and example have held us up to the highest standard of excellence in service to the surrounding community, the professional community, and the larger world we serve.

Our other national and international sources of inspiration and knowledge on the subjects of ROSC and TIC are too numerous to name, but they have our gratitude. Special thanks to all the treatment and recovery support providers in the addiction and mental health fields, whose patient, gifted, and dedicated work has healed and empowered so many people. But our deepest gratitude goes to the individuals, families, and communities whose lives are affected by trauma, addiction, and mental health challenges. Their strengths, trials, and successes are proving that resilience and recovery are realities.

This manual has been enhanced by the insight of six expert reviewers, and our overall TIC efforts will be enhanced through the involvement of a new Advisory Council. We thank these dedicated individuals, listed in full in Appendix C.

And finally, this manual would never have been possible without the passion and vision of its author, Pamela Woll, MA, CPS. Our partner and consultant since 2001, Pam has brought to this process her unique ability to synthesize models and topics that have traditionally been addressed separately, and to make their combination accessible, understandable, and useful. Our concept of the ROSC framework has been enhanced by Pam’s highlighting of the role and importance of TIC within this framework, and of their place in the larger context that is the health of the whole population.
Preface

Pamela Woll, MA, CPS
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At the time of this writing, if we took a map of the world and started to shade in red all the places where pain, shame, fear, grief, guilt, illness, deprivation, and rage were staples of everyday life, we would soon be looking at a bright red picture of the world. And those who understand the effects of toxic stress and trauma tell us that underneath each of those red splotches lie the seeds of more pain in the next generation, and in many generations to come.

More and more friends and colleagues have spoken lately of the struggle to keep their spirits alive in the face of this overwhelming reality. The sheer volume and complexity of challenge in the world—even in our own communities—renders each one of us powerless against it. There is hope, though, but it lives in each little thing we can do about some small part of the problem in the next year, the next week, the next five minutes. There is our power.

In offering an opportunity to write about how a number of well documented solutions fit together, the Great Lakes Addiction Technology Transfer Center has given me a gift of immeasurable value: A chance to do something that is at once useful and enormously satisfying. Special thanks to Executive Director Lonnetta Albright, BSEd, CPEC for her visionary leadership, her mentorship, and her faith, and to Director of Operations Rafael Rivera, MBA, CADC, for his thoughtful, patient, and encouraging service as director of this project. To these two friends, and to all Great Lakes ATTC staff, my love, admiration, and gratitude.

Our heroes, teachers, and mentors in the realms of trauma and recovery have taught us well:

• Resilience lies at the heart of every one of us, no matter how troubled we might be.
• In an atmosphere of safety and respect, the effects of toxic stress and trauma can be stabilized, and these wounds to the body, mind, spirit, and relationship can be healed.
• Recovery from toxic stress, trauma, substance use disorders, and mental health challenges may at times be a mystery, but it is an undeniable reality.
• Integrated resilience- and recovery-oriented systems—rooted in the community—form an essential framework for our responses to the many acute and chronic conditions we face, and trauma-informed approaches are absolutely critical to their success.
• If formal and informal leaders work together, every step we take toward understanding, prevention, intervention, stabilization, healing, and/or recovery—even on the smallest local level—can serve as a step toward the health of the whole population.

The enormity of the problem cannot defeat us, provided we work together and stay focused on the power of the solution and the task before us at this moment. Pioneers in resilience theory, strength-based services, recovery-oriented systems, peer-driven support, and population health approaches have given us a wealth of resources to guide us and examples to inspire us.

These pages offer a snapshot of their legacy and a few suggestions for getting started. Thank you for opening this manual, and for choosing hope, service, and solutions.
Executive Summary

Addressing Stress and Trauma

Stress is an everyday factor of human life, relationships, systems, and communities. When stress comes too early, lasts too long, or bears down too hard—or when it carries loss, pain, danger, betrayal, or deprivation—it can easily overwhelm our capacity to cope and rise above adversity. We bear these cumulative wounds of body, mind, and spirit, each taking its toll on our health, well-being, development, relationships, functioning, and capacity for hope and happiness.

As a society, we grapple with ever-rising and ever-deepening sources and experiences of toxic stress and trauma. Many of these wounds can trigger effects that spread the stress to others in our families, our communities, and society as a whole. No wonder Blanch and Shern (2011) called toxic stress “a public health crisis of major proportions.”

The tip of this iceberg is the presence of behavioral health challenges (substance use disorders and mental health conditions), so the responsibility for healing has long fallen on the behavioral health field. Tasked with addressing increasingly chronic, complex, and deeply entrenched symptoms and conditions—many instilled or aggravated by toxic stress and trauma—the field’s leaders have begun to implement:

• Recovery-oriented systems of care (ROSC), an overarching framework that brings together multiple service systems, service participants, community stakeholders, and people in recovery to build and implement integrated, strength-based, collaborative, empowering services and approaches, with their roots in the family and community and recovery as their central organizing principle

• Trauma-informed care (TIC), a collection of approaches that establish and preserve the safety, strength, resilience, dignity, integrity, well-being, and recovery of all service participants, family members, community members, people in recovery, and service providers.

Because the iceberg itself is a complex set of circumstances that leaves individuals, families and communities vulnerable to the many effects of toxic stress and trauma, it is equally important for communities and the full range of service and justice systems to adopt trauma-informed approaches and become full partners in recovery-oriented systems of care.

A Challenge to Leadership

In behavioral health, allied systems, and surrounding communities, it is time for formal and informal leadership to address this crisis together, as a growing number of states, cities, and smaller communities have begun to do. It is imperative that leaders take an inclusive,

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collaborative team approach toward studying, envisioning, planning for and carrying out trauma-informed approaches within recovery-oriented systems of care, considering this manual as a resource for these efforts.

Each Section of this document offers a brief set of suggested “first steps” for leaders who are willing to accept this challenge:

1. **The Role of Leadership**: Resolve to question and be prepared to let go of any preconceptions that limit your understanding, narrow your focus, or weaken your grasp of the complexity of the challenges addressed in this manual and other resources.

2. **Transforming the Vision**: Establish and maintain a steady focus on strength, resilience, and recovery and a scope of vision large enough to hold the whole picture, no matter what pieces of the puzzle you face at any given moment.

3. **Resilience, Stress, and Trauma**: See the effects of trauma in the context of a broad range of human experiences, and on a continuum that runs from resilience to stress, to toxic stress, to trauma and its many effects.

4. **Trauma-informed Approaches**: Place the safety and stability of each individual, family, and community at the center of your efforts to build trauma-informed approaches.

5. **Recovery-oriented, Trauma-informed Approaches**: Adopt long-term recovery as the central guiding and organizing principle for your efforts, ROSC as the framework for your integrated systems and services, trauma-informed approaches as a central and critical element of ROSC, and the health of the whole population as the context in which all these efforts take place.

6. **Implementing Trauma-informed Approaches**: Equip yourself with the full range of conceptual and strategic resources for implementing trauma-informed approaches, always taking into account the complexity of human change processes and the importance of courageous, inspiring, and collaborative leadership.

7. **Workforce Development**: Use your knowledge of trauma, recovery, trauma-informed approaches, and recovery-oriented systems of care to form a foundation for your recruitment, hiring, supervision, mentorship, staff support policies and practices, and orientation and development of your Board of Directors.

8. **Accepting the Challenge**: Remember the reality of recovery and resilience, and the growing evidence that recovery-oriented systems and trauma-informed approaches represent true and valid hope for the safety and well-being of the people you serve and the families and communities that hold their lives.

Toxic stress and trauma may be powerful, self-perpetuating forces, but so are the human spirit, our capacity for connection, and the transformation that can take place when we put our heads and hearts together.

Just as stress and trauma spring from multiple sources and experiences, so do solutions. From the community stakeholders who wield informal influence over their neighbors’ understanding to the system leaders whose decisions affect thousands of people, each partner is valuable, each effort is needed, and each success is an affirmation of our collective strength and resilience.
About This Manual

Addressing Stress and Trauma in Recovery-oriented Systems and Communities: A Challenge to Leadership is written for:

- Leaders of behavioral health and other health, human service, education, and criminal justice agencies, organizations, and systems
- Community leaders, including leaders of civic organizations, faith communities, charitable organizations, recovery community organizations, and businesses
- Informal “opinion leaders” who are willing to use whatever opportunities they have to influence the thoughts and decisions of these leaders and their constituents

This manual is designed to stimulate thought, start conversations, promote understanding, point out resources, suggest opportunities for collaboration, and provide tools for the planning process. It includes eight Sections, each providing a high-level overview of one facet of this topic:

1. “The Role of Leadership” outlines the importance and complexity of the subject and the need for trauma-informed approaches within recovery-oriented systems.
2. “Transforming the Vision” presents two central considerations in building a truly useful vision to guide planning.
3. “Resilience, Stress, and Trauma” describes toxic stress and trauma and their growing impact on individuals, families, communities, and cultures—and the resilience that lives in even the most troubled lives.
4. “Trauma-informed Approaches” introduces principles and practices of these approaches.
5. “Recovery-oriented, Trauma-informed Approaches” introduces recovery-oriented systems of care and explores the role of trauma-informed approaches and three other essential constructs within this overarching framework.
6. “Implementing Trauma-informed Approaches” highlights guidelines, models, and resources that can guide the implementation process and offers insights from ROSC implementation efforts.
7. “Workforce Development” offers challenges and suggestions to be considered in the development of a trauma-informed workforce.
8. “Accepting the Challenge” summarizes the processes recommended in this manual and offers hope that these efforts can succeed.

A Group Effort

Like virtually everything discussed in the Sections that follow, reading and responding to this manual can and should be a group effort. Suggestions:

- Divide the Action Notes strategically.
- Coordinate efforts among multiple organizations, departments, or initiatives.
- After people have read their sections and begun their Action Notes, discuss lessons learned and next steps.
The Action Notes

Each Section ends with a boxed-in “Action Notes” tool, inviting you and your colleagues and teams to look more closely at some of the considerations discussed in the Section as they apply to your organization, system, or community. Some of the Action Notes are brief worksheets, and others are suggestions for more detailed explorations. Taken together, these tools support a collaborative process for planning the implementation of trauma-informed approaches in your organization, system, or community.

Using a Team Approach

The most influential person in your system or community may be the least likely to have time to read this document—and even less likely to have time to complete the Action Notes—but like virtually everything discussed in the Sections that follow, reading and responding to the manual can and should be a group effort. For example, an organization—or better yet, a whole community or system, multiple organizations, or multiple departments within an organization—might:

- Divide the Action Notes strategically—perhaps by role, interest, or influence—among the central people involved in the planning process
- Coordinate efforts among multiple partner organizations, departments, or initiatives
- Convene after people have read their sections and begun their Action Notes, and discuss what they have learned and what they are willing to do

Ideally, this would take place as part of—or inspire the establishment of—a TIC/ROSC initiative or learning community within a human service organization, a multi-system ROSC transformation process, or an ongoing movement toward trauma-informed approaches within a community. Those who have the time, and those who are willing to carve out the time, can become the resident experts who inform the planning process. Their knowledge must come, not just from books and articles, but also from significant input from staff, volunteers, service participants, family members, and community members.

Who Are “We”?

When the words “we” and “our” are used in this document, they refer, not to the publishing organization or to the behavioral health field alone, but to society as a whole. These words are used deliberately, as a way of emphasizing our collective responsibility, invoking our collective knowledge base, and soliciting our collective efforts.
Section 1: The Role of Leadership

We believe that America is facing a public health crisis of major proportions. The health of our citizens, our economic productivity, the stability of our institutions, and our global leadership are all being undermined by social conditions creating toxic levels of stress, which in turn interact with biological vulnerabilities to affect both individuals and communities.

—Andrea Blanch and David Shern

What if many of the most daunting challenges to human well-being had a common center, and you had the tools to reach into that center and begin to heal, not only human lives, but also the families, communities, and service systems that hold those lives?

What if you found a shield that could protect the people you have served, that could turn away many of the forces that erode the strength you have worked so hard to help them build?

What if these and other tools fit together, worked together, made one another stronger by their mutual presence? But there was only one catch: You had to share them—not just share them, but actively engage others in their use, and keep going even when you hit the hard crust of the way things have always been done.

This is where you are right now, as a leader and as a human being. You may think this manual is about implementing trauma-informed care (TIC) within recovery-oriented systems of care (ROSC), but it is really about you—what you are already doing, what you have the opportunity to do, and what you are willing to do.

Trauma-informed Care

“Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization.”

NCTIC, SAMHSA

Understanding

Progress toward effective responses to toxic stress and trauma has often suffered at the hands of widely held misconceptions, including:

- Treating the word “trauma” as if it were synonymous with posttraumatic stress disorder (PTSD), one of the many conditions that sometimes arise in the wake of trauma
- Thinking of trauma only as something that occurs in an individual in response to an isolated event or a single type of experience

• Taking a narrow view of the types of experiences that contribute to trauma, separate from the continuum of human stress exposure and response

• Underestimating the potential of chronic toxic stress (e.g., economic deprivation, effects of prejudice and discrimination, living with chronic or life-threatening illness) to raise the level and complexity of responses to other types of traumatic experiences

• Assuming that all or most of the people exposed to potentially traumatic stressors will develop PTSD or other serious disorders

• Considering people who do develop these disorders weak or “flawed”

• Thinking of the problem of trauma primarily as a problem of memory—the discomfort associated with the presence or suppression of memories of traumatic experiences—whose symptoms should all disappear if the traumatic memories are faced and resolved

• Thinking of trauma as a purely psychological phenomenon, confined to the mind alone

• Thinking of measures for addressing trauma only in terms of identification and clinical treatment of diagnosed disorders, without considering the range of community resilience, prevention, and early intervention measures that are equally critical

• Confusing trauma-informed approaches with trauma-focused (also called trauma-specific) treatment—therapeutic approaches designed to heal the effects of trauma, in many cases by processing memories of traumatic experiences

• The assumption that an organization or system can implement a trauma-informed approach by holding a “one-shot” training or training series for selected staff

• The assumption that acute-care treatment approaches are sufficient to promote long-term recovery

• The assumption that recovery-oriented and trauma-informed approaches are entirely separate constructs, to be addressed separately and supported with separate human and financial resources

• A belief that recovery-oriented and trauma-informed approaches are the concerns of behavioral health (mental health and substance use disorders) organizations and systems alone, with little or no relationship to the communities they serve or to the many health, human service, educational, and justice systems that surround them

In reality:

• Human experience runs on a continuum that includes mild stress; extreme stress; toxic stress; and the kinds of pain, danger, and helplessness that instill trauma. These conditions can come from many types of experiences in the life of an individual, a family, a community, or a culture, and can trigger a wide variety of synergistic effects. From culture to culture and from one economic level to the next, there are many disparities in the variety and intensity of stress, danger, and deprivation that
individuals, families, and communities face—and in the quality, accessibility, and acceptability of health care and other forms of professional support.

