Toward a Trauma-Informed Workplace:

Assessing the Trauma- informed Capabilities of a Community Mental Health Program Using a Fidelity Scale

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Winter Term 2023

This paper is submitted in partial fulfillment of the requirements for

the Doctor of Nursing Practice Degree

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Abstract

A community mental health clinic in the Pacific Northwest (The Clinic) wanted to incorporate the *Adverse Childhood Experience (ACE) Questionnaire for Adults* into the new client intake process. The intention was to gain deeper insight into their clients, and to guide the development of relevant, trauma-related programs. Screening for trauma, and the environments in which this is done, may be unintentionally re-traumatizing (Endres, 2015; Yatchmenoff et al, 2017). This is particularly important to consider in the public mental health sector which serves a disproportionately high number of trauma survivors (Endres, 2015; Trauma Informed Oregon, n.d.). Therefore, best practices indicate trauma screening should be conducted by informed clinicians in environments which provide evidence-based practices for mitigating the effects of trauma; This is collectively referred to as trauma-informed care (TIC) (Endres, 2015; Trauma Informed Oregon, n.d.). A staff survey indicated concern about The Clinic's trauma-specific services. Therefore, a quality improvement (QI) study was conducted to evaluate the trauma-informed capabilities of The Clinic as a prerequisite of screening for ACEs. Baseline data were assessed using the Plan Do Study Act (PDSA) approach (Institute for Healthcare Improvement, n.d.) and one of the first, most comprehensive, and widely used screening tools (Fallot, R., Harris, M., 2015). This project established a standardized trauma-informed framework, provided meaningful insight into The Clinic's culture, and demonstrated site readiness to screen for adverse childhood experiences (ACEs). Additionally, these results helped to identify existing strengths and highlighted opportunities for growth toward providing safe, relevant, and empowering care to The Clinic's high-risk patient population.

Problem Description

Adverse Childhood Experiences (ACEs) are remarkably common and have been identified as causative factors in the development of poor mental and physical health outcomes (Hughes et al, 2017; Kalmakis et al, 2015; Merrick et al, 2017; Mersky, 2021; Oral, 2015; Petrucelli, 2019). This is especially relevant for the community mental health providers at The Clinic as research indicates their clients have experienced trauma at a lifetime prevalence rate of greater than ninety percent (ACEs Aware, n.d.; Cusak et al, 2004).

Results from an anonymous staff survey at The Clinic indicated a high degree of familiarity with both ACEs and trauma-informed care (TIC). However, despite their eagerness to do so, staff expressed concern over site readiness for implementing ACEs screening. This was due to a general perception that The Clinic may lack essential resources to support both clients and staff and, therefore, was not fully trauma informed.

TIC is not a specific, evidence-based intervention nor is it outlined by a universal definition (Yatchmenoff et al, 2017). But for clinical sites concerned about the quality of their program, numerous investigators have provided formal guidelines and planning toolkits for assessing and establishing TIC (Harris and Fallot, 2001; Yatchmenoff et al, 2017). The first step in this process is a thoughtful cultural evaluation of both organizational and clinical practices (TIC, 2022). An effective assessment should provide insights into both site-specific deficits and opportunities for growth. Utilizing one such planning tool, this project will serve as the initial assessment of the trauma informed practices at The Clinic. This data will be utilized to guide the implementation of ACEs screening, to gain better insight to this patient population, and to inform the development of meaningful, site-specific support programs.

Available knowledge

There are both benefits and risks associated with assessing a client's trauma history. Benefits including health promotion, the development of stronger patient-provider relationships, improved clinical decision making, and the collection of information with which to develop relevant, trauma-specific services (ACEs Aware, n.d.; Endres, 2015). For clients, the primary risk is inadvertent re-traumatization. For staff, risks include experiencing vicarious trauma, secondary traumatic stress, and compassion stress, all of which contribute to clinician burnout (Trauma Informed Oregon, n.d.).

Assessing a client's trauma history can be as straightforward as administering a ten-item ACEs questionnaire. However, barriers to screening are typically complex, site-specific, and related to the context in which trauma is addressed, namely the lack of a trauma-informed workplace (Yatchmenoff et al, 2017). While there is no singular definition of TIC, it has been defined as a holistic strengths-based care model which proactively assesses for traumatic stress experienced by both clients and providers and responds with integrative and/or collaborative treatment (Forkey et al, 2021; Ranjbar, 2019; SAMHSA, 2014). Commonly reported barriers to implementing TIC pertain to clinician skill and clinic infrastructure. Skill-related barriers include a lack of awareness of trauma, staff discomfort around discussing trauma, and a fear of re-traumatizing patients. Infrastructure-related barriers include insufficient clinician time, lack of leadership, and a dearth of mental health resources to which clinicians can refer patients (Bellis et al, 2019; Maunder, 2020; McLennan et al, 2020; Rairdon et al, 2021; Stork, 2020). Implementing TIC necessitates a trauma-informed environment that emphasizes physical, psychological, and emotional safety (Ranjbar, 2019). Clinical sites that fail to establish a trauma-informed culture are at risk for further traumatizing both the clients and staff in addition to

experiencing poor client retention and worse clinical outcomes (Endres, 2015; Trauma Informed Oregon, n.d.). In support of creating a trauma-informed clinic, Fallot and Harris (2015) developed the Creating Cultures of Trauma-Informed Care (CCTIC) Fidelity Scale. This is a standardized self-assessment and planning tool to evaluate the current state of trauma-informed capabilities, and to provide clearer guidelines for making appropriate program modifications.

Rationale

According to the National Conference of State Legislatures, since 2018 more than 30 U.S. states have enacted or adopted legislation related to providing mental health services addressing childhood trauma, childhood adversity, toxic stress, or ACEs themselves (Scarlett, n.d.). California is leading the way with a $45 million "ACES Aware" initiative. This campaign offers a "how-to" providing practical support for screening implementation. Inspired by the rising national awareness of TIC, and informed by the ACEs Aware Initiative, this quality improvement (QI) project was designed using the PDSA Model (IHI, n.d.) and the CCTIC Fidelity Scale. The PDSA model was selected for its effectiveness in measuring and assessing iterative organizational change, while the CCTIC Fidelity Scale offered an established roadmap for evaluating trauma-informed capabilities. This approach was determined to provide the most efficient, cost-effective, and collaborative method for gathering and disseminating a variety of data to the site leadership team.

Specific Aims

The specific aim of this project was to assess the degree to which an urban community mental health clinic is trauma informed and to share that assessment with clinic leadership. The

goal was to provide meaningful insight into organizational culture and highlight any opportunities for TIC-related improvements. Additionally, this data may help to establish a trauma informed framework supporting organizational goals including the implementation of ACEs screening and the development of meaningful, patient-centered support programs.