- Toxic stress, chronic deprivation, and trauma can raise people’s vulnerability to a wide range of physical, mental, and behavioral health conditions. Some of these challenges can overwhelm an individual’s ability to learn or maintain basic life skills and functions, including the ability to think clearly, solve problems, manage stress and emotions, and form safe and productive relationships.

- Each human being is born with and later acquires a number of factors that make him or her more vulnerable or resistant to the effects of adversity. Although stressful and threatening experiences can trigger a number of these vulnerabilities, most people who are exposed do not develop PTSD or other disorders. Many people are resistant (no effects or very mild and transient effects) or resilient (relatively mild effects that resolve without intervention). Even those who do develop serious or chronic disorders and disabilities still have a great capacity for healing, significant strengths and abilities, and essential contributions to make to their communities and to society as a whole.

- Individuals and families with identified risks or disorders are not the only appropriate concern of behavioral health systems. Behavioral health brings to public health and prevention efforts a crucial perspective on the many effects of toxic stress and trauma, and essential strategies for promoting community and family resilience, addressing economic and health disparities, improving overall population health, and systematically addressing the many factors that raise the risk of toxic stress and trauma.

- Within the framework of recovery-oriented systems of care, trauma-informed approaches are essential core elements, with implications for—and requiring the involvement of—all levels and facets of organizations, systems, communities, and society as a whole.

- Trauma-informed approaches nurture and protect the core of the human being, and recovery-oriented systems nurture and protect the fruits of wellness and healing, but their roots and branches are intertwined.

- Like ROSC, trauma-informed approaches are meant to protect, not only individuals and families, but also entire organizations, service systems, and communities.

- These approaches help people build or rebuild critical life skills and functions they have lost—or never had a chance to develop—due to overwhelming and often disabling conditions, in many cases related to toxic stress and trauma.

- These approaches foster protection and long-term healing, not just from substance use disorders and mental health challenges, but from many of the chronic physical, social, behavioral, educational, economic, and legal challenges that join forces to snuff out human hope and potential and destroy individuals, families, and communities.

If you are reading this, chances are your position in your organization, system or community has put the well-being of individuals or families in your care. Whether or not that position...
holds you directly responsible for addressing toxic stress and trauma, the nature and complexity of these conditions and their effects has certainly burdened you with their consequences. Although the list of complexities presented in this Section might seem a bit daunting, from a distance it shows:

- A diverse set of challenges, rooted in common human vulnerabilities and triggered by a variety of experiences
- A collection of human strengths, protective factors, interventions, and support resources that can prevent, mitigate, heal, and transform these experiences
- A series of opportunities and choices for organizational, system, and community leaders, and a moral imperative to work together to seize these opportunities and take well planned and decisive action—starting now

**Action Notes for Section 1**

Is there a team in your organization, system, or community that is already studying some of the kinds of issues and possibilities addressed in this manual, and would you be willing to share this with them? If not, is there a team—or combination of teams—that would be an appropriate body to explore the concepts and suggestions presented in the manual?

If you were to design a team—or add to an existing team—to study this manual and pull ideas from it, which individuals, organizations, or departments within your organization, system, or community would you invite into the team?

Who would you like to see in charge of the team, and why?

What would your role be?

At this point, before you read the rest of the document, what do you think your team’s greatest challenges might be?

What do you think your team’s greatest (internal or external) resources might be?
Section 2: Transforming the Vision

The greatest danger for most of us is not that our aim is too high and we miss it, but that it is too low and we reach it.

—Michelangelo

A well directed response requires vision, which requires clear and well directed sight. But in the avalanche of information available on toxic stress and trauma, it can be difficult to stay focused on the center of all the problems and possible solutions. To keep our focus clear, this manual begins by suggesting a center-point for our vision—strength, resilience, and recovery—and reminding us to step back from all the pieces of this puzzle from time to time, focusing instead on the picture that they form.

Focusing on Strength, Resilience, and Recovery

Toxic stress and trauma are widespread, often devastating experiences. Their effects wound the body and the mind, rob families and communities of peace and safety, and far too often prove fatal. There are real victims and, in many cases, real perpetrators. These are medical issues, moral issues, financial issues, social justice issues, and criminal justice issues. When we learn of the many effects of toxic stress and trauma, our natural reactions include shock, sadness, fear, empathy, and anger.

Under the weight of all these realities, we might find it difficult to take strength-based approaches, yet these approaches are essential to recovery—and to our efforts to stem the tide of toxic stress and trauma. Instead of focusing on stopping harmful processes and practices, strength-based approaches harness the power of individuals’ own values, goals, skills, and courage by starting the relationships, opportunities, insights, choices, and behaviors that can lift them over their old patterns and transform their lives forever. Strength-based approaches:

- Affirm the dignity and freedom of all people, no matter how many indignities they have suffered, no matter how many challenges they still face
- Walk with “victims” until they understand that they are survivors, and walk with survivors until they take their place as heroes in their own and others’ lives
- Generate hope by identifying and believing in the values, aspirations, attributes, and skills that each individual, family, community, and culture embodies and cultivates in the healing process
- Make it safe for people to reclaim—and in some cases claim for the first time—the power of choice and the power of true connection
- Make it safe for the story to be told, heard, honored, and eventually transformed

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3 Attributed without citation in Ken Robinson (2009), *The Element*, p. 260, and often attributed to Michelangelo since the late 1990s.
• Protect, nourish, empower, and sustain, not only people who have experienced toxic stress and trauma, but also the friends, family members, neighbors, and service providers who witness their pain and rejoice in their success.

In a field where service plans and service reimbursement are based on diagnoses and symptoms, it may be difficult to expand the focus on strengths beyond the inclusion of a few strength-based questions in the assessment process and staff training in pointing out people’s positive qualities. In a community that has experienced the negative effects of some members’ post-trauma symptoms, it may be hard not to think in terms of “good citizens” and “bad citizens.” In a society where any form of flaw or weakness is stigmatized—often in defense against our own sense of human vulnerability and limitation—it may be difficult to recognize and acknowledge the strength that lives in even the most troubled human being. But we must learn to do all these difficult things, if we want to promote well-being, healing, and recovery.

**Looking at the Whole Picture**

Toxic stress, trauma, and their effects are most often considered and dealt with on an individual basis—person by person, experience by experience, symptom by symptom, and diagnosis by diagnosis. This response may point to effective ways of addressing specific symptoms and diagnoses, but it fails to address the synergy of all these elements and the environments in which they take place. It can also have only limited impact on the forces—including some elements of our communities and our service delivery systems and approaches—that spread and perpetuate toxic stress and trauma.

Only a look at the big picture can bring all the little pictures into focus. And although our society has often thought of toxic stress as a social issue and trauma as a therapeutic one, it is both logical and useful to consider them together. For example:

• All these experiences meet in the human body, mind, and spirit, where they combine to wield powerful influence over our development, our physical and neurological health and balance, the way we process stress and emotions, the way we perceive and treat ourselves and others, and the sense we make of our experiences and our worlds.

• The way we react to a particular stressor is sometimes influenced primarily by that stressor, but often influenced by the shape that a combination of stressors has taken in our lives.

• We are, after all, human beings. The many layers of stories we carry with us cannot be reduced to the categories that assessment forms, funding streams, and clinical protocols...
require. These stories may not dictate the terms of policy, treatment, reimbursement, or recovery support, but they must be honored and must feed the wisdom of all who seek to help. If we know how to listen, each human story becomes a story of strength.

One important implication of all this is that:

- Psychological trauma is the concern, not only of behavioral health and recovery support, but also of policy, prevention, medicine, faith leaders, and the community as a whole.
- Social justice is the concern, not only of policy and community leaders, but also of public health, medicine, prevention, intervention, treatment, and recovery support providers.
- The understanding and prevention of toxic stress and trauma—in this generation and the next—is everyone’s concern.

**Turning Challenges into Opportunities**

Here are a few ways leaders can begin to approach these responsibilities we all share:

- **Use toxic stress and trauma as a lens** through which you can hone your understanding of the many challenges you see in individuals, families, systems, and communities.
- **Use resilience, trauma-informed care, trauma-informed systems, and trauma-informed communities as a lens** through which you can assess potential solutions and guide the development of policies and programs, within and beyond your own system.
- **Incorporate resilience, stress, trauma, and trauma-informed approaches** into your concepts of recovery-oriented systems and the many models that guide your vision.
- **Incorporate a long-term recovery focus** and the integration of recovery support services, rooted in the community, into your concept of trauma-informed approaches.
- **Commit whatever resources you can to implementing strength-based, recovery-oriented, trauma-informed approaches** in all of the processes, personnel, organizations, systems, and communities you influence—and be open to creative ways of leveraging and sharing resources, to reap the greatest benefit in spite of budgetary limitations.
- **Be a vocal and persistent coalition builder and advocate** of integrative, recovery-oriented, multidisciplinary, multi-system, big-picture approaches toward addressing the problem of toxic stress and trauma—and all its causes and effects—on community and societal levels.

And here is the beginning of a vision that these measures might help us approach:

- **Prevention programs** that collaborate with public health entities and with the range of community-based efforts to promote safe, respectful, and supportive communities, schools, faith communities, medical care, youth-serving organizations, human service providers,
and public safety and criminal justice approaches

- **Behavioral health and recovery support providers and systems** that initiate and conduct integrated, multi-system efforts to identify and address health disparities and traumagenic circumstances, and to and intervene in the progression of post-trauma effects

- **Treatment and recovery support systems and providers** that collaborate with schools and medical, child welfare, faith, law enforcement, criminal justice, and social service systems and their providers in the development and implementation of safe, evidence-based screening, brief intervention, and referral efforts in these community-based locations

- **Behavioral health screening processes** that are overwhelmingly strength-based and include safe, respectful, non-stigmatizing, evidence-based questions to identify the presence of trauma and the need for trauma-specific assessment

- **Strength-based, evidence-based assessment and appropriate referral** to individualized trauma-informed treatment and recovery support for all children, youth, and adults (including older adults) who need behavioral health services, and trauma-focused assessment and referral of those identified as possible trauma survivors or living in currently traumagenic circumstances

- **Safe, effective, evidence-based trauma-focused treatment** available to all who need it and can safely engage in it, no matter where or why they entered the treatment, allied human service, or criminal justice system

- **Referrals that follow “warm referral” principles and practices**, starting with an informational call or visit from the referring provider, followed by provider assistance and trained and effective peer support during the referral and transition process

The remaining sections describe a variety of tools for moving toward this vision, tools that are meant to be shared and adapted to the strengths and challenges of each community.

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`Action Notes for Section 2`

How would you describe your vision for strength based, trauma-informed approaches?

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________
Section 3: Resilience, Stress, and Trauma

We have learned, given the numbers of trauma survivors and their often debilitating post-traumatic responses, that this constitutes a public health challenge of the first magnitude.

—Susan Salasin

As we approach the subject of toxic stress and trauma, it is important that we bring with us an enduring vision of resilience, both the major casualty of trauma and the major force behind wellness, healing, and recovery. In some form, resilience lives in even the most painful circumstances. Take, for example, the woman or man whose symptoms make getting out of bed and stepping into the shower an almost insurmountable challenge. Under that pain and pressure, just showing up at your door and asking for help can be a stunning act of strength and courage.

Toxic stress and trauma are injuries that can have strong and often direct impact on human vulnerability to a wide variety of physical, developmental, medical, cognitive, psychiatric, behavioral, social, cultural, spiritual, criminal justice, educational, employment, economic, and human rights challenges—many of them life threatening. A few examples:

- The chronic stress inflicted by poverty or low income, unemployment, poor nutrition, homelessness, racism/prejudice/stigma and discrimination, life in troubled families and communities, environments that reflect a sense of hopelessness, chronic or terminal illness in oneself or a loved one, and a host of other conditions can cause a sort of “weathering” process that can hinder development, wear down human stress and immune systems, and speed up the aging process.
- Acute and chronic exposure to experiences of extreme stress and threat can destabilize human responses to stress and fundamentally change people’s relationship with the memory of traumatic experiences, in some cases leading to conditions such as posttraumatic stress disorder (PTSD).
- The experience of toxic stress and trauma can also raise vulnerability to a variety of other mental health challenges, e.g., anxiety disorders, depressive disorders (including bipolar disorder), personality disorders, conduct disorders, and psychotic disorders.

A Few Clarification Points

*Traumagenic Experiences (sometimes referred to as “Potentially Traumatic Events,” or PTE)*

Events and circumstances with the potential to overwhelm our coping abilities and induce trauma.

*Trauma*

The individual’s subjective experience at the time (with different people traumatized by different types, levels, and sequences of experiences, at different life stages).

*Post-trauma Effects*

Physical, cognitive, psychological, social, and spiritual effects, ranging from mild and/or temporary challenges to increased vulnerability to more serious acute or chronic conditions.

- People who experience severe or chronic neglect and/or abuse in childhood are particularly vulnerable to lifelong challenges in cognition, attachment, trust, self-concept, stress and emotion regulation, and other symptoms of complex or developmental trauma.\(^7\)

- The use of alcohol or drugs to “medicate” the pain left by toxic stress and trauma can raise the risk of substance use disorders, affect many other areas of functioning, and place people in dangerous situations with high potential for retraumatization.\(^8\)

- Toxic stress and trauma often have lasting physical effects on natural brain chemicals, hormones, muscle tension, heart rate, inflammation, and immune functioning, effects that can raise the risk of many acute and chronic illnesses.\(^9\) Behavioral reactions to the pain left by trauma (e.g., alcohol and drug use, overeating, lack of self-care, unprotected sex) can further increase this risk.

- In communities affected by violence, poverty, racism, and discrimination, these forces can combine to wear down individual, family, and community resistance to trauma.

- Trauma in one generation can affect future generations, often through its effects on parents’ behavior, attachment styles, and modeling of responses to stress; family functioning; cultural identity; levels of resources available to the family, the community and/or the culture; and “epigenetic” changes that affect the way our DNA expresses itself.\(^10\)

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The impact of toxic stress- and trauma-related injuries can have far-reaching consequences, regardless of the behaviors, social interactions, life patterns, illnesses, or disabilities they trigger.

There are so many pathways (e.g., genetic, biological, behavioral, social, environmental) through which the effects of toxic stress and trauma are passed on—from experience to person, from person to reaction, from reaction to the next person, and from generation to generation—that these conditions might accurately be characterized as highly contagious and self-perpetuating. Among the strongest factors that can increase individual, family, and community vulnerability are social isolation and lack of access to resources.  

**The Scope of the Problem**

According to Fallot and Harris (2009), “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.” However, the problem extends far beyond traumatic “events.” Many people—particularly people who find their way to public treatment, child welfare, and criminal justice settings—have lived with multiple forms of prolonged or recurring traumagenic circumstances. Growing economic challenges in many communities, and the erosion of funding for services, often foster increases in deprivation, fear, frustration, and hopelessness, sometimes leading to escalating levels of crime and violence and diminishing levels of social support, self-care, and help-seeking. The number, intensity, and chronicity of these circumstances often add layers of complexity to people’s post-trauma effects—and layers of difficulty to the challenge of addressing them.

**The ACE Study**

In the Adverse Childhood Experiences (ACE) Study, Kaiser Permanente and the Centers for Disease Control and Prevention interviewed 17,421 respondents from a general, largely affluent HMO adult (average 57 years) population. They looked at the prevalence of ten types of adverse childhood experiences (ACEs), including various forms of abuse, neglect, and family dysfunction. A respondent’s “ACE score” indicated the total number of types of ACEs he or she had experienced. More than half reported at least one type of ACE, one fourth reported two or more types of ACEs, and one in 16 reported four types of ACEs.

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Studies also indicate that the prevalence of ACEs and their consequences among people served in public health and treatment systems is often much higher. Estimates vary by study, but according to the National Center for Trauma-Informed Care, “The majority of people in human service and justice systems have trauma histories. Many have experienced multiple sources of trauma. Many service providers and first responders have also been impacted by trauma.”

The earlier in life people experience trauma, the more likely they are to experience significant and lasting effects. The ACE study found strong correlation between ACE scores and challenges later in life. Higher ACE scores were associated with dramatically higher rates of:

- Poor self-rated health
- Mental health conditions and their sequelae, e.g., self-defined current depression and self-reported suicide attempts
- Behavioral and behaviorally mediated challenges, e.g., poor job performance, poor occupational health, bone fractures, smoking (particularly early-onset smoking), physical inactivity, severe obesity, alcoholism, intravenous drug use, history of having sex with 50 or more partners, sexually transmitted diseases, unintended pregnancy
- Additional health conditions, e.g., chronic obstructive pulmonary disease and other lung diseases, hepatitis, diabetes, stroke, ischemic heart disease, cancer

Subsequent studies have confirmed many of these findings, and some have found higher rates of adult-life mental health issues (in general), interpersonal and family difficulties, victimization through sexual harassment or assault, and perpetration of rape and other criminal acts.

**Beyond the ACEs: Toxic Stress in The Larger Environment**

Of course, the ACE Study and similar investigations do not even begin to measure the incidence or effects of adversity within the community or the cultural history—or any of the synergistic effects of these elements, with one another and/or with family circumstances, across the lifespan. An early effort in this direction was the Philadelphia Urban ACE Study, undertaken for the Institute for Safe Families. Surveys of 1,784 adults revealed higher prevalence of family-related ACEs than in the original ACE Study, but also found that 40.5% of adults had witnessed violence as children, 34.5% had experienced discrimination based on race or ethnicity and 27.3% had felt unsafe in their neighborhoods or unable to trust their neighbors, with more than 37% reporting four or more adverse childhood experiences.

Studies that map the influence of these environmental stressors on a scale comparable to that of the ACE Study—and voices calling for these studies—are needed desperately, and needed now, regardless of the obstacles. While we advocate and wait for empirical evidence of the impact of this constellation of stressors, we will have to rely on whatever evidence we can collect through

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15 Felitti, V.J. et al., loc. cit.

informal qualitative and quantitative measures, combined with the common sense that tells us what it all means: Many circumstances—often interrelated—are overwhelming our natural resilience and triggering a variety of significant, progressive, and self-perpetuating challenges to human well-being. Grasping the scope of these challenges within our own communities can provide motivation and momentum to harness the strengths, relationships, and resources that can prevent and heal these wounds. The next Section discusses some of these opportunities.

### Action Notes for Section 3 (Part 1)

An important early step is an inventory of strengths in the community you serve—your neighborhood, a municipality, state, or catchment area for an organization or health or human service system. Who might be good people to enlist in gathering and interpreting information about resources? For example, who would be good at researching resources in these areas?

<table>
<thead>
<tr>
<th>Resources in (or for) the Community</th>
<th>People to Gather Information About Them</th>
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</thead>
<tbody>
<tr>
<td><strong>Examples of Resources that Promote Economic and Financial Viability</strong></td>
<td></td>
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<tr>
<td>Employment, job training, financial aid</td>
<td></td>
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<tr>
<td>Support/training for small businesses</td>
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<tr>
<td>Student/employee wellness programs</td>
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<tr>
<td>Tutoring, support for schools/students</td>
<td></td>
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<tr>
<td>Help/support for homeowners/renters</td>
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<tr>
<td><strong>Examples of Resources that Promote Social and Family Wellness and Cohesion</strong></td>
<td></td>
</tr>
<tr>
<td>Cultural and cross-cultural efforts</td>
<td></td>
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<tr>
<td>Community outreach/welcome efforts</td>
<td></td>
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<tr>
<td>Parent support, parenting skills training</td>
<td></td>
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<tr>
<td><strong>Examples of Resources that Promote Physical and Behavioral Health</strong></td>
<td></td>
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<tr>
<td>Prenatal support, nutrition, education</td>
<td></td>
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<tr>
<td>Food, nutrition, and exercise programs</td>
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<tr>
<td>SUD prevention/recovery communities</td>
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<tr>
<td>Recovery coaching/life coaching</td>
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<tr>
<td>Education/support for safer sex</td>
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<tr>
<td>Counseling/support for health coverage</td>
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<tr>
<td>Health literacy/peer support programs</td>
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<tr>
<td>Behavioral health treatment/prevention</td>
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<tr>
<td>Services for people with disabilities</td>
<td></td>
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<tr>
<td>Health education across the life span</td>
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<tr>
<td><strong>Examples of Resources that Reduce Crime and Violence</strong></td>
<td></td>
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<tr>
<td>Violence prevention coalition/programs</td>
<td></td>
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<tr>
<td>Efforts to reduce gang activity/violence</td>
<td></td>
</tr>
<tr>
<td>Crime reduction/victim support</td>
<td></td>
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<tr>
<td>Community/law enforcement programs</td>
<td></td>
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</tbody>
</table>
The next step might be to compile a “ballpark” estimate of the scope of toxic stress and trauma in your community, and its total—and inclusive—human, social, and financial cost to your community, service systems, and the people you serve. Some of the data that will feed this effort will be quantitative data on “health indicators” (measures of population health and well-being), but qualitative information is also important. You can compare it with national data, and use it as a baseline for comparison. One challenge in interpretation may be the fact that any of the indicators in these areas may reflect both cause—circumstances that can lead to toxic stress and trauma—and effect—conditions that are triggered or exacerbated by toxic stress and trauma.

Before you start, who might be good people to enlist in gathering and interpreting this information? For example, who would be good resources on indicators in the following areas?

<table>
<thead>
<tr>
<th>Areas of Social Challenge and Cost</th>
<th>People to Gather and Interpret Information</th>
</tr>
</thead>
</table>

*Examples of Measures of Economic and Financial Viability*

- Unemployment, low income
- Loss of jobs and small businesses
- Missed school/work days due to illness
- Educational challenges, dropout
- Foreclosures, default, homelessness

*Examples of Measures of Social and Family Wellness and Cohesion*

- Evidence of racism/discrimination
- Evidence of family/individual isolation
- Rates of separation and divorce
- Need for/use of child protective services

*Examples of Measures of Physical and Behavioral Health*

- Percentage low birth weight/pre-term
- Rates of malnutrition and obesity by age
- Use of alcohol, tobacco, illicit drugs
- Rates of HIV, STIs, teen pregnancy
- Percentage lacking health coverage
- Use of emergency medical services
- Incidence/cost of mental illness/SUD
- Incidence and cost of chronic illnesses
- Incidence and cost of disabilities
- Average age of mortality

*Examples of Measures of Crime and Violence*

- Reports of violence in the community
- Any measures of gang involvement
- Crime rates in general in the community
- Challenges in community reintegration
- Need for law enforcement responses
Section 4: Trauma-informed Approaches

When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization.

—National Center for Trauma-Informed Care

Like human beings, human service fields have been evolving, from primitive approaches that often wounded more than they healed to more careful, respectful, and effective approaches rooted in an understanding of human strength and vulnerability and a commitment to human dignity. Trauma-informed approaches, including trauma-informed care within human service systems, have both built on this evolutionary process and provided concrete and conceptual tools and guidelines for further progress.

Unlike trauma-focused or trauma-specific interventions, trauma-informed care is not something to add to an organization’s or a system’s menu of services, but a new way of thinking about and providing existing services. Elements of systems that must be trauma informed include:

- Practitioners, the services they provide, and their perceptions of the people they serve
- Policies, protocols, and service environments
- Systems, organizations, and organizational cultures
- Partnerships to foster trauma-informed communities

Although it first took hold in behavioral health, trauma-informed care has begun to influence other human service systems as well, including child welfare, criminal justice, and primary medical care. In some areas, community-wide trauma-informed initiatives have also begun to transform communities’ approaches to civic services, community support structures, and public education. These efforts counter two of the strongest forces locking stress and trauma in place—isolation and lack of resources—by fostering collaboration and resource sharing.

Traditional Human Service Approaches

Most behavioral health providers and organizations have evolved beyond the institutionalization of people with mental health challenges and the “break ‘em down so you can build ‘em back up” approach to substance use disorders, but those old traditions have left their mark on the field and on associated communities of recovery. Many related health,
human service, and criminal justice systems may have even more to learn. Designed more for control and containment than for healing, traditional human service and criminal justice paradigms can be ineffective for—even harmful to—people with histories of trauma. A quick synthesis of some of the literature on trauma-informed care reveals a number of potentially counterproductive elements in the old paradigm, e.g.:

- A hierarchical structure and reliance on rule, control, and consequences, with efforts to control and manage participants (e.g., seclusion, restraint) often resulting in destabilization, retraumatization, and triggering of traumatic memories
- Attributing to the individual too much responsibility (e.g., blaming the victim) or too little responsibility (e.g., considering people helpless and “doing for them”)
- An overall focus on problems and deficits, with strengths considered as afterthoughts, marginalized within assessment processes, and neglected in planning processes
- Interpretation of behaviors as symptoms, even if they may have started out as necessary, adaptive ways of surviving traumatic circumstances—and might still provide protection
- Over-medication and inappropriate medication for conditions and crises that would be better addressed through skill building and more effective responses by staff members
- Interpretation of challenges as individual problems, rather than seeing them in the context of relationships, systems, communities, cultures, and history—and failure to consider this larger environment’s potential to instill resilience, healing, and recovery
- Separate service systems, each with its own view of the individual and approaches that may run counter to those of other systems, resulting in, at best a sense of confusion or cognitive dissonance, and at worst the undermining of one system’s efforts by another
- Emphasis on individual diagnoses, considered and treated separately from one another
- Failure to connect with the broader community, or to call on the strengths that it holds

Current knowledge of trauma-informed approaches comes from the bitter experience of many trauma survivors, and from the creativity and courage of service participants, families, staff, and administrators who have forged safer, more respectful, and more effective approaches. The momentum toward this model is increasing as the research community gathers more and more evidence of the reach and consequences of trauma and the benefits of trauma-informed care.

**Essential Elements of Trauma-informed Approaches**

Anyone’s life might be affected by toxic stress and/or trauma, so trauma-informed care must be a universal effort, reaching all staff and service participants. TIC is rooted in an understanding of the three stages of trauma recovery documented by Judith Herman, MD in her foundational book, *Trauma and Recovery.* In Stage 1, “Safety and Stabilization,” one of the survivor’s primary responsibilities is to learn to identify and manage post-trauma effects and the triggers that might activate them, and—wherever possible—to avoid dangerous and potentially destabilizing circumstances, including treatment processes that can trigger post-trauma symptoms (e.g., through harsh confrontation or shaming, or by invoking strong emotions or memories). Trauma-informed care is essential at each stage, but its first critical task is to protect people who are in Stage 1, and to teach them skills that will help them protect themselves.