Context

The Clinic is an outpatient mental health clinic within a large urban city in the Pacific Northwest. The Clinic staff includes psychiatric mental health providers, case managers, nurses, and peers. Services include medication management, case management, individual and group therapies, and skills training. The Clinic is part of a larger community mental health agency providing mental health treatment services, housing, peer support and mentoring services to adults with SPMI throughout two counties. Over 52% of agency funding comes from Medicaid and the remainder through private philanthropic sources. The agency operates 40 facilities providing outpatient and residential mental health treatment, transitional and permanent housing, peer support, life skills training and other mental wellness programs. In 2021, the agency served more than 2200 adult clients.

Interventions and Study of the Interventions

This study involved two PDSA cycles. The first was the submission of an anonymous, eleven-question, electronic survey assessing staff awareness of both ACEs and TIC. The survey also solicited feedback on perceived barriers to screening for trauma and areas in which staff would like additional support for this practice change (Appendix A). The seven respondents included social workers, case managers, and peers. Survey data indicated a need to further assess The Clinic's trauma-informed infrastructure in advance of ACEs screening.

A second PDSA cycle, inspired by the first, involved selecting the CCTIC Fidelity Tool, gathering, analyzing, and interpreting the data, and sharing this information with site leadership. The information sources were in-person observations (IPOBS), policy documents (PDR), and interviews with the Clinical Director (CEOINT), staff (STINT), and peers. The CCTIC Fidelity Tool is not intended as a means of rigorous scientific measurement. Each of the scored elements reflect a current snapshot of subjectively interpreted capabilities. These can be used as baseline data for pre-post assessment measures in future TIC-related improvement projects. The stepwise approach of the PDSA model allows the team to determine which change, or combination of changes, may have the greatest clinical impact while minimizing practice disruptions. Assessment Data were compiled and scored per the CCTIC Program Fidelity Scale Instruction Guide (Appendix B).

Measures

The staff survey was created in Google Drive and shared via email. It was designed to establish a baseline familiarity with ACEs, TIC, and to gauge general staff interest in incorporating ACEs into the standard workflow. The survey included a combination of Likert scale questions (N=7), with 1 being the lowest and 5 being the highest value for each measure, one yes or no question, and short answer responses (N=3). The Likert scale was chosen as a widely accepted method for assessing attitudes, beliefs, and behaviors particularly when considering practice policy changes (Joshi et al, 2015).

The CCTIC Fidelity Scale is another Likert scale assessment in which 1 is the lowest and 5 is the highest value for each measure. The measures assessed by this QI study (N=44) were divided among 6 domains addressing both services-level and systems-level aspects of TIC (See

Appendix A). The values associated with each measure were used to generate a trauma-informed score for each of the 6 domain subscales as well as an overall trauma-informed culture score (See Appendix A). Pertinent strengths and challenges were also documented.

Analysis

All staff survey responses (N=7) were captured electronically in Google Drive. A mean score was calculated for each question containing a Likert scale response.

Data for the CCTIC Fidelity Scale (Appendix A) were collected and quantified to generate subdomain scores (N=44), domain total scores (N=6), and a scaled total score. Additionally, subjective strengths and challenges findings were noted during interviews. All data collection and score calculations for this tool were hand documented.

Ethical Considerations

Existing policies and procedures were a primary information source for this QI project. It was determined the project goals aligned with organizational values and guidelines. All individuals participated voluntarily and anonymously. No client or staff health information were collected or shared, and any personal information or opinions discussed were protected by the Health Insurance Portability and Accountability Act of 1996 (ASPE, n.d.). Per the OHSU Investigational Review Board, this project (IRB STUDY# 00024885) was deemed not to qualify as human subjects research and required no further review.

Results

Staff survey results indicated a strong familiarity with ACEs (4.3), and high confidence in screening for them (4.3), despite only 28.6% having previous ACEs screening experience. Likewise, the respondents indicated a strong familiarity with TIC (4.3), and comfort discussing trauma (4.6). Staff revealed they would like more training on both ACEs (4.4) and TIC (4.3) and

feel less confident that The Clinic is trauma informed (3.9). Specific barriers to implementing ACEs screening highlighted by staff include a lack of training and time constraints. Specific requests for support include additional training and guidance on referring clients for trauma-related follow up care.

Per the CCTIC Fidelity Scale, The Clinic achieved an overall trauma-informed rating of 4.0.; This indicates being "Very Trauma Informed." The Clinic excels in domain #2 (Formal Services Policies) achieving a rating of "Fully Trauma Informed." The Clinic received a rating of "Very Trauma Informed" in domains 1,3,5, and 6 and scored lowest in domain #4 (Administrative Support for Program-Wide Trauma-Informed Services) earning the designation of "Somewhat Trauma Informed."

Notable strengths of The Clinic include: an active Peer Advisory Board, strong organizational transparency, weekly supervision groups, numerous opportunities for ongoing staff skills building, an organizational dedication to the principles of TIC, and a robust, though poorly publicized, referral network for trauma specific services (Appendix B).

Summary

There were two objectives within this QI project. The first was survey of staff familiarity with ACEs and TIC in advance of implementing ACEs screening. Results of this survey inspired the second objective which was to assess the current state of trauma-informed capabilities at The Clinic. Utilizing a novel survey and an established assessment tool, two PDSA cycles were completed. This project addressed staff concerns of a potential lack of TIC by providing a quantitative evaluation of 6 TIC subdomains and an overall TIC rating for The Clinic. The data

suggest The Clinic is trauma informed and is well-prepared to implement ACEs screening as a standardized component of their new client intake process.

Interpretation

Per a review of established policies and procedures, The Clinic and its parent organization share a principled commitment to TIC. Thus, it was not surprising when The Clinic screened as overall "Very Trauma Informed." Nonetheless, it is recommended that even organizations with high-functioning TIC programs engage in ongoing monitoring and program evaluation to maintain quality service delivery (SAMHSA, 2014). And as further emphasized throughout the literature, successful integration of TIC requires meaningful insight into the context in which it is delivered (Menschner, 2016; Wilson, 2017). Both objectives were achieved using this QI approach.