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When people are stable enough to progress to Stage 2, “Remembrance and Mourning,” safe trauma-focused services that address traumatic memories may become important facets of the healing process. And in Stage 3, “Reconnection,” ongoing recovery support also takes on special importance, as people reconnect with others and with their own senses of meaning and purpose.

Many implementation and practice models have been developed to capture and communicate the essential elements of trauma-informed care—and, with some variation, they emphasize many of the same characteristics.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has made significant contributions to our understanding of what will help people with histories of toxic stress and trauma stay safe and recover from the many effects of these experiences. Two seminal sources are the 10 Guiding Principles listed in SAMHSA’s working definition of trauma-informed care20 and the discussion of safety—including strategies for promoting safety and an exploration of the aspects of treatment in which safety is critically important—in SAMHSA’s Treatment Improvement Protocol (TIP) 57, Trauma-Informed Care in Behavioral Health Services.21 A synthesis of those elements tells us the following:

Establishing and protecting safety is very much the heart of trauma-informed approaches. A conscious, intentional TIC system-change process might lead to a number of measures. Safety in the environment requires that organizations and practitioners assess and address all potentially triggering objects, spaces, processes, and interactions. Safety from recurrence of trauma requires:

- Relationships among staff, clients, and families that earn and establish trust through consistent respect and partnership (e.g., engagement, transparency, inclusiveness, collaboration, mutuality, empowerment, cultural competence, and client/family choice)
- Effective monitoring and protection of stability at all levels, and pacing of services and approaches so that they remain consistently appropriate for current levels of stability

Safety from trauma symptoms requires psychoeducation and training in managing traumatic memories, trauma-related triggers, grief, sleep disturbances, and the range of reactions to personal and historical trauma. A strength- and resilience-based approach normalizes symptoms, teaches balance, builds resilience, and taps into healing cultural connections. And the role of service participants and people in recovery is elevated in recognition of the absolute importance and healing potential of reciprocal, trauma-informed peer support.

Now it is time to step back a bit from the focus on trauma-informed approaches and look at the larger context. Along with its leadership in trauma-informed care, SAMHSA has also spearheaded a nationwide movement toward recovery-oriented systems of care (ROSC) and explored a number of conceptual models and their implications for behavioral health and recovery support services. The next chapter looks at the way trauma-informed care fits into a ROSC framework, and at the relationships among these constructs and a few of the many related conceptual models.

**Action Notes for Section 4**

On an organizational, system, or community level, readiness for trauma-informed approaches often depends on a number of considerations. Off the top of your head, write a few words about your organization’s, system’s, or community’s progress in moving toward trauma-informed approaches in each of these areas:

Mission and vision: _____________________________________________________________

Collaboration with other systems: _________________________________________________

History of TIC Initiatives: _________________________________________________________

Policies: ___________________________________________________________________

Procedures: __________________________________________________________________

Safety measures: __________________________________________________________________

Atmosphere: ___________________________________________________________________

Composition of leadership: _______________________________________________________

Management/supervision styles: _________________________________________________

Roles for service recipients: ____________________________________________________

Staff understanding of TIC: _______________________________________________________

Service provision styles: __________________________________________________________________

Ways of responding to crises: ____________________________________________________

____________________________________________________________________________________
Section 5: Recovery-oriented, Trauma-informed Approaches

My paradigms are tired of shifting! My paradigms need stability!

—Anonymous

Like the Executive Director quoted above, many leaders cannot help perceiving each new conceptual model as one more “flavor of the month” and each new page of guidelines as yet another set of demands competing for scarce resources. Some systems and organizations find themselves flipping from approach to approach according to the prevailing winds. Trauma-informed approaches, which play such an essential role in so many aspects of human services, are among the many conceptual models that tend to be marginalized at times—or assumed to be covered in other models—whenever they are not the central focus of a crisis, a mandate, or a funding opportunity.

Fortunately, there is one framework that can hold all the major entities responsible for health and well-being—service systems, service providers, communities, families, and individuals—and promote the many approaches necessary for safe, respectful, effective provision of services and support that are:

- Integrated and holistic
- Strength based and skill based
- Recovery oriented
- Trauma informed and trauma responsive
- Culturally competent and culturally humble
- Person and family centered
- Rooted in the community

This framework, called Recovery-oriented Systems of Care (ROSC), has been the subject of growing national attention in the past decade. Unfortunately, a narrow focus on a few aspects of ROSC will not ensure that all critical aspects will be addressed. So ROSC—in its entirety and its complexity—is the brief but central focus of this Section, with special attention to the role of trauma-informed approaches within that framework, and to the ways in which these intersect with three other aspects of a true ROSC that are particularly relevant to the understanding and pursuit of trauma-informed approaches: a population health perspective, integrated medical and behavioral health services, and cultural competence/cultural humility in all approaches.

Recovery-oriented Systems of Care

In recent years, concepts and practices of recovery-oriented systems of care (ROSC) have gained steady ascendance in the behavioral health field, because they make human and financial sense: ROSC implementation can improve immediate and long-term outcomes and save money.

22 From an elevator conversation with the Executive Director of a statewide human service organization.
Many readers of this document will be familiar with the ROSC framework, which is working to address the complex and chronic nature of substance use disorders and mental health challenges by:

- Replacing traditional crisis-oriented, deficit-focused, and professionally directed models of care, instead following a vision directed by people in recovery
- Emphasizing the hope and reality of long-term recovery and recognizing that there are many pathways to recovery
- Encompassing a range of trauma-informed, strength-based, person- and family-centered, community-oriented considerations and approaches
- Taking an integrated, whole-system, multi-system approach and using recovery as the central guiding principle in service planning and implementation
- Not replacing treatment, but integrating recovery principles and peer-based recovery support services into all aspects of pre-treatment, treatment, and post-treatment services
- Preparing and compensating providers of ongoing peer-based recovery support, often rooted in the community, and integrating their efforts with those of treatment providers
- Empowering service participants, people in recovery, and families to wield true influence on policy, assessment, service planning and delivery, and evaluation, and to occupy leadership roles within the system and the larger community

Of course, the nature of a recovery-oriented system of care rests on the nature of recovery itself. In 2005 and 2006, the Substance Abuse and Mental Health Services Administration convened two large and diverse stakeholder groups—including significant representation by people in recovery—and invited them to craft definitions and principles related to recovery from mental health conditions and substance use disorders, and elements of recovery-oriented systems of care. A synthesis of both groups’ characterization of recovery would include these statements:

Recovery is a reality. It emerges from hope and gratitude and exists on a continuum of improved hope and wellness. Recovery is self-directed, empowering, individualized, person centered, holistic, non-linear, and strength based. It involves a personal recognition of the need for change and transformation and a process of healing and self-definition. Essential elements of recovery include peer and ally support, respect, and responsibility. Recovery has cultural dimensions. It involves addressing discrimination,

transcending shame and stigma, and (re)joining and (re)building a life in the community.  

The recovery paradigm has evolved in dynamic ways in the 21st century, as reflected in White, 2008:

"Calls for a “chronic care” model of addiction treatment grew out of and in turn intensified a shift in the organizing paradigm of the addictions field from one of pathology (focus on the etiology and patterns of AOD problems) and intervention (focus on professional-directed addiction treatment) to a focus on the lived solution (focus on long-term addiction recovery). This emerging recovery paradigm is evident in calls to reconnect addiction treatment to the larger and more enduring process of addiction recovery, and to growing scientific interest in AA, other Twelve Step programs, and secular and religious alternatives to Twelve Step programs. At the treatment system level, it is also evident in:

- the emergence of recovery as an organizing fulcrum for national, state, and urban addiction treatment policy;
- efforts to define recovery;
- calls for a fully developed recovery research agenda;
- federal programs promoting peer-based recovery support services such as CSAT’s Access to Recovery and Recovery Community Services Program; and
- calls to use recovery as an integrating bridge for the addiction and mental health fields."

If recovery is the essence of ROSC, the system is the form it takes. White (2008) characterizes this system as follows:

"The phrase recovery-oriented systems of care...refers to the complete network of indigenous and professional services and relationships that can support the long-term recovery of individuals and families and the creation of values and policies in the larger cultural and policy environment that are supportive of these recovery processes. The “system” in this phrase is not a federal, state, or local agency, but a macro-level organization of the larger cultural and community environment in which long-term recovery is nested."

**Toward Recovery-oriented, Trauma-informed Systems and Communities**

Trauma-informed care (TIC) is an integral and essential element of a recovery-oriented system of care (ROSC). And yet many organizations and systems have undertaken their TIC initiatives separate from their ROSC transformation processes, with little or no communication, coordination, or collaboration between them—or they have addressed one and not the other. This has been the case too often, even though:

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27 Ibid.
• Effects of toxic stress and trauma are major contributors to the complexity and intransigence of many disorders and symptoms, circumstances that often necessitate significant recovery support. A thorough grounding of treatment and recovery support leaders, staff, and volunteers in TIC can deepen and enhance their understanding of challenges to recovery and strengthen their responses to those challenges.

• Essential components of TIC (including many of its guiding principles) are also essential components of ROSC. Integrating TIC within a ROSC framework makes it possible to share resources, eliminate duplication of efforts, forge more effective ways of implementing both, and assume leadership roles in national TIC and ROSC efforts.

• Recovery support services conducted without sufficient grounding in TIC can be ineffective, even harmful. Old traditions within some treatment and recovery cultures embrace or tolerate harsh confrontation and/or shaming—practices that can destabilize vulnerable service participants—as ways of motivating people to change their behaviors.

• Services that are called trauma-informed care but are based on an acute-care model, or conducted without the benefit of long-term peer support, have limited value in the treatment of complex and chronic conditions. Thus far the realms of trauma treatment/research and TIC still seem to be experiencing some challenges in integrating peer support.

ROSC is an essential framework in which trauma-informed care is more likely to take place, and a medium for integrating TIC within multiple systems and in the community as a whole.

Related Models and Approaches

Many related conceptual models, constructs, and approaches are also essential components of recovery-oriented systems of care, and they require a ROSC framework and a trauma-informed approach for their viability and success. Three of these areas of thought and practice are described briefly below, because of their particular importance to recovery-oriented systems of care and trauma-informed approaches, and because of the importance of ROSC and TIC in their successful implementation. They are:

• A population health (traditionally referred to as public health) perspective
• Integrated medical and behavioral health services
• Cultural competence and cultural humility

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28 For example, the theme of the 2013 Annual Meeting of the International Society for Traumatic Stress Studies was "Resilience After Trauma: From Surviving to Thriving." Out of hundreds of symposia, there were only three presentations on peer-based services. Two of these were 12-minute talks within four-presentation symposia, and the third was the case study of a program in Rwanda.
A Population Health Perspective

In systems whose functions and funding structures revolve around the identification and treatment of individuals’ problems, it can be difficult not to see all of these systems’ responsibilities through that lens. It can be easy to lose sight of the larger backdrop of collective health and well-being. To address these challenges, a population health perspective:

- Takes into account the health of an entire group (e.g., the population of a community) and seeks to improve the health of the entire group
- Identifies health inequities or disparities among population groups, including those related to social determinants of health—social, environmental, cultural, and physical factors that can have a measurable impact on health
- Leads naturally to “universal” approaches meant to prevent and contain illness by fostering community resilience and eliminating conditions that raise the level of risk
- Addresses challenges along the whole continuum, from universal approaches to the clinical treatment of diagnosed disorders and support for ongoing recovery, placing many services and supports in natural settings within the community

With their chronic-care emphasis on community-grounded services and support for long-term recovery, recovery-oriented systems of care take a population health perspective. This perspective is also critical to effective approaches toward toxic stress and trauma.

As discussed in earlier Sections, environmental factors (e.g., physical, socioeconomic, policy) often interact with genetic/epigenetic, psychological, social, and spiritual factors to lock toxic stress and trauma in place—and to transmit their effects widely—within a family, a community, or a culture. Clearly an understanding of trauma and recovery is incomplete without consideration of the full range of environmental factors, and services for trauma and its sequelae may have only temporary positive effects—in this generation, and certainly in the next—if these environmental factors continue to promote toxic and traumagenic experiences. The solution must include measures that will strengthen families, communities, and cultures.

TIC and recovery considerations also play essential roles in population health and prevention programs—particularly in prevention concerns for children (e.g., fostering long-term recovery among parents, for the health, development, and safety of their children), but also in the full spectrum of population health concerns. And prevention efforts—particularly those that might disturb the denial and lack of trust that many children need to maintain for their own protection in troubled families—should be conducted in safe and trauma-informed ways. Flaherty (2013) points out many characteristics that prevention and recovery have in common—many of them also shared by trauma-informed approaches. According to Flaherty, prevention and recovery both:

- Improve the quality of life in communities, neighborhoods, and families
- Require consistent action from multiple stakeholders, particularly people in recovery
- Bring power to the community and its families and members
- Build resiliency and sustain recovery over time
- Create a comprehensive plan in which everyone can have a stake
- Hold community institutions responsible for reflecting best practices and community values
- Access community “subsystems” that can support attaining and sustaining recovery

• Promote individual, family, and community health
• Reduce mental health and substance use disorders
• Build resilience, wellness, and recovery
• Focus on reducing individual and community risk factors
• Are grounded in evidence-based research and real-world experience, informed by qualitative and quantitative adoption and outcome data
• Provide outcomes at the community level, rather than just at the program level
• Simultaneously consider a wide-ranging set of potential challenges
• Use all risk and protective factors learned from individual interventions to alter the social, cultural, economic, and physical environment of a community
• Build individual and community recovery capital

The concept of “recovery capital” deserves special attention. A staple of ROSC, that term refers to the characteristics and resources in the individual, the family, social relationships, and the community that make people strong and healthy and promote the resolution of alcohol and other drug challenges. Although there are differences between the concepts of resilience and recovery capital, there are even more similarities. Together they form a powerful connection among population health, prevention, recovery, ROSC, and trauma-informed approaches.

**Integrated Medical and Behavioral Health Services**

Defined as “the systematic coordination of general and behavioral healthcare,” healthcare integration is a major topic of thought, discussion, and effort within behavioral health and primary care. Although, at the time of this writing, trauma-informed care and recovery-oriented systems and services are not yet featured prominently in these discussions, it is only a matter of time until necessity places them center stage, for a number of reasons. For example:

• Effects of toxic stress and trauma are major contributors to the existence and complexity of many chronic physical and behavioral health conditions, as evidenced by higher levels of trauma history among people with these conditions. Medical teams often miss opportunities to ask the questions that might help them intervened early in the process.

• Symptoms of, and treatment for, many behavioral health conditions and post-trauma effects can raise vulnerability to many physical illnesses. For example, either the use of most psychotropic medications or the presence of conditions that are common among trauma survivors (e.g., eating disorders, high levels of the stress hormone cortisol) can increase food consumption, blood sugar levels, and weight gain, raising the risk of diabetes, cardiovascular disease, and gastrointestinal problems. And smoking, use of street drugs, and overuse of alcohol or prescription medications—also more common among trauma survivors—all raise a variety of serious health risks.

• Primary medical care is often driven by a sense of urgency—little time to build trusting relationships—and many tests and procedures are painful and invasive. This can raise the risk of triggering traumatic memories and emotions, de-stabilizing behavioral health.

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and trauma recovery and jeopardizing patients’ ability to cooperate with medical staff. Few fields need a strong focus on trauma-informed care more than the medical field.

- Like treatment of post-trauma effects and behavioral health conditions, treatment of chronic physical illness is often followed by neglect of medical regimens and return to any behavioral excesses that may have contributed to these illnesses. Many patients are also bewildered by medical terms and instructions, so they “get lost” in referral and follow-up processes. The long-term perspective and integrated peer support services that have become staples of ROSC are desperately needed within primary care systems. Waller (in White, 2014) notes that ROSC has helped illuminate the value of integrated care, and suggests some significant opportunities for success, through creative use of auxiliary staff to provide counseling and case management to primary care patients.

Many experts caution that behavioral health still has much work to do to integrate mental health and SUD systems. But in the evolution of healthcare integration, trauma-informed approaches and recovery-oriented systems of care can both play vital roles: An understanding of trauma and its sequelae makes it clear that physical and psychological health are highly interdependent, and ROSC provides a framework in which healthcare integration can thrive.

**Cultural Competence and Cultural Humility**

It is often impossible to speak accurately of the causes, experience, and effects of trauma without considering the many roles of culture, ethnicity, cultural history, and cultural beliefs. Distant or recent, history holds far too many examples of mass trauma inflicted on one culture or sub-culture by another, and there are many physical, social, psychological, and genetic means by which trauma spreads from generation to generation.

Culture also has powerful influences on the way one interprets, describes, and even experiences traumatic events and any symptoms that may follow. In terms of ethnic background, what people of one culture might generally experience as an emotional or psychological disturbance, someone from another culture might experience as—for example—a physical or spiritual illness, or a pain in the stomach or the heart. Other facets of culture such as age, gender, or immersion in a violent culture can also affect the impact of trauma. For example:

- Children often react with physical symptoms. This is particularly common in younger children who have no words for the emotional effects of trauma.
- Many older adults’ reactions—mediated by their more vulnerable stress systems—include profound confusion and disorientation.
- In some cases gender role expectations may influence the way people interpret natural reactions to extreme stress (e.g., whether they interpret a rush of adrenaline as anger, fear, or guilt), and physical differences between men and women (e.g., hormone levels, availability of key stress chemicals) can affect both immediate and longer-term effects.
- In cultures or sub-cultures in which the experience of toxic stress and trauma is an everyday expectation (e.g., people in war zones, prisons or jails, gangs, or impoverished and/or violence-ridden neighborhoods), the effects of stress and trauma may be woven into the culture, embedded deep in people’s actions, attitudes, and reaction patterns.

Like other forms of respect, respect for culture is a critical component of recovery-oriented systems of care, and of effective responses to people who have experienced toxic stress and trauma, and to people with behavioral health conditions in general. The use of culturally inappropriate approaches and the misinterpretation of culturally mediated characteristics as pathology have wounded far too many vulnerable people. Cultural competence and respect for the uniqueness of each human being are essential, as is a sense of cultural humility—a constant awareness of the limits of our own knowledge and understanding of the many cultures that have contributed to the individual, and a sincere will to show respect in all we say and do.

Conceptual and implementation models of cultural competence share much with models of trauma-informed and recovery-oriented services, providers, organizations, systems, and communities—and indeed have contributed much to the development of these models. Many of the underlying values, principles, and guidelines are the same. For example, one of the principal elements that proponents of culturally competent services have consistently advocated—empowerment of individuals, families, cultures, and communities—is both an essential requirement and a natural result of trauma-informed and recovery-oriented organizations, services, systems, and communities.

The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards) call for “effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.”

SAMHSA’s guidelines for trauma-informed care exceed those standards, specifying that “The organization addresses cultural, historical, and gender issues; the organization actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, geography, etc.), offers gender responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.”

If the prospect of change in many of these areas sounds daunting, never forget that there are many tools, many experts, many implementation models that can guide and support providers, organizations, systems, and communities in their efforts to become trauma informed—and in the change process itself. The next Section takes a brief look at some of these resources.

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Section 6: Implementing Trauma-informed Approaches

There are a hundred stages of change, the first 96 being precontemplation.

—Stuart Duckworth

As a broad conceptual model, trauma-informed care resonates deeply with individuals’ and organizations’ experiences and inspires commitment and creativity. But large-scale change processes require concrete, step-by-step approaches, taken with care and respect for the existing organizational culture, the values that drive it, and the people who depend on it. This Section:

- Provides TIC implementation suggestions from SAMHSA’s TIP 57 and other sources
- Presents lessons learned in ROSC implementation
- Describes a few of the better-known national TIC implementation models
- Offers a few ideas for fostering trauma-informed communities
- Introduces the concept of Technology Transfer, a model for diffusion and implementation
- Presents a few thoughts on effective, human-centered implementation of new models and practices.

Navigating the Implementation Process

In TIP 57, Trauma-Informed Care in Behavioral Health Services, SAMHSA has identified ten stages in which organizations become trauma informed, along with a list of practical ideas for organizations that wish to implement trauma-informed approaches. These two resources are combined below:

1. **Commit to creating a trauma-informed agency.**
   a. Show organizational and administrative commitment to TIC.
2. **Create an initial infrastructure to initiate, support, and guide changes.**
   a. Assign a key staff member to facilitate change.
   b. Create a trauma-informed oversight committee.
3. **Involve key stakeholders, including consumers who have histories of trauma.**
   a. Create a peer-support environment.
4. **Assess whether and to what extent the organization’s current policies, procedures, and operations either support TIC or interfere with the development of a trauma-informed approach.**
   a. Review and update vision, mission, and value statements.
   b. Conduct an organizational self-assessment of trauma-informed services.
5. **Develop an organizational plan to implement and support the delivery of TIC within the agency.**
   a. Use trauma-informed principles in strategic planning.

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38 This quote is attributed to Stuart Duckworth. The 2009 document in which it is supposed to have appeared remains elusive, but the quote is too good not to include.
39 Substance Abuse and Mental Health Services Administration (2014), loc. cit.
b. Develop an implementation plan.
c. Develop policies and procedures to ensure trauma-informed practices and to prevent retraumatization.
d. Develop a disaster plan.

6. Create collaborations between providers and consumers and among service providers and various community agencies.
   a. Develop trauma-informed collaborations.

7. Put the organizational plan into action.
   a. Incorporate universal routine screenings.
   b. Apply culturally responsive principles.
   c. Use science-based knowledge.

8. Reassess the implementation of the plan and its ability to meet the needs of consumers and to provide consistent TIC on an ongoing basis.
   a. Obtain ongoing feedback and evaluations

9. Implement quality improvement measures as needs and problem areas are identified.
   a. Change the environment to increase safety

10. Institute practices that support sustainability, such as ongoing training, clinical supervision, consumer participation and feedback, and resource allocation.

As essential as organization-level TIC efforts may be, their reach is limited without trauma-informed support at the state and federal levels. The National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center (NTAC) for State Mental Health Planning identified 12 priorities for trauma-informed behavioral health systems (here reproduced verbatim from the 2007 version adapted from the 2003 NASMHPD/NTAC report). These priorities include:

1. Trauma function and focus in state mental health department
2. State trauma policy or position paper
3. Workforce recruitment, hiring, and retention
4. Workforce orientation, training, support, job competencies, and standards re: trauma
5. Consumer/trauma survivor/recovering person involvement/trauma-informed rights
6. Financing criteria and mechanisms to pay for development and implementation
7. Clinical practice guidelines for working with children/adults with trauma histories
8. Policies, procedures, rules, regulations, and standards to support access to trauma treatment, develop trauma-informed service systems, and avoid retraumatization.
9. Needs assessment, evaluation, and research to explore prevalence and impact; assess trauma survivor satisfaction, service use, and needs; and monitor and adjust services
10. Universal trauma screening and assessment
11. Trauma-informed services and service systems
12. Trauma-specific services, including evidence-based and promising models

In many ways, a recounting of all these general considerations is simply one view of the tip of a very large iceberg—and even the tip covers a great deal of territory. It is no wonder many leaders at levels are overwhelmed as they prepare to take on this challenge. Achara (in White, 2011a) offers lessons learned in helping craft Connecticut’s and Philadelphia’s ROSC

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Transformation processes and included among the methods taught in her ROSC Transformation Leadership Initiative. These include recommending that leaders break the process down into three critical stages:

- **Conceptual alignment**, crafting a shared vision based on a core set of values and principles and instilling a sense of urgency
- **Practice alignment**, bringing specific practices in line with that vision
- **Contextual alignment**, looking at implications for policy, fiscal, and regulatory processes, and for collaboration with the broader community

The leader of Philadelphia’s ROSC transformation, Arthur C. Evans, PhD (in White, 2011b), stresses the critical role of empowering leadership in this process: “Transformational change requires that leaders share their expertise, motivate and empower others to be innovative and become change agents within their realm of influence.” Achara notes the importance of courageous leadership: “In the process of helping stakeholders navigate a complex change process, there will inevitably be bumps along the way. The nature of those bumps may be different for each community, but they will always surface. Successful leaders expect the challenges and are not deterred by them. They are willing to take risks, they are persistent, and they are comfortable with the ambiguity inherent in a process-oriented approach.”

It is not only the activities undertaken, or the order in which they occur, that can spell success or failure for implementation efforts, but also key elements of the ways in which these challenges are met. Achara recounts a number of important considerations for system leaders that have emerged out of the ROSC transformation experience (excerpted below). For example:

- **It is critically important for system leaders to connect the dots, to explain how [this initiative] helps to connect all of the other initiatives underway in the system** (p. 9)
- **To address staff anxiety about change, role clarity, etc.: involve staff in the process from the beginning. Make it comfortable for stakeholders to express their concerns, fears, confusion, etc.** (p. 11)
- **Take a strategic, incremental approach to aligning the administrative context. Identify the types of changes in the service system that you would like to see. Prioritize those changes. Then for each of those priorities ask stakeholders what is getting in the way, or what might get in the way of integrating this particular approach, service, or support.** (p. 12)

**Three Trauma-informed Care Implementation Models**

Most larger systems—and a growing number of organizations—that have embarked on a large-scale TIC implementation process have designated full-time trauma-informed care coordinators, and many have adopted TIC implementation models to help them navigate these waters. Three of the better-known models are introduced briefly in the next few pages.

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Risking Connection®, a model for understanding and responding to the needs of people who have been wounded in interpersonal relationships, was developed in 1999 out of a partnership between the Sidran Institute (www.sidran.org) and the Trauma Research, Education and Training Institute (TREATI), under a commission from the state mental health authorities of Maine and New York.

As described at www.sidran.org, “Risking Connection® teaches a relational framework and skills for working with survivors of traumatic experiences. The focus includes relationship as healing and self-care for service providers.” A few points about this model:

- Risking Connection® is based on a clinical theory called Constructivist Self Development Theory (CSDT, developed by Lisa McCann, PhD and Laurie Anne Pearlman, PhD), which looks at individuals’ responses to trauma as meaningful adaptations to their experience.
- This model identifies four primary components of the therapeutic relationship: Respect, Information, Connection, and Hope (RICH).
- The 20-hour training curriculum based on Risking Connection® emphasizes the role of therapeutic relationship, empowerment of service participants and providers, collaboration, psychoeducation, understanding symptoms as adaptation, and meaning making.
- The model also addresses the effects of this work on service providers.

The Sanctuary Model®

Another model that is receiving growing recognition is The Sanctuary Model®, developed by Sandra Bloom, MD, Joseph Foderaro, LCSW, Ruth Ann Ryan, MSN, CS, Brian Farragher, LCSW, MBA, Sarah Yanosky, LCSW and Linda Harrison, MEd, LPC. According to Bloom and colleagues, the model is informed by “the psychobiology of trauma, the active creation of nonviolent environments, principles of social learning, and an understanding of the ways in which complex adaptive systems grow, change, and alter their course.”45

The Sanctuary Model® (www.sanctuaryweb.com) provides a framework for understanding the universal impact of toxic stress and trauma and engaging members of an organization, a system, or a community, including ways of keeping people active and interested and tools for working through conflicts.

One central theme of The Sanctuary Model® is that the process of change and healing is essentially the same whether it is taking place in someone receiving services, the service provider, the organization, the family, or the community. The Sanctuary Model® begins the healing process at the center, in this case, the service provider. Healthy individuals, organizations, and systems are far more likely to heal—and far less likely to wound—and people who have benefitted from a process are better prepared to bring that process to others.