The immediate impact of this QI study was a validation of The Clinic's current TIC efforts and a recognition of site readiness to implement ACEs screening; Implementing this screening is the logical objective of a future QI initiative. Additionally, this project highlighted several TIC-related growth opportunities for The Clinic including appointing a designated trauma specialist and/or trauma work group, gathering trauma-related client data to inform future service offerings, and prioritizing in-person client intake interviews over virtual meetings. Each of these initiatives align directly with recognized trauma-informed principles (Trauma Informed Oregon, n.a.; Yatchmenoff et al, 2017). These projects would require significant workflow modifications, the possible addition of staff or modification to current job duties and would necessitate ongoing support from both leadership and staff. When needed, this QI study has demonstrated

an effective approach in which the PDSA model and the CCTIC tool provide a meaningful framework for pre and post intervention assessments at this site.

Limitations

This QI project was conducted at a specific site; therefore, the data collected are not generalizable beyond this clinic. Additionally, the information collected by the CCTIC is largely comprised of the subjective opinions. Efforts were made to solicit survey data from a variety of clinic staff. As it is not feasible to survey every employee, the data may be inherently biased toward those more motivated by a TIC-related QI project. Finally, the CCTIC, while robust, was originally developed twenty years ago. This tool may be improved by reflecting a more current understanding of trauma including questions regarding specific cultural considerations, collective trauma, and the critical importance of peer support.

Conclusions

Community mental health clinicians must appreciate how effective treatment for this population requires TIC to mitigate the inevitable impacts of trauma and toxic stress (ACEs Aware, n.d.; Endres, 2015). This QI project examined one method for evaluating trauma-informed care capabilities utilizing an established assessment protocol. The results provided a more nuanced insight into site-specific offerings, the recognition of a strong trauma-informed foundation, and a readiness to standardize screening for a history of traumatic experiences. The Clinic will benefit from future QI projects that address more specific needs of both staff and clients. This data can then be used to inform the development of relevant, trauma-informed services and to promote ongoing workplace wellness. No funding was received for this study.

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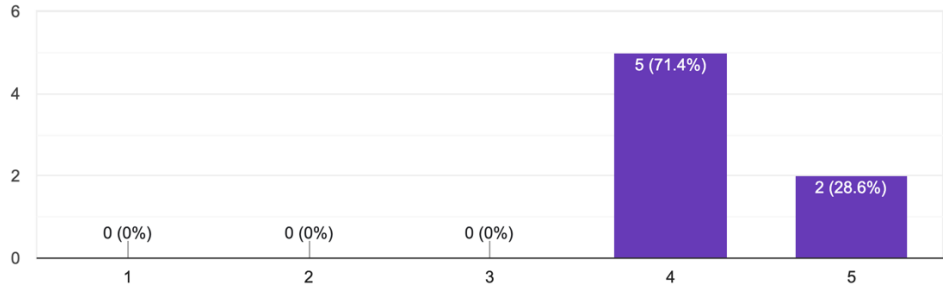
Appendix A

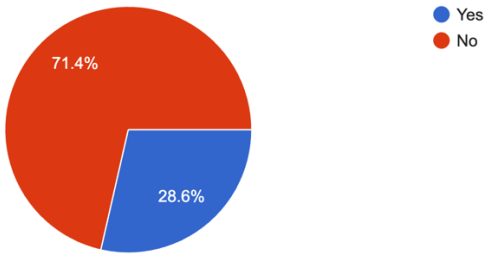
How familiar are you with Adverse Childhood Experiences (ACEs)?

7 responses



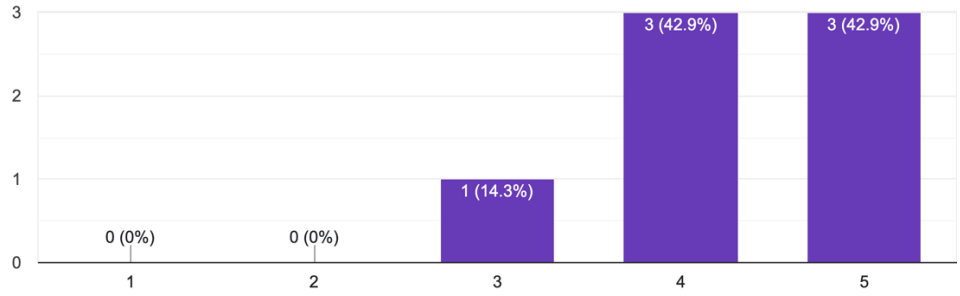
Have you ever screened participants for ACEs?

7 responses



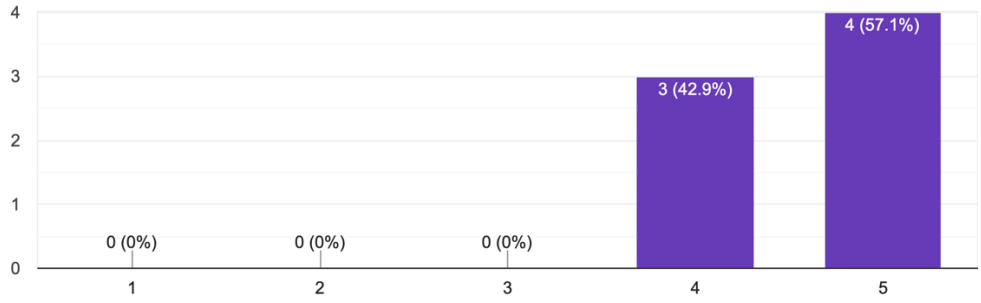
I feel confident screening my participants for ACEs

7 responses



How confident are you discussing trauma with participants?

7 responses



What are the barriers to implementing ACEs screening into your participant intake workflow?

7 responses

I feel like it can bring up some tramatic things, without being able to put a theraputic lid on it.

Have not been trained

I don't do intakes so n/a for me

Lack of formalized training

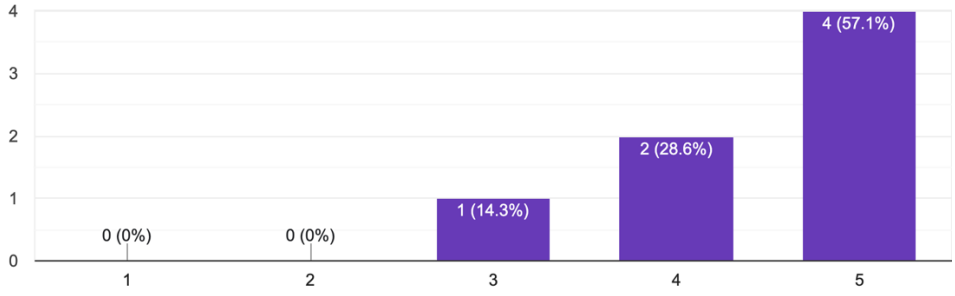
I believe the only "barrier" would be the additional time added. However, I do think it is worth the time.