This model relies on four key domains of healing, embodied in the acronym S.E.L.F.: Safety (in self, relationships, environment), Emotions (identifying/modulating emotions), Loss (feeling grief and recognizing that change includes loss), and Future (new roles, ways of relating, identity as a “survivor”). The model is passed on through the S.E.L.F. Curriculum and the group training program by the same name. Its guiding principles are the Seven Sanctuary Commitments, to be embraced at all levels of the organization:

- Commitment to nonviolence
- Emotional intelligence
- Social learning
- Open communication
- Democracy
- Social responsibility
- Growth and change

Creating Cultures of Trauma Informed Care

Maxine Harris, PhD and Roger D. Fallot, PhD of Community Connections (www.communityconnectionsdc.org) have written extensively of cultures of trauma-informed care and address the implementation of trauma-informed care as a process of culture change. One of the central tools of this model is a Self-Assessment and Planning Protocol, addressing service-level and administrative or system-level changes, divided into six domains, with major questions to consider in each domain—and many concrete sub-questions suggested by each major question. In Part A, “Services-level Changes,” here are the major questions for the first three domains:

- In Domain 1, Program Procedures and Settings, organizations ask: “To what extent are program activities and settings consistent with five guiding principles of trauma-informed practice: safety, trustworthiness, choice, collaboration, and empowerment?”
- In Domain 2, Safety—Ensuring Physical and Emotional Safety, organizations ask: “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?”
- In Domain 3, Trauma Screening, Assessment, Service Planning, and Trauma-Specific Services, organizations ask: “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 trauma-specific services?”

In Part B, “Systems-Level/Administrative Changes,” questions for three more domains:

- In Domain 4, Administrative Support for Program-Wide Trauma-Informed Services, organizations ask: “To what extent do program or agency administrators support the integration of knowledge about violence and abuse into all program practices?”
- In Domain 5, Staff Trauma Training and Education, organizations ask: “To what extent have all staff members received appropriate training in trauma and its implications for their work?”
- In Domain 6, Human Resources Practices, organizations ask: “To what extent are trauma-related concerns part of the hiring and performance review process?”

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Fostering Trauma-informed Communities

As overwhelmed as most communities are by the social and economic challenges they need to address, it may be hard to imagine how they might rally around the idea of a trauma-informed approach, something that sounds at first like a luxury. But the realization that toxic stress and trauma are both causes and consequences of many of the challenges they face has inspired some communities—often at the instigation of one persistent thought leader—to explore how an inclusive, universal trauma-informed approach might make a number of solutions fall into place. Three examples:

• In the Florida city of Tarpon Springs, virtually every group and civic organization in the city is involved in the community-wide Peace4Tarpon initiative.47

• In Camden, New Jersey, the “Healing 10” initiative is working to have a multi-disciplinary coalition of ten agencies certified in The Sanctuary Model, hoping to reach up to half of the city’s youth each year with integrated, trauma-informed approaches.48

• The Canadian village of Alkali Lake is home to a Shuswap band of Original People living with the intergenerational legacy of genocide, land seizure, and forcible removal of their children to abusive boarding schools. By 1972, an estimated 93 percent of Alkali Lake’s teen and adult population drank “heavily,” and rates of unemployment, hunger, domestic violence, child abuse and neglect, and suicide had reached epidemic proportions. Due to a community-wide sobriety movement that began slowly in the early 1970s, sobriety became the rule by the mid-1980s, and it remains so today.49

Many such successful movements begin with and continue to emphasize positive central themes, focusing on resilience and recovery, rather than on problems and trauma. A movement organized around building community strength will attract, energize, and hold people who might be frightened off by a meeting on “trauma-informed communities” or might soon be discouraged by a process that emphasizes the negative. If the topic is resilience, people will still bring up the subject of trauma, but they will address it within an overall framework of hope.

A community might adapt TIC implementation models and tools to help guide its journey toward wellness, and some models are designed to build community resilience. For example:

• In the Community Resiliency Model (http://traumaresourceinstitute.com/community-resiliency-model-crm/), community members are trained to use skills for stabilizing and re-balancing their bodies’ stress systems, and to teach their neighbors to do the same.

• Psychological First Aid (http://www.nctsn.org/content/psychological-first-aid) trains community members to form response teams and provide practical help and support after disasters and terrorism. Some communities (e.g., Philadelphia) are also adapting this approach to address the effects of ongoing community violence.

• In Mental Health First Aid (http://www.mentalhealthfirstaid.org/cs/), community members learn to normalize and respond to people who are in emotional crisis or developing mental health challenges, and to refer them to appropriate sources of help.


One new source of information on a variety of trauma-informed/resilient communities is a web site called the “Community Resilience Cookbook,” http://communityresiliencecookbook.org. The site is a project of ACEs Connection, www.acesconnection.com, a popular web-based network dedicated to understanding and addressing adverse childhood experiences.

Trauma-informed Communities: Goals and Action Steps

Guidance from the National Collaborative on Adversity and Resilience

At a 2013 retreat, the National Collaborative on Adversity and Resilience identified six strategic goals and five action steps for creating trauma-informed communities.

Strategic Goals:

1. Create a common language informed by robust data and brought to life by compelling stories of healing and recovery. Use key messages to inform and inspire policymakers, practitioners, funders, the private sector, the media and the public.
2. Educate leaders, policy-makers and the public about ACEs, brain development and effective interventions, including the paradigm shift from asking “What’s wrong with you?” to “What happened to you?”
3. Identify, promote and bring to scale research-informed, community-driven and cost-effective trauma and adversity prevention and recovery strategies, services and programs.
4. Engage elected and appointed officials, private sector leaders and other influencers as champions for health, educational, economic and related policy changes that improve community resilience, health equity and social justice.
5. Increase and leverage public and private funding for translational research, strategic collaboration, professional training, communication and the development of standards for trauma-informed services, organizations and communities.
6. Develop strong and adaptive leadership among members and allied organizations, coalitions and movements that share our commitment to a more just, healthy and resilient world.

Action Steps:

1. Establish a fluid, inclusive and forward-looking organizational structure modeled on best practices for collective action.
2. Leverage existing Internet and social media platforms and networks for sustained dialogue, decision-making, research and information-sharing.
3. Design shared measures of success to evaluate our progress and be accountable to our members and supporters.
4. Convene regularly to take collective action, widen our spheres of influence and advance our purpose and goals.
5. Secure funding to nurture and sustain our work.

The National Collaborative on Adversity and Resilience is a group of national leaders in Adverse Childhood Experience (ACE) research, policy, and practice.

The Collaborative developed these goals and action steps at a December, 2012 retreat co-sponsored by the Johnson Foundation Institute and the Institute for Safe Families. The report, Proceedings of the National Collaborative on Adversity and Resilience, is available for download at http://www.healthfederation.org/publications/NCAR%20Final%20Report.pdf
As a field, and as a larger society, we have no shortage of innovative models and practices, but we do sometimes have a hard time persuading individuals, organizations, and systems to adopt new approaches. Meeting these challenges is one of the major missions of the National Addiction Technology Transfer Center (ATTC) Network. With 10 Regional Centers, four National Focus Centers, and a Network Coordinating Office, the SAMHSA/CSAT-funded ATTC Network is a nationwide, multidisciplinary resource for professionals in the addictions treatment and recovery field, dedicated to raising awareness of evidence-based and promising treatment and recovery practices, building workforce skills for state-of-the-art service delivery, and changing practices and improving outcomes by helping people incorporate these skills into everyday use.

One of the Network’s most fundamental tools is Technology Transfer, which the Network calls “A multidimensional process that intentionally promotes the use of an innovation. Technology transfer begins during the development of an innovation, continues through its dissemination, and extends into its early implementation. This process requires multiple stakeholders and resources and involves activities related to the translation and adoption of an innovation. Technology transfer is designed to accelerate the diffusion of an innovation” (with “diffusion” defined as “The planned or spontaneous spread of an innovation”).

According to the Network:

“The key components of the proposed ATTC Network Technology Transfer Model and terms reflect years of field-driven experience and incorporate a variety of theories and empirical work on the innovation process. Practical applications of the key terms and conceptual model include clarifying for key stakeholders the multi-tiered change process needed for successful implementation of EBPs and assisting stakeholders in determining how to invest limited resources to increase the utilization and monitoring of EBPs.” The ATTC model provides “a framework that can be used to identify specific technology transfer activities and their intended objectives, determine which activities are most appropriate to their level of resource commitment, monitor the progress of efforts to support EBP implementation over time, and demonstrate accountability for stewardship of public resources.”

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An organization, system, or community interested in adopting informed care—or any new practice or approach—might find the ATTC Technology Transfer model a useful tool. It can help change agents:

- Provide a standard language that stakeholders can use to describe their tasks and the process as a whole
- Place the stages of diffusion in context, so key partners can prepare for a multi-tiered change process
- Promote adoption of evidence-based practices with high fidelity, and with respect for any cultural considerations and their implications for adoption
- Create a common understanding that increases partners’ satisfaction with the process
- Focus the organization’s, system’s, or community’s purchasing power, by providing a realistic look at what activities in the various stages are likely to accomplish

The Human Side of Innovation

Like the individuals they are made of, organizations and systems often balk at the prospect of change, accept it (if at all) in stages, and find ways of undoing approaches that seem to have been forced on them. When implementation efforts fail, it is most often the neglect of these and other human dynamics that has led to their failure.52 People who have made the process of change their life’s work can help systems and organizations introduce change in ways that are more respectful of, and acceptable to, the people whose lives will be affected. Few of these experts offer better suggestions in this area than Michael A. Diamond, PhD, in his seminal 1996 article on the human side of innovation.53 A few examples:

- No matter how much they admire expertise, members of an organization, system, or community tend to resent experts who swoop in to tell them what their problems are and offer solutions. Rather than taking an “expert authority” stance, it is better to approach stakeholders in an attitude of openness and humility and let them, not only help solve the challenges at hand, but first help define the challenges and plan the solutions. Much of the success of a change process depends on whether or not the people who are supposed to implement the solution buy into the definition of the problem and the nature of the solution. A more collaborative approach makes it more likely that stakeholders will accept, participate, and contribute to the process.

- Understand that the “resistance” that change processes often inspire is a natural expression of the anxiety people feel when they perceive that change is being imposed on them. No matter how much they want to learn and improve, people tend to feel powerless, uncertain, and inferior if they have the impression that the way they have been doing things is now considered wrong or inadequate. However, if they have been part of the planning process from the beginning, participating in empowered and meaningful ways, they can become the ones who have chosen change—a position of strength and dignity. Their input might make the planning process more effective, and their identification with the change process might add to its success.

52 Ibid.

• Understand and respect the fact that adoption of the new also means the loss of the old, including the sense of certainty that long-time routines and rituals carry, and all the ways in which traditional responses have been woven into the organizational culture. It is helpful to give each individual opportunities for, and support in, identifying and grieving these losses and building a new vision that works for both the individual and the process as a whole. As it is with any grieving process, there is no set timetable or way of working through it, and grieving in community with others is most healing.

• Diamond presents the concept of a “transitional space,” not so much a physical but a psychological space in which people can work through their thoughts and feelings about the change process, explore the implications of change, make mistakes without dire consequences, and work toward taking responsibility for changing.

• He also emphasizes the fundamental importance of building and maintaining organizational resilience. If leaders have promoted collaboration and trust through their own respectful and collaborative approaches throughout the organization’s or the system’s history, stakeholders are more likely to respond effectively to change.

Evans (in White, 2011b) also underscores the importance of collaborative leadership, both in the transformation process and in trauma-informed, recovery-oriented systems and services as a whole: “We can’t say to providers, ‘We want you to work with people in a collaborative way, to be respectful, to listen, to have more of an equal relationship as opposed to a hierarchical relationship’ if we don’t in turn exemplify that in our relationships with providers.”

**Inventory of Resources**

With all these options and considerations in mind, it is time to think—at least in hypothetical terms—about the resources you will need to foster and sustain the change process. An important early step is an inventory of resources that can be mobilized in these efforts. You might think about identifying the best people to contribute to that inventory, including people with particularly strong familiarity on three levels:

• Human—the many people you need to enlist in your efforts

• Conceptual—the models, frameworks, policies, procedures, protocols, and strategies that will help you make this a reality

• Material—financial assets and opportunities and the equipment, supplies, and facilities that support these kinds of efforts

Whether your goal is the adoption of a trauma-informed approach, a ROSC transformation process, or another equally challenging change process, the Action Notes on the following pages give you a place to begin listing some of the strongest resources you have and some of the resources you need—and thinking about where you are in the implementation process.

Then the next Section will hone in on one important and often overlooked aspect of trauma-informed care implementation and ROSC transformation: workforce development.

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Action Notes for Section 6 (Part 1)

Resources for Trauma-informed Care Implementation

Name some of the human resources who might be particularly important to involve in planning, promoting, or carrying out these efforts, e.g., leadership, management, line staff, consultants, volunteers, people in recovery, community members, members of allied systems, representatives of funding bodies, and other stakeholders who would be valuable assets and partners—particularly the early adopters and opinion leaders who tend to wield strong formal or informal influence.

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Name some of the conceptual resources that might be particularly useful or effective in planning, promoting, or carrying out these efforts, e.g., models (conceptual, implementation, or practice), policies, procedures, or protocols related to any facets of the implementation process.

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Name some of the material resources that might be particularly useful in planning, promoting, or carrying out these efforts, e.g., financial assets, funding opportunities, collateral, books, audiovisuals, work space, furniture, office products, etc. that might be needed or useful in the change process.

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Action Notes for Section 6 (Part 2)

This set of Action Notes invites you to spearhead an effort to take inventory of: 1) the ways in which trauma-informed approaches are already in place in your organization, system, or community; and 2) elements of trauma-informed approaches that should be added. First, who else should be key players in gathering this information, and what roles should they play?

Name: _________________________ Role(s): ______________________________________________

Name: _________________________ Role(s): ______________________________________________

Off the top of your head, write a few words about some trauma-informed approaches that are already in place in terms of the clinical areas identified in TIP 57:

Providing psychoeducation: ___________________________________________________________

Offering trauma-informed peer support: __________________________________________________

Normalizing symptoms: ______________________________________________________________

Identifying and managing trauma-related triggers: __________________________________________

Drawing connections between trauma and symptoms: ______________________________________

Teaching balance: ___________________________________________________________________

Building resilience: __________________________________________________________________

Addressing sleep disturbances: _________________________________________________________

Building trust: ______________________________________________________________________

Acknowledging grief and bereavement: __________________________________________________

Monitoring and facilitating stability: _____________________________________________________

Fostering engagement: __________________________________________________________________

Establishing appropriate pacing and timing: _______________________________________________

Managing traumatic memories: __________________________________________________________________

Managing legal proceedings: __________________________________________________________________

Providing culturally competent services: ________________________________________________

Addressing historical trauma: __________________________________________________________________

Providing integrated treatment of trauma and substance use disorders: _________________________
Section 7: Workforce Development

In creating and sustaining a trauma-informed workforce, organizations need to foster a work environment that parallels the treatment philosophy of a trauma-informed system of care. Doing so allows counselors to count on a work environment that values safety, endorses collaboration in the making of decisions at all levels, and promotes counselor well-being.

—SAMHSA

As essential as trauma-informed policies and practices may be, the heart and soul of trauma-informed approaches live in the people who provide services and support. This is as true of a community-based shelter or soup kitchen as it is of a major treatment organization or a state behavioral health agency. Although people may have higher levels of vulnerability in behavioral health settings, anyone who provides services or support to a trauma survivor has the potential to trigger new injuries—and the potential to contribute to the healing process.

This Section presents a few considerations in recruiting, preparing, retaining, and sustaining a trauma-informed workforce. Some of these ideas will be specific to behavioral health providers, and others might be adapted for staff in any health or human service setting.

Recruitment and Retention

In Trauma-informed Care in Behavioral Health Services, SAMHSA offers a number of considerations for recruiting, hiring, and retaining staff, including these suggestions drawn from the work of Andrea Blanch (2003, 2007), Ann Jennings (2004a), and Michael Hoge and colleagues (2007):

- Reach out to, recruit, and hire employees who are trauma informed or have formal education or training in providing trauma-informed or trauma-specific services.
- Hire counselors and peer support staff who have experienced trauma and are stable and progressing in their trauma recovery. Along with the regular duties of their positions, these employees can serve as “trauma champions,” helping the organization progress toward trauma-informed care in many ways.
- Survey the demographics of the population served and recruit staff who reflect those characteristics.

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55 Substance Abuse and Mental Health Services Administration (2014), loc. cit., p. 175.
56 Substance Abuse and Mental Health Services Administration (2014), loc. cit.
• Take trauma-related education, training, and job responsibilities into consideration in determining incentives, bonuses, and promotions.

In a field that experiences high staff turnover—and the resulting cost and disruption in continuity of care—organizations need effective strategies for retaining trauma-informed staff. TIP 57 includes advice for administrators, reprinted verbatim on this and the following page.

Advising to Administrators from SAMHSA TIP 57:
Preventing Turnover and Increasing Workforce Retention

To prevent behavioral health staff turnover and increase retention of qualified, satisfied, and highly committed trauma-informed counselors, consider:

• Offering competitive wages, benefits, and performance incentives that take into account education, training, and levels of responsibility in providing trauma-informed or trauma-specific services.
• Creating a safe working environment that includes both the physical plant and policies and procedures to prevent harassment, stalking, and/or violence in the workplace and to promote respectful interactions amongst staff at all levels of the organization.
• Establishing an organizational policy that normalizes secondary trauma as an accepted part of working in behavioral health settings and views the problem as systemic—not the result of individual pathology or a deficit on the part of the counselor.
• Instituting reasonable, manageable caseloads that mix clients with and without trauma-related concerns.
• Letting staff offer input into clinical and administrative policies that directly affect their work experience.
• Providing vacation, health insurance (which includes coverage for psychotherapy/personal counseling), and other benefits that promote the well-being of the staff.
• Implementing regular, consistent clinical supervision for all clinical staff members.
• Providing ongoing training in trauma-informed services offered by the organization.


Training the Workforce

One of the most challenging tasks of human service leadership is to foster in staff, colleagues, and partners an understanding of deep and complex subjects—and to do this as quickly and as economically as possible. When it comes to toxic stress, trauma, and trauma-informed care:

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60 Substance Abuse and Mental Health Services Administration (2014), loc. cit.
• The depth and complexity of the subject—and the lure of simplistic approaches—can both be significant. This can make for a difficult and sometimes risky balancing act.

• Common misconceptions about trauma, its effects, and stage-appropriate responses can make it difficult for providers to hear and apply accurate information on these subjects.

• The learner’s own experience of toxic stress and trauma can deepen understanding, but it can also complicate the learning process and the application of lessons learned.

• If this information is not integrated with the other conceptual models embraced by the system (e.g., recovery-oriented services, cultural competence, integrated healthcare), training might be—at best—implemented in costlier and less effective ways and—at worst—dismissed as just another flavor of the month, to be endured and then ignored.

• It is clear that all staff and volunteers have the potential to harm people who are experiencing vulnerabilities, but the prospect of training all personnel can be daunting.

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**Advice to Administrators, Reprinted from SAMHSA TIP 57: Trauma-informed Staff Training**

- Establish training standards for the evidence-based and promising trauma-informed practice models (such as Seeking Safety) adopted by your organization.

- Bring expert trainers with well developed curricula in TIC and trauma-specific practices into your organization.

- Select a core group of clinical supervisors and senior counselors to attend multisession training or certification programs. These clinicians can then train the rest of the staff.

- Use sequenced, longitudinal training experiences instead of single-session seminars or workshops.

- Emphasize interactive and experiential learning activities over purely didactic training.

- Provide ongoing mentoring/coaching to behavioral health professionals in addition to regular clinical supervision to enhance compliance with the principles and practices of TIC and to foster counselor mastery of trauma-specific practice models.

- Build organization-wide support for the ongoing integration of new attitudes and counselor skills to sustain constructive, TIC-consistent changes in practice patterns.

- Provide adequate and ongoing training for clinical supervisors in the theory and practice of clinical supervision and the principles and practices of TIC.

- Include information and interactive exercises on how counselors can identify, prevent, and ameliorate secondary traumatic stress (STS) reactions in staff trainings.

- Offer cross-training opportunities to enhance knowledge of trauma-informed processes throughout the system.


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Most models for implementing trauma-informed care (including those described briefly in Section 5) include options for expert consultation, training, and technical assistance. However, when financial circumstances rule out these kinds of comprehensive approaches—and a half-hearted approach would be ineffective and even dangerous—it might come down to finding the
best compromise. Still, that compromise must include ample training, supervision, mentorship, technical assistance, and staff support.

For training delivery, SAMHSA’s TIP 57 recommends:

- Engaging expert consultants with well established TIC models, and training and technical assistance processes that feature interactive, “hands-on” approaches
- Having these consultants train, mentor, and provide ongoing technical assistance to clinical supervisors and a few other key clinical staff whose training skills and grasp of the subject make them good choices for training their peers
- When they are ready, having these supervisors and staff trainers train, mentor, and supervise other staff members and participate in ongoing improvement processes
- For any staff who will also be using trauma-specific approaches—particularly past-focused approaches that involve the processing of memories of traumatic experiences—using expert consultants who comply with all recommendations and requirements for training, certification, licensure, etc. associated with these clinical models

Because trauma is, among other things, a clinical issue, administrators often think of trauma-informed care training as something that targets key clinical staff only. In reality, though, the experience of trauma can increase the vulnerability of an individual in any relationship, in any role, in any setting. If the first purpose of TIC is to respect that vulnerability and protect the individual and the healing process, then every employee and every volunteer needs a solid grounding in trauma-informed approaches—and a role in the collaborative team that is crafting, implementing, and participating in the evaluation and improvement of these approaches.

It is true that many service participants experience greater vulnerability in clinical functions (e.g., assessment, group or one-to-one sessions with counselors) than in some non-clinical functions (e.g., meal time, recreation activities, employment skills training). The more intimate the activities in which staff engage, the more intensive the levels of TIC training they will need. When it is time to map out a training program for staff in trauma and trauma-informed care, many leaders choose a tiered approach. In this sort of approach, for example:

- All staff, at all levels of the organization or system—participate in the first tier, basic training designed to introduce TIC efforts; spark curiosity and buy-in; lay the foundation for a trauma-informed culture and ongoing learning process; normalize the experience of toxic stress, trauma, and post-trauma effects; instill an understanding that any service participant might carry deep vulnerabilities; make staff and volunteers aware of safety issues and ways of addressing them; raise awareness of secondary trauma and other provider challenges; encourage self-care; and give basic information about options for seeking help.
- Staff (professional and paraprofessional) with more intensive contact with service participants participate in the basic training, then go on to participate in the next tier, which would present deeper and more detailed information, skills training, and supervision in the principles and practices of trauma-informed care and self-care.

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61 Substance Abuse and Mental Health Services Administration (2014), loc. cit.
• At each successive level of clinical responsibility and participant vulnerability, another tier is added, with increasing levels of depth and skill training. Appropriate staff proceed to each more intensive tier after completing the previous tier.

• After completing the TIC tiers, any providers of trauma-focused services participate in the top tier, with training, supervision, technical assistance, effectiveness standards, and any certification or licensure required for the models they will be using.

A number of issues can make training in trauma-informed care more challenging and require extensive exploration, clarification, staff discussion, and ongoing monitoring and mentorship. Even seasoned clinicians can fall prey to these kinds of challenges. Most notably, it can be very difficult for staff to accept a staged approach toward trauma recovery and the emphasis on safety and stabilization that is the bedrock of trauma-informed care.

Aware that the effects of service participants’ past experiences can hinder treatment and make the present more difficult—and often steeped in the traditional belief that the way out of the pain is to “dig up” painful memories and face them—many trainees rebel against the idea of focusing on stabilization in Stage One. Without careful clarification and awareness of the psychoeducation, support, and skill training that are part of stabilization, they can interpret the instruction to “stabilize them” as “detox/medicate them and send them on their way.” Many also interpret present-focused approaches and the caution against “digging for trauma” as a requirement that they silence participants who try to talk about their traumatic experiences. It can take extensive dialogue and exploration of options in training, and ongoing supervision and discussion, to help staff understand the importance of stabilization, grasp the many important distinctions, and embrace an approach that honors but does not search for traumatic memories.

**Helping Staff Stay Afloat**

“Compassion fatigue” has become a popular catch-all phrase for a range of natural reactions to the sometimes overwhelming burden of exposure to others’ extremely painful and frightening experiences—and their consequences. Compassion is a significant strength, and identifying it as part of the problem leaves many human service providers wondering just how to work the magic spigot and have just the right amount of compassion. It may be more helpful to break this concept down into its component elements and address each element as it arises. For example:

• Immersion in deficit-based models, with their primary focus on problems, symptoms, and diagnoses, can erode important resources for weathering traumatic material. Implementing strength-based approaches can improve outcomes and activate hope, optimism, empowerment, and faith in one’s ability to make a difference.

• Human service providers are notorious for neglecting self-care in order to meet others’ needs, underestimating the power of stress and fatigue, with all their physical and neurochemical effects on mood, perspective, and energy levels. Policy, supervision, and mentorship can address these challenges effectively, but only if leadership is willing and able to discourage overwork; refrain from making overtaxing demands; and provide training and support in time management, stress modulation, and stress reduction.

• Some service participants’ post-trauma effects—particularly the effects of complex or developmental trauma—can add layers of confusion, conflict, and turbulence to all their relationships. In these cases, high levels of interpersonal stress and frustration might prove even more challenging to service providers than the traumatic material itself.
• Some of what is thought of as “secondary trauma” may actually be unresolved primary trauma, grief, guilt, shame, and/or anger triggered by exposure to others’ traumatic material and ensuing emotions. Service providers are responsible for monitoring and pursuing their own growth and healing—and abstaining from any roles that take them beyond their levels of recovery. Supervisors and managers are responsible for knowing their staff well enough to recognize the signs and intervene within the boundaries of their professional roles—and for creating environments that make it safe to ask for help.

• Sometimes what seems like compassion fatigue might be an old fashioned case of countertransference, over-identification with the individual or the circumstances, a sense of personal failure at their inability to take away people’s pain and anxiety, or seeing the people they serve through the lens of their own needs (e.g., the need for control, the need to feel successful) and challenges. Ongoing employee development must work to instill an acceptance of responsibility for maintaining clear delineation and boundaries.

• And there is such a thing as “vicarious traumatization,” the effect of taking in so much traumatic material—often on a chronic basis—that it overwhelms one’s coping abilities and alters one’s world view. The leader’s job is to ensure that there are many accessible options for guidance and support, and to create an atmosphere in which it is understood that sometimes there simply is too much pain and that these reactions are normal and natural. Leaders must allow staff the grace and the space to rest, reset, recover, and reconnect with their many sources of strength and spirit.

Now it is time to step back and look at the implications of all the thoughts and suggestions presented in this manual. The next and final Section reviews the tasks suggested in the Action Notes at the end of each Section and offers some thoughts on hope.