I think a barrier might be the amount of intake forms we ask participants to complete with us when moving in, including safety plans, PORT tools, consent forms and ROI's. Spacing out the forms over multiple engagements would be a way to reduce that barrier.

Acuity of symptoms, difficulty capturing participants for intake paperwork

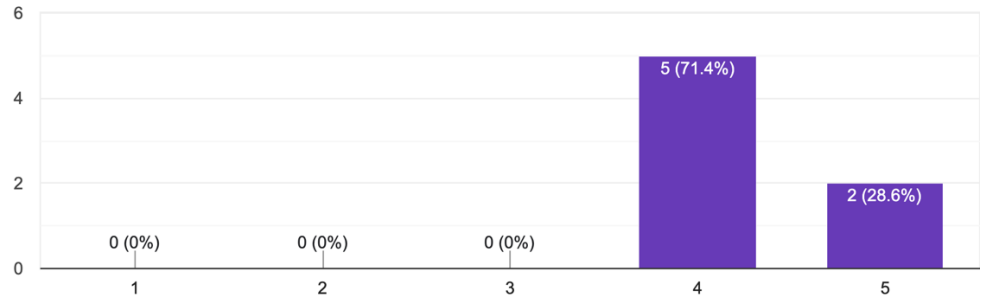
I would benefit from additional training on ACEs

7 responses



How familiar are you with trauma informed care?

7 responses



How would you define trauma informed care?

7 responses

Being aware that trauma exist and being mindful that your interactions with individuals can be hurtful without the intent. So approach with care, active listening, and a person centered mindset.

Understanding how trauma effects our clients in their abilities to live and access care

Approaching individual care through the lense that they have experienced trauma and that impacts how they interact with the world. Creating a safe place for them to process and live based on that trauma, and adjusting care plans to not be retraumatizing

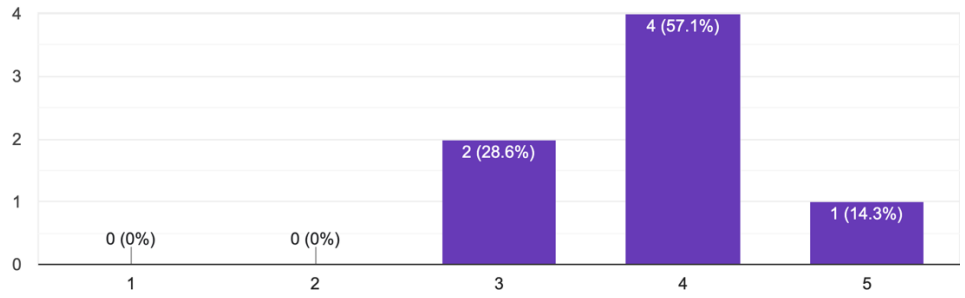
Recognizing the prevalence of trauma across a spectrum of lives experiences,

An adaptive approach that functions on the belief that everyone has trauma that has impacted them. It is an approach that focuses on creating a sense of safety and minimizing harm.

Acknowledging and being mindful on every level of interaction that someone may have experienced trauma and adjusting our approach and surroundings to create a space/relationship that isn't activating of any of the person's possible traumas.

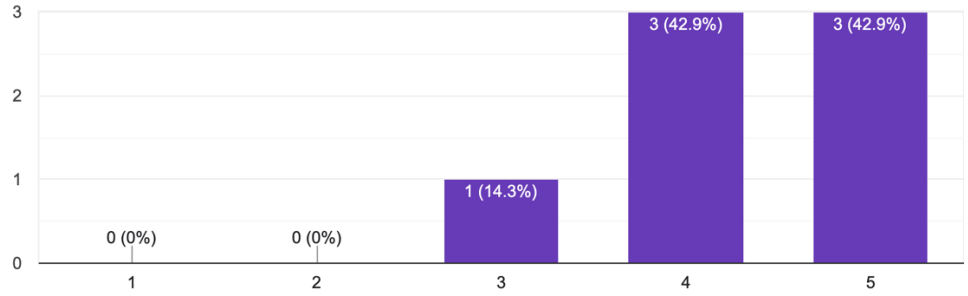
Do you feel New Narrative is a trauma informed workplace?

7 responses



I would benefit from additional training on trauma informed care

7 responses



What, specifically, might you want from the agency, your team, or your supervisors to best support participants when screening for ACEs and providing follow up care?

5 responses

To be mindful of the atmoshere the participant may be living in or dealing with at the time, before making mandatiry deadlines. I feel that an individual can participate in the ACE's when they have proper supports lined up. After I took it I was sad and a little depressed. If I wasn't already participating in therapy and practicing daily coping skills; it would have been hard to shake off.

Just keep the conversation going! The more we talk about it and the more training we get, the more we learn. Even if a lot of it is review, I think we should do TIC trainings consistently

More training

I would want more training for staff around how to support participants when discussing trauma, including when and how to draw boundaries when the topics become more therapy based as well as redirecting participant's to their therapist (if they have one) in a trauma informed way.

I would like to learn more about the follow up care after a screening has been completed.

Appendix B

Creating Cultures of Trauma-Informed Care: Program Fidelity Scale Version 1.3 (1-14)
Community Connections, Washington, D.C. (*Draft; not for distribution without the written permission of the authors.*)

Domain 1. Program Procedures and Settings: "To what extent are program activities and settings consistent with five core values of trauma-informed cultures of care: safety, trustworthiness, choice, collaboration, and empowerment?"

Domain 1A. Safety for Consumers and Staff—Ensuring Physical and Emotional Safety: *"To what extent do the program's activities and settings ensure the physical and emotional safety of female and male consumers and staff members?"*

Criterion/Indicators	1 None of the possible indicators is present.	2 One or two indicators are present.	3 Three indicators are present.	4 Four or five indicators are present.	5 Six or seven indicators are present.	Source of Evidence
1. Physical Setting: a) a) The area around the program (sidewalks and parking lots, e.g.) is safe for women and men and the program is accessible for both clients and staff. b) The program's entrance area and waiting room is safe and hospitable, offering adequate personal space; exits are clearly marked and accessible; c) If there are security personnel present, they are trained in customer service as well as in maintaining safety; d) The program's signage is clear and welcoming; it directs people to the most frequently used areas (e.g., rest rooms, intake and reception areas); e) The program's décor includes images and colors that fit well with the recovery goals of the clients; ideally, some of the art work, paint, and flooring should have been created or selected by a team of consumers; f) The program has designated "quiet spaces" for use by clients and staff who need or want a place of respite; g) Staff offices are safe and/or have appropriate safety back-ups like "panic buttons."						CEO Interview (CEOINT) Client Interview (CLINT) Staff Interview (STINT) Clinical Record Review (CRR) Policy Document Review (PDR) In-Person Observation (IPOBS) Survey Review (SURR)
	Findings ***Strengths:*** ***Challenges:***					