**Action Notes for Section 7**

For a picture of where your staff and stakeholders are in terms of their need for training and support in trauma and TIC, you might want to collaborate on a survey in your organization, system, or community—one that allows respondents to remain anonymous—to find out:

• How much staff and volunteers at all levels seem to know and understand about toxic stress, trauma, and trauma-informed care (SAMHSA provides guidelines in TIP 57)

• How staff, volunteers, service participants, and family and community members are being affected by exposure to other individuals’ traumatic material and reactions

• What levels of resources (e.g., peer support, supervision, mentorship, social networks, employee assistance programs, counseling or therapy) people in each of these groups have for coping with and resolving these effects

• What additional resources they would be willing to use if those resources were available
Section 8: Accepting the Challenge

Three frogs are sitting on a log. One of them decides to jump. Now how many frogs are sitting on the log?

(Answer: Three frogs. Just making the decision doesn’t get the frog off the log!)

—Riddle heard in a recovery meeting

Like the frog in the old riddle, most of us have learned over and over again that not even inspiration, vision, conviction, motivation, resolution, determination—not even all those qualities put together—will be enough to make things happen. It takes action. But unlike that contemplative frog, change leaders often find that it takes, not one leap, but a series of leaps, plus the persistence to lure the other two frogs off the log.

If you have read through this document, and perhaps begun to address the Action Notes at the end of each section, you might have something close to the bare bones of a place to start.

The most important tasks are the ones that involve reaching out to potential collaborators: people with answers, people with more questions, people whose input will make things easier, people whose input will make things harder—but better—in other words, people who can help you do the things you cannot do alone.

To sum up those Action Notes, here are some interesting projects for leaders who know that the growing impact of toxic stress and trauma is a serious threat that requires careful effort, integrated with recovery-oriented systems and the full spectrum of related efforts.

From Section 1: The Role of Leadership

Identify one or more teams in your organization, system, or community that are studying the kinds of issues and possibilities addressed in this manual—or start a new
team. Consider sharing this manual with them, and think about the role you should play in these efforts and the challenges and resources you expect to find in the process.

From Section 2: Transforming the Vision

Clarify (or update) your own vision regarding trauma-informed responses, then build on this by looking for opportunities to participate in any collective vision- and mission-building processes within your organization, system, or community.

From Section 3: Resilience, Stress, and Trauma

Catalyze a collaborative effort to compile: 1) an inventory of strengths within the community you serve; and 2) a “ballpark” estimate of the total—and inclusive—human, social, and financial cost of toxic stress and trauma on your organization, your community, your service systems, and the people you serve.

From Section 4: Trauma-informed Approaches

Spearhead a collaborative effort to take inventory of your organization’s, community’s, or system’s progress toward trauma-informed approaches in several key areas of planning and operation.

From Section 5: Recovery-oriented, Trauma-informed Approaches

Gather a multidisciplinary group that can take inventory, within your organization, system, or community, of ways in which efforts toward trauma-informed approaches, recovery-oriented systems of care, and any other models and frameworks are working together, and the extent to which information, resources, and collaborative efforts are being shared among these efforts.

From Section 6: Implementing Trauma-informed Approaches

With help, make lists of the human, conceptual, and material resources that are being, might be, or should be mobilized to support these efforts in your organization system, or community.

From Section 7: Workforce Development

Conduct a survey in your organization, system, or community—one that allows respondents to remain anonymous—to find out:

- How much staff and volunteers at all levels seem to know and understand about toxic stress, trauma, and trauma-informed care
- How staff, volunteers, and service participants are being affected by exposure to other individuals’ traumatic material and reactions
• What levels of resources each of these groups has for coping with and resolving those effects
• What additional resources they would be willing to use if those resources were available to them

Evidence of Hope

When people have lived with the effects of toxic stress and trauma for a long time—a year, a lifetime, many generations—the capacity to trust may be the first casualty, with hope and determination falling not far behind.

As a society, we have watched our human and financial resources erode as the progressive effects of toxic stress and trauma have compromised our collective physical, psychological, behavioral, social, cultural, financial, spiritual, and moral health. All this has increased the senses of isolation and scarcity that wear at the fabric of human health, resilience, and recovery. Given all the ideas in this and thousands of other documents, it might not be too hard to envision collaborative solutions, but believing those solutions can happen is another matter.

Remember: Resilience is real. Most people not only survive but thrive, in spite of pain or poverty or grinding stress.

Recovery is real. Overwhelming numbers of people with chronic, once-debilitating substance use disorders and/or mental health challenges are living full lives, transformed lives. Most did not do it alone, though, and many have become that strength for others.

And for anyone who doubts that trauma-informed care can overcome the silos and the scarcity and expand to the scale we need, there is the best possible precedent: recovery-oriented systems of care. In a growing number of organizations, systems, and communities—even in large cities and states—diverse groups of stakeholders have pooled their ideas and resources in service of recovery. This movement is a sign of hope; a source of ideas; and a sound partner in efforts to empower individuals, families, and communities.

The architects and advocates of trauma-informed care and recovery-oriented systems of care need one another. One nourishes and protects the roots, and the other tends the branches, but it is the same tree. It is all of us, and each one of us is responsible.

This is our challenge, and our best hope.
## Appendix A: Reviewers and Advisory Panel

### Reviewers

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<thead>
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<th>Name</th>
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### Advisory Panel

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Addressing Stress and Trauma in Recovery-oriented Systems and Communities: A Challenge to Leadership
Great Lakes Addiction Technology Transfer Center
Page 61

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Appendix C: A Few Web Sites on Trauma, Trauma-informed Care, and Recovery-oriented Systems of Care

http://acesconnection.com  A “community of practice” designed to help people prevent childhood trauma and further problems, with resources and blog posts for members and non-members

http://acestoohigh.com  An organization that searches out and highlights measures being taken to reduce or address the incidence of childhood exposure to traumagenic experiences, including resources and a blog for professionals and the general public

http://acestudy.org  The resource site of the Adverse Childhood Experiences (ACE) Study, a large longitudinal study of connections between childhood adversity and the development of physical, psychological, and behavioral challenges in adult life

http://communityresiliencecookbook.org  A repository of information, ideas, and examples of communities that are engaging in trauma-informed care and resilience-building efforts

http://dbhids.org/practice-guidelines  Web site for ordering Philadelphia Behavioral Health Services Transformation practice guidelines for recovery and resilience oriented treatment, developed by the Philadelphia Department of Behavioral Health and Intellectual disAbility Services, including basic information on the Guidelines and a link for free download

http://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816  Web site for ordering SAMHSA’s new TIP 57: Trauma-Informed Care in Behavioral Health Services

http://tfcbt.musc.edu/  A web-based Trauma Focused Cognitive- Behavioral Therapy (TF-CBT) Training

http://traumaresourceinstitute.com  The Trauma Resource Institute, providing training in trauma- and resilience-informed approaches using the Trauma Resiliency Model and the Community Resiliency Model, featuring skills for stabilizing stress responses

http://traumaticstressinstitute.org/  The Traumatic Stress Institute, providing training, technical assistance, and other resources to professionals working with people who have experienced childhood trauma and attachment challenges

http://www.attcnetwork.org/index.asp  The Addiction Technology Transfer Center National Network, offering a wide variety of free resources from its Regional Centers and National Focus Area Centers

http://www.attcnetwork.org/regcenters/generalContent.asp?rcid=3&content=STCUSTOM2  Home page of the ARIVES project, a study and online course entitled Addiction Recovery and Intimate Violence Educational System developed by Larry W. Bennett, PhD

http://www.attcnetwork.org/regcenters/index_greatlakes.asp  The home site of the Great Lakes Addiction Technology Transfer Center, with many free resources on many topics, with special emphasis on recovery management and recovery-oriented systems of care

http://www.center4si.com/training/index.cfm  The T3 Institute, providing training on a number of health and human service topics

http://www.coleva.net  Consequences of Lifetime Exposure to Violence and Abuse, a web site that uses pictorial links to more information, diagrams, papers, etc. Includes much information about the physical consequences of exposure.
http://www.communityconnectionsdc.org/  The Community Connections web site, with information and resource on the Trauma Recovery and Empowerment Model (TREM) and Creating Cultures of Trauma-informed Care.

http://www.humanpriorities.com  Pam Woll’s web site, with resources on resilience, trauma, and other human service topics for free download

http://www.istss.org/Home1.htm  International Society for Traumatic Stress Studies, the primary international organization for trauma research and treatment, with an annual meeting featuring an extensive selection of presentations by the field’s leading experts

http://www.nctsn.org  SAMHSA’s National Child Traumatic Stress Network, with many resources for professionals and the general public

http://www.nctsnet.org  National Child Traumatic Stress Network (NCTSN), with many resources for various audiences on childhood trauma and related topics

http://www.ptsd.va.gov  National Center for Posttraumatic Stress Disorder, with many resources for professionals and lay audiences

http://www.ptsd.va.gov/professional/ptsd101/ptsd-101.asp  Excellent online course from the National Center for PTSD

http://www.instituteforsafefamilies.org/philadelphia-urban-ace-study  Philadelphia Urban ACE Study, information about the study and a link to the study report

http://www.ptsdalliance.org/  PTSD Alliance, a coalition designed to provide resources to a variety of audiences

http://www.samhsa.gov/data/womentx/womentx.pdf  Results from the alcohol and drug survey study pertaining to women (2005)

http://www.samhsa.gov/nctic/  SAMHSA’s National Center for Trauma-Informed Care, offering resources and information about trauma-informed care

http://www.samhsa.gov/samhsanewsletter/Volume_18_Number_2/TIP51.aspx  SAMHSA’s TIP 51, Substance Abuse Treatment: Addressing the Specific Needs of Women

http://www.sanctuaryweb.com  Home site of The Sanctuary Model of trauma-informed care, with information on a number of related topics

http://www.seekingsafety.org  Dr. Lisa Najavits’s site for her Seeking Safety model, with information on the model and materials, ordering information, and documentation of the empirical evidence behind this model

http://www.sidran.org  The Sidran Institute, offering traumatic stress education and advocacy, including the Risking Connection model

http://www.stephaniecovington.com  Stephanie Covington’s web site, with many resources on gender and treatment

http://www.theannainstitute.org  The Anna Institute, with many resources on trauma, many of them available for free download

http://www.trauma-pages.com  David Baldwin’s Trauma Pages, offering a wide variety of resources, including free articles from some of the leading experts on trauma

http://www.williamwhitepapers.com/papers/topics/gender_papers/  A cornucopia of papers and monographs for free download from William White’s site, with his collected works on a variety of topics, many with a focus on recovery management and recovery-oriented systems of care
Appendix D: SAMHSA TIC Principles and Strategies

Many implementation and practice models have been developed to capture and communicate the essential elements of trauma-informed care—and, with some variation, they emphasize many of the same characteristics. In its working definition of trauma-informed care, the Substance Abuse and Mental Health Services Administration (SAMHSA) identifies ten guiding principles for trauma-informed care, principles that reflect many of the predominant TIC models. They are reprinted here verbatim:

1. **Safety**: Throughout the organization, staff and the people they serve feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety.

2. **Trustworthiness and transparency**: Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients, and family members of people being served by the organization.

3. **Collaboration and mutuality**: There is true partnering and leveling of power differences between staff and clients and among organizational staff, from direct care staff to administrators; there is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making.

4. **Empowerment**: Throughout the organization and among the clients served, individuals’ strengths are recognized, built on, and validated and new skills developed as necessary.

5. **Voice and choice**: The organization aims to strengthen the staff’s, clients’, and family members’ experience of choice and recognize that every person’s experience is unique and requires an individualized approach.

6. **Peer support and mutual self-help**: are integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety, and empowerment.

7. **Resilience and strengths based**: a belief in resilience and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma builds on what clients, staff and communities have to offer rather than responding to their perceived deficits.

8. **Inclusiveness and shared purpose**: The organization recognizes that everyone has a role to play in a trauma-informed approach; one does not have to be a therapist to be therapeutic.

9. **Cultural, historical, and gender issues**: The organization addresses cultural, historical, and gender issues; the organization actively moves past cultural stereotypes and biases (e.g., based on race, ethnicity, sexual orientation, age, geography, etc.), offers gender responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.

10. **Change process**: is conscious, intentional and ongoing; the organization strives to become a learning community, constantly responding to new knowledge and developments.

For people who have been affected by trauma, the danger does not subside simply because the traumatic stressors have been removed. In Treatment Improvement Protocol (TIP) 57, Trauma-

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63 Ibid.
In Informed Care in Behavioral Health Services, SAMHSA identifies three central aspects of care in which safety is absolutely important:

- **Safety from trauma symptoms:** These symptoms—and the side effects of medications sometimes used to treat them—can be painful and frightening. Until people understand their symptoms, know they are strong in spite of their symptoms, and learn how to manage and reduce them, the symptoms themselves can be sources of danger.

- **Safety in the environment:** Trauma sensitizes us to many possible signs of danger. Treatment contains many “triggers” for post-trauma reactions (e.g., sounds, smells, interpersonal tension, rapid transitions, premature reminders of the trauma), and it is each service provider’s responsibility to help people map and manage their triggers.

- **Safety from recurrence of trauma:** Many forces raise the risk that people who have been traumatized will engage in dangerous or self-destructive relationships and behaviors. An important focus of treatment is helping people replace these behaviors, make more positive choices, and learn to take appropriate measures to protect themselves.

In each of the following categories, TIP 57 offers a number of concrete strategies for promoting safety and addressing key treatment issues in clinical settings:

- Provide psychoeducation
- Offer trauma-informed peer support
- Normalize symptoms
- Identify and manage trauma-related triggers
- Draw connections between trauma and symptoms
- Teach balance
- Build resilience
- Address sleep disturbances
- Build trust
- Acknowledge grief and bereavement
- Monitor and facilitate stability
- Foster engagement
- Establish appropriate pacing and timing
- Manage traumatic memories
- Manage legal proceedings
- Provide culturally competent services
- Address historical trauma
- Provide integrated treatment of trauma and substance use disorders

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Addressing Stress and Trauma in Recovery-oriented Systems and Communities: 
A Challenge to Leadership

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February, 2015