Creating Cultures of Trauma-Informed Care: Program Fidelity Scale Version 1.3 (1-14)
Community Connections, Washington, D.C. (*Draft; not for distribution without the written permission of the authors.*)

	1 None of the possible indicators is present.	2 One or two indicators are present.	3 Three indicators are present.	4 Four or five indicators are present.	5 Six or seven indicators are present.	Source of Evidence
2. Interpersonal Contacts: a) The program's first contact (by phone or in person) with prospective clients is welcoming and respectful. b) The staff (including the reception staff) are attuned to signs of distress among clients and respond in a gentle, compassionate way. c) In making contact with clients, staff take into account whether clients may be involved in potentially dangerous situations (e.g., domestic violence or living in a shelter); d) Clients are given clear guidelines in advance about what to expect of the program; e) All staff are given clear guidelines in advance about what to expect of the program; supervisors and managers set the tone by offering clear and reassuring messages about the program's tasks and expectations; f) All staff members (including senior administrators) feel supported when they have challenges in their work; "we are all in this together." g) Staff doing work that takes them into areas away from the office feel safe and supported by the program.						CEO Interview (CEOINT) Client Interview (CLINT) Staff Interview (STINT) Clinical Record Review (CRR) Policy Document Review (PDR) In-Person Observation (IPOBS) Survey Review (SURR)
	Findings ***Strengths:*** ***Challenges:***					

Creating Cultures of Trauma-Informed Care: Program Fidelity Scale Version 1.3 (1-14)
Community Connections, Washington, D.C. (*Draft; not for distribution without the written permission of the authors.*)
Domain 1B. Trustworthiness for Consumers and Staff—Maximizing Trustworthiness through Task Clarity, Consistency, Transparency, and Interpersonal Boundaries: ***"To what extent do the program's activities and settings maximize trustworthiness by making the tasks involved in service delivery clear, by ensuring consistency and transparency in practice, and by maintaining boundaries that are appropriate to the program?"***

Criterion/Indicators	1 None of the possible indicators is present.	2 One indicator is present.	3 Two or three indicators are present.	4 Four indicators are present.	5 Five indicators are present.	Source of Evidence
a) The program makes it clear who will do what, when and with what goals in mind; it is clear which actions will be taken and who is responsible for these actions—this is true in all aspects of the program's functioning, for both clients and staff. b) The program is transparent in the way it operates; administration and managers share information openly with staff and clients (without violating their own responsibilities regarding confidentiality) c) The program reviews its services with each prospective consumer, based on clear statements of the goals, risks, and benefits of program participation, and obtains informed consent from each consumer; new staff go through a parallel process in which expectations are clarified and responsibilities made clear. d) The program has a clear procedure for the review of any allegations of boundary violations, including sexual harassment and inappropriate social contacts. e) Administrators and supervisors consistently validate the importance of staff support.						CEO Interview (CEOINT) Client Interview (CLINT) Staff Interview (STINT) Clinical Record Review (CRR) Policy Document Review (PDR) In-Person Observation (IPOBS) Survey Review (SURR)
	Findings ***Strengths:*** ***Challenges:***					

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Domain 1C. Choice for Consumers and Staff—Maximizing Consumer and Staff Choice and Control. ***"To what extent do the program's activities and settings maximize consumer and staff experiences of choice and control?"***

Criterion/Indicators	1 None of the possible indicators is present.	2 One indicators are present.	3 Two or three indicators are present.	4 Four indicators are present.	5 Five or six indicators are present.	Source of Evidence
1. Routine Practice: a) Staff review the program's service options (e.g., types of services offered, locations, housing possibilities, choices regarding clinicians—including gender) with each consumer prior to the development of an initial recovery or service plan b) The program routinely asks consumers about how and when they would like to be contacted. c) The program ensures that each service option is as independent of others as possible, so that a consumer's choice about one service does not necessarily affect another. d) The consumer's goals are given the greatest weight in recovery planning. e) Staff members are provided options, when possible, regarding factors that affect their daily work (hours and flex-time; timing of leave; décor of office; trainings offered). f) The program offers a balance between autonomy and clear guidelines for staff members' work responsibilities; it is alert for ways to maximize staff choice regarding how they meet their job requirements.						CEO Interview (CEOINT) Client Interview (CLINT) Staff Interview (STINT) Clinical Record Review (CRR) Policy Document Review (PDR) In-Person Observation (IPOBS) Survey Review (SURR)
	Findings ***Strengths:*** ***Challenges:***					

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Criterion/Indicators	**1** None of the possible indicators is present.	**2**	**3** One indicator is present.	**4**	**5** Both indicators are present.	**Source of Evidence**
Crisis Preferences: a) The consumer collaborates in developing a plan (e.g., Wellness Recovery Action Plan and/or a crisis/safety plan) that indicates the consumer's preferred options, including responses from staff, in crisis situations. b) The program consistently takes into account these preferences in responding to client crises, including preferences regarding gender of supportive others.						CEO Interview (CEOINT) Client Interview (CLINT) Staff Interview (STINT) Clinical Record Review (CRR) Policy Document Review (PDR) In-Person Observation (IPOBS) Survey Review (SURR)
	Findings ***Strengths:*** ***Challenges:***					

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Domain 1D. Collaboration for Consumers and Staff —Maximizing Collaboration and Sharing Power: *"To what extent do the program's activities and settings maximize collaboration and sharing of power between staff and consumers? Between staff and supervisors and administrators?"*

Criterion/Indicators	**1** None of the possible indicators is present.	**2** One indicator is present.	**3** Two indicators are present.	**4** Three indicators are present.	**5** Four indicators are present.	**Source of Evidence**
a) The program has a routine and effective way of gathering consumer opinions about the program's direction and operations; weighs consumers' opinions in their decision-making; and communicates clearly with consumers the process of decision-making. Alternatives include a Consumer Advisory Board, regularly used focus groups, suggestion boxes, etc. b) The program has a routine and effective way of gathering staff opinions about the program's direction and operations; weighs staff opinions in their decision-making; and communicates clearly with staff the process of decision-making. All staff are included in any change process, including support staff. c) The program cultivates a model of doing things "with" rather than "to" or "for" consumers. d) The program creates ways to engage consumers as partners in plans for the recovery support services they need and want.						CEO Interview (CEOINT) Client Interview (CLINT) Staff Interview (STINT) Clinical Record Review (CRR) Policy Document Review (PDR) In-Person Observation (IPOBS) Survey Review (SURR)
	Findings ***Strengths:*** ***Challenges:***					

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Domain 1E. Empowerment for Consumers and Staff—Prioritizing Empowerment and Skill-Building: *"To what extent do the program's activities and settings prioritize consumer and staff empowerment and growth? For women and men?"*

Criterion/Indicators	1 None of the possible indicators is present.	2 One indicator is present.	3 Two or three indicators are present.	4 Four indicators are present.	5 Five or six indicators are present.	Source of Evidence
a) The program routine recognizes consumer strengths and skills in the planning, implementation, and evaluation of its services. b) The program routine recognizes all staff members' strengths and skills in the planning, implementation, and evaluation of its services. c) In each formal activity, the program helps to develop or enhance consumer skills explicitly. d) In each contact, the consumer feels validated and affirmed. e) The program offers training designed to strengthen or develop specific skills needed by staff in order to perform their jobs well. f) The program emphasizes shared accountability and responsibility throughout its hierarchy (in contrast to blaming the person with the least power).						CEO Interview (CEOINT) Client Interview (CLINT) Staff Interview (STINT) Clinical Record Review (CRR) Policy Document Review (PDR) In-Person Observation (IPOBS) Survey Review (SURR)
	Findings ***Strengths:*** ***Challenges:***					

Creating Cultures of Trauma-Informed Care: Program Fidelity Scale Version 1.3 (1-14)
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Domain 2. Formal Service Policies: "To what extent do the formal policies and procedures of the program reflect an understanding of trauma and recovery?"

Criterion/Indicators	1 None of the indicators are present.	2 One or two indicators are present.	3 Three or four indicators are present.	4 Five or six indicators are present.	5 Seven or eight indicators are present.	Source of Evidence
a) The program has developed written policies that seek to eliminate involuntary or coercive practices (seclusion and restraint, involuntary hospitalization or medication, outpatient commitment). For those programs whose clients are "mandated" to treatment, efforts are made to maximize the realistic choices enrollees have. These efforts are part of the program's written policies. b) The program has a written de-escalation policy that minimizes possibility of re-traumatization; the policy includes reference to a consumer's statement of preference for crisis response, including preferences regarding gender of those involved as supports. c) The program's policies regarding confidentiality (incl. limits and mandated reporting) and access to information are clearly written, maximize legal protection of privacy, and are communicated to each consumer. e) The program has clearly written and easily accessible policies outlining consumer and staff rights and responsibilities as well as a grievance policy. f) The program's policies address issues related to staff safety, e.g., community visits, being alone in an area of the building, incident reviews reduce staff vulnerability g) The program's policies address the need for debriefing after critical incidents, Both staff and clients involved in the incident are also engaged in the debriefing, which has as its goal an understanding and preventive approach (in contrast to a blaming one).. h) All services are based on trauma-informed values and the curricula and materials used are trauma-informed.						CEO Interview (CEOINT) Client Interview (CLINT) Staff Interview (STINT) Clinical Record Review (CRR) Policy Document Review (PDR) In-Person Observation (IPOBS) Survey Review (SURR)
	Findings ***Strengths:*** ***Challenges:***					

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Domain 3. Trauma Screening, Assessment, Service Planning and Trauma-Specific, Gender-Specific Services: "To what extent does the program have a consistent way to identify individuals who have been exposed to trauma and to include trauma-related information in planning services with the consumer? To what extent are trauma-specific services readily available"

Criterion/Indicators	1 None of the possible indicators is present.	2 One indicator is present.	3 Two or three indicators are present.	4 Four indicators are present.	5 Five or six indicators are present.	Source of Evidence
1. Screening, Assessment, and Service Planning: a) Universal Trauma Screening. Within the first month of service participation, every consumer has been asked about exposure to trauma. b) The trauma screening includes questions about lifetime exposure to sexual, physical, and emotional abuse. c) The trauma screening is implemented in ways that minimize consumer stress; it reflects considerations given to gender of interviewer, timing, setting, relationship to interviewer, consumer choice about answering, and unnecessary repetition. d) Unless specifically contraindicated due to consumer distress, the program conducts a more extensive assessment of trauma history and needs and preferences for trauma-specific services for those consumers who report trauma exposure. e) The program conducts gender-specific assessments for women and men, and for girls and boys, if applicable. These assessments are based on knowledge of gender differences in socialization as well as biology. f) Recovery planning is conducted in an individualized, person-centered way that is based on trauma theory and knowledge.			**Findings** ***Strengths:*** ***Challenges:***			CEO Interview (CEOINT) Client Interview (CLINT) Staff Interview (STINT) Clinical Record Review (CRR) Policy Document Review (PDR) In-Person Observation (IPOBS) Survey Review (SURR)

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Criterion/Indicators	1 None of the possible indicators is present.	2 One indicator is present.	3 Two or three indicators are present.	4 Four indicators are present.	5 Five indicators are present.	Source of Evidence
2. Trauma-Specific Services: a) The program ensures that those individuals who report the need and/or desire for trauma-specific services are either offered them on-site or referred for appropriately matched services. b) Trauma-specific services are effective; they have an evidence base for the population being served. c) Trauma-specific services are accessible. People can get to them easily and they are offered at times that meet the members' needs. d) Trauma-specific services are affordable for the members. e) Trauma-specific services, in style and content, are responsive to the preferences of the program's consumers.			**Findings** ***Strengths:*** ***Challenges:***			CEO Interview (CEOINT) Client Interview (CLINT) Staff Interview (STINT) Clinical Record Review (CRR) Policy Document Review (PDR) In-Person Observation (IPOBS) Survey Review (SURR)

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Domain 4. Administrative Support for Program-Wide Trauma-Informed Services: "To what extent do agency administrators support the integration of knowledge about trauma and recovery into all program practices?"

Criterion/Indicators	**1** None of the possible indicators is present.	**2** One indicator is present.	**3** Two or three indicators are present.	**4** Four indicators are present.	**5** Five indicators are present.	**Source of Evidence**
1. Overall Administrative Support: a) The program has adopted a formal policy or mission statement that refers to the importance of trauma and the need to account for consumers' experiences of trauma in all aspects of program operation. b) The program has a clear philosophy, reflected in its day-to-day operations, that takes trauma into account. The philosophy is reflected in written materials as well as in informal practices. c) The program has named a trauma specialist ("champion") and workgroup(s) to lead agency activities in trauma-related areas and provides needed support for these initiatives. d) The group reflects the composition of the staff and people in recovery in terms of gender, race, and cultural background. All constituencies in the program are represented on the workgroup. e) Program administrators monitor and participate actively in responding to the recommendations and activities of the trauma leadership team or workgroup						CEO Interview (CEOINT) Client Interview (CLINT) Staff Interview (STINT) Clinical Record Review (CRR) Policy Document Review (PDR) In-Person Observation (IPOBS) Survey Review (SURR)
	Findings ***Strengths:*** ***Challenges:***					

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Criterion/Indicators	**1** None of the possible indicators is present.	**2** One indicator is present.	**3** Two or three indicators are present.	**4** Four indicators are present.	**5** Five indicators are present.	**Source of Evidence**
2. Services Offered by the Program: a) The program offers simultaneous, integrated services for mental health, substance abuse, and trauma. b) The program uses role models and mentors, who may also be people in recovery. c) The program makes available, on site or by referral, primary care, spiritual, employment, and parenting services. d) The program offers specific services for pregnant women or makes referrals to such programs. e) The program offers child care or helps make arrangements for such care for parents who need it						CEO Interview (CEOINT) Client Interview (CLINT) Staff Interview (STINT) Clinical Record Review (CRR) Policy Document Review (PDR) In-Person Observation (IPOBS) Survey Review (SURR)
	Findings ***Strengths:*** ***Challenges:***					

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Criterion/Indicators	**1** None of the possible indicators is present.	**2**	**3** One indicator is present.	**4**	**5** Both indicators are present.	**Source of Evidence**
3. Trauma Survivor/Person in Recovery Involvement: a) Administrators actively solicit the opinions of people in recovery who have had experiences of trauma. By membership on a Consumer Advisory Board (CAB), by focus groups, by individual interviews, and/or by suggestion boxes, people in recovery can have their voices heard. Both male and female survivors are represented. b) People in recovery who have had lived experiences of trauma are actively involved in all aspects of program planning and oversight. Both female and male survivors are represented.						CEO Interview (CEOINT) Client Interview (CLINT) Staff Interview (STINT) Clinical Record Review (CRR) Policy Document Review (PDR) In-Person Observation (IPOBS) Survey Review (SURR)
	Findings ***Strengths:*** ***Challenges:***					

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Criterion/Indicators	**1** None of the possible indicators is present.	**2** One indicator is present.	**3** Two indicators are present.	**4** Three indicators are present.	**5** Four indicators are present.	**Source of Evidence**
4. Program Data-Gathering and Program Evaluation: a) Program gathers data addressing the needs and strengths of consumers who are trauma survivors and evaluates the effectiveness of the program and trauma-specific services. Gender, race, and age may be important categories in understanding these data. b) Administrators include at least five key values of trauma-informed cultures in consumer satisfaction surveys: safety, trustworthiness, choice, collaboration, and empowerment. The respondent's gender, race, and age may be factors considered in understanding these data. c) Administrators include at least five key values of trauma-informed cultures in staff satisfaction surveys: safety, trustworthiness, choice, collaboration, and empowerment. The respondent's gender, race, and age may be factor considered in understanding these data. d) Results of both the consumer and staff surveys are consistent with a trauma-informed culture. All ten of the key values ratings are at the "agree" or higher level on the rating scale.						CEO Interview (CEOINT) Client Interview (CLINT) Staff Interview (STINT) Clinical Record Review (CRR) Policy Document Review (PDR) In-Person Observation (IPOBS) Survey Review (SURR)
	Findings ***Strengths:*** ***Challenges:***					

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Domain 5. Staff Trauma Training, Education, and Support: "To what extent have all staff members received appropriate training in trauma and its implications for their work?"

Criterion/Indicators	**1** None of the possible indicators is present.	**2** One indicator is present.	**3** Two or three indicators are present.	**4** Four indicators are present.	**5** Five indicators are present.	**Source of Evidence**
a) All staff (including administrative and support personnel) have participated in at least 2.5 hours of "basic" trauma education that addresses at least the following: 1) trauma prevalence, impact, and recovery; 2) ensuring safety and avoiding re-traumatization; 3) maximizing trustworthiness (clear tasks and boundaries); 4) enhancing consumer choice; 5) maximizing collaboration; 6) emphasizing empowerment;. b) All staff have participated in at least 2.5 hours of education addressing the necessity of staff support and care in a trauma-informed context. c) All new staff receive at least one hour of trauma education as part of orientation. d) Direct service staff have received at least three hours of education involving trauma-specific techniques (e.g., grounding, teaching trauma recovery skills). e) All staff are provided adequate resources for self-care, including supervision, consultation, and/or peer support that addresses secondary traumatization.						CEO Interview (CEOINT) Client Interview (CLINT) Staff Interview (STINT) Clinical Record Review (CRR) Policy Document Review (PDR) In-Person Observation (IPOBS) Survey Review (SURR)
	Findings ***Strengths:*** ***Challenges:***					

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Domain 6. Human Resources Practices: "To what extent are trauma-related considerations part of the hiring and performance review process?"

Criterion/Indicators	**1** None of the possible indicators is present.	**2** One indicator is present.	**3** Two indicators are present.	**4** Three indicators are present.	**5** Four indicators are present.	**Source of Evidence**
a) Prospective staff interviews include trauma-related questions. (What do applicants know about trauma, including sexual, physical, and emotional abuse? About its impact? About recovery and healing? Is there a "blaming the victim" bias? Is there potential to be a trauma "champion?") b) Staff performance reviews include trauma-informed skills and tasks, including the development of safe, trustworthy, collaborative, and empowering relationships with consumers that maximize consumer choice. c) The program routinely assesses staff members' knowledge of trauma relevant for the program's goals (see content in Domain 5). This may be done following educational events or as part of performance reviews or in ongoing supervision. d) The program has a consistent way to recognize outstanding performance among staff.						CEO Interview (CEOINT) Client Interview (CLINT) Staff Interview (STINT) Clinical Record Review (CRR) Policy Document Review (PDR) In-Person Observation (IPOBS) Survey Review (SURR)
	Findings ***Strengths:*** ***Challenges:***					

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Agency/Program _____ **Date** _____

Person(s) Completing Scale:_____

Domain 1. Program Procedures and Settings

1A.1. **# of indicators**_____ **Rating.** _____
1.A.2. **# of indicators**_____ **Rating.** _____
1B. **# of indicators**_____ **Rating.** _____
1C.1. **# of indicators**_____ **Rating.** _____
1C.2. **# of indicators**_____ **Rating.** _____
1D. **# of indicators**_____ **Rating.** _____
1E. **# of indicators**_____ **Rating.** _____
Domain 1 Subtotal **# of indicators**_____ **Rating (average of the first seven ratings):** _____

Domain 2. Formal Services Policies

Domain 2 Subtotal **# of indicators**_____ **Rating:** _____

Domain 3: Trauma Screening, Assessment, and Service Planning

1. **# of indicators**_____ **Rating.** _____
2. **# of indicators**_____ **Rating.** _____
Domain 3 Subtotal **# of indicators**_____ **Rating (average of the two ratings):** _____

Domain 4: Administrative Support for Program-Wide Trauma-Informed Services

1. **# of indicators**_____ **Rating.** _____
2. **# of indicators**_____ **Rating.** _____
3. **# of indicators**_____ **Rating.** _____
4. **# of indicators**_____ **Rating.** _____
Domain 4 Subtotal **# of indicators**_____ **Rating (average of the four ratings):** _____

Domain 5: Staff Trauma Training and Education

Domain 5 Subtotal **# of indicators**_____ **Rating.** _____

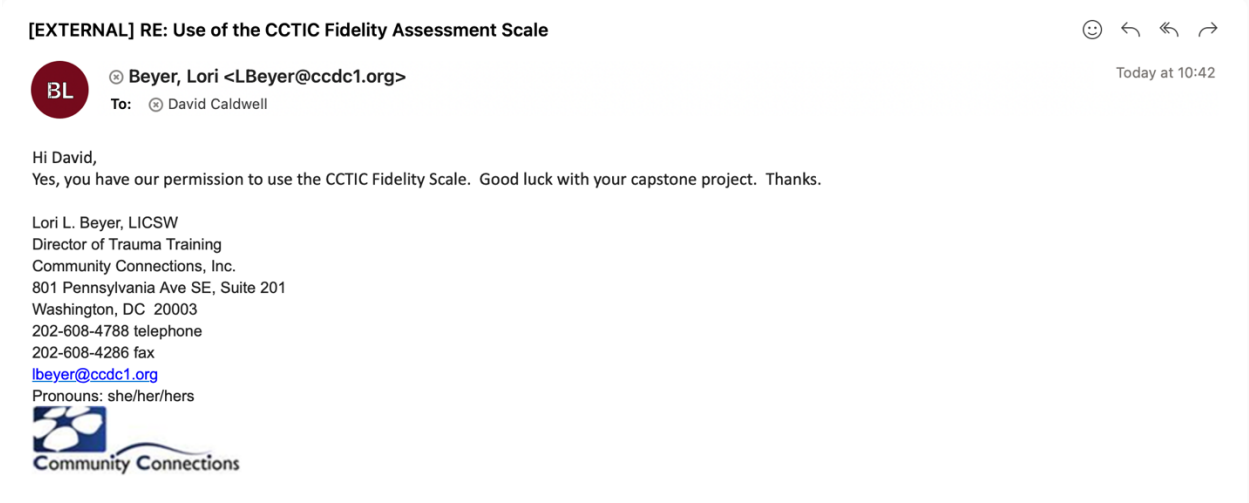
Domain 6: Human Resources Practices

Domain 6 Subtotal **# of indicators**_____ **Rating.** _____

Grand Total of Ratings (from right column)_____**÷ 6 = Overall Mean of** _____
Interpretive ranges for overall mean*: 1.00-2.00 = *Beginning the trauma-informed process;* 2.00-3.00 = *Not very trauma-informed;* 3.00-4.00 = *Somewhat trauma-informed;* 4.00-5.00 = *Very trauma-informed;* 5.00 = *Fully trauma-informed.

Grand Total of Indicators _____

 The authors gratefully acknowledge the assistance of Stephanie Covington, Eileen Russo, Colette Anderson, and Kim Selvaggi in developing and formatting this scale.



[EXTERNAL] RE: Use of the CCTIC Fidelity Assessment Scale

BL Beyer, Lori <LBeyer@ccdc1.org>
To: David Caldwell
Today at 10:42

Hi David,
Yes, you have our permission to use the CCTIC Fidelity Scale. Good luck with your capstone project. Thanks.

Lori L. Beyer, LICSW
Director of Trauma Training
Community Connections, Inc.
801 Pennsylvania Ave SE, Suite 201
Washington, DC 20003
202-608-4788 telephone
202-608-4286 fax
lbeyer@ccdc1.org
Pronouns: she/her/hers
Community Connections

Appendix C

Domain 1: Program Procedures and Settings	Rating
1A.1. Physical Settings	4
1A.2. Interpersonal Contacts	5
1B. Trustworthiness for Consumers and Staff	4
1C.1. Choice for Consumers and Staff	5
1C.2. Crisis Preferences	5
1D. Collaboration for Consumers and Staff	5
1E. Empowerment for Consumers and Staff	5
Average rating	**4.7**

Strengths:

- An established Peer Advisory Board had significant input into the design of physical spaces
- Weekly supervision meetings are conducted for all staff
- There is strong organizational transparency
- Leadership conducts "open houses" at multiple sites throughout the year sharing policy updates and creating space for staff questions and concerns
- The Clinic has both male and female clinicians to accommodate client preference
- Consumer and staff satisfaction surveys are conducted annually
- A variety of ongoing skills trainings are available to staff
- The Clinic has an official budget for ongoing staff training and skills building

Challenges:

- There is no room for clients to have officially designated "quiet spaces"
- The intake process is in flux as the intake department has been recently downsized to one employee
- Most intakes are conducted virtually. This has led to inconsistent intake procedures, difficulty establishing patient rapport, and delays in obtaining necessary consent forms
- Ongoing skills building is not required and necessitates self-initiative

Domain 2: Formal Services Policies	Rating

Domain subtotal	**5.0**
Strengths: • There is a very strong culture of support	
Challenges: • There are no officially written client de-escalation policies	

Domain 3: Trauma Screening, Assessment, and Service Planning	**Rating**
1. Screening, Assessment, and Service Planning	5
2. Trauma-specific services	3
Average rating	**4.0**
Strengths: • Individual therapists endorse a strong working knowledge of trauma and the importance of a trauma-informed workplace	
Challenges: • There is no standardized process for trauma screening • Trauma-specific services are primarily referrals to external providers • The availability of trauma-specific services to clients is based largely on their insurance or ability to pay out of pocket	

Domain 4: Administrative Support for Program-Wide Trauma-Informed Services	**Rating**
1. Overall Administrative Support	3
2. Services Offered by the Program	3
3. Trauma Survivor/Person in Recovery Involvement	5
4. Program Data-Gathering and Program Evaluation	3
Average rating	**3.5**
Strengths: • The organization operates with a strong philosophy supporting TIC • The Clinic has a strong referral network for a variety of services • 60% of staff identify has having lived experience with mental illness	
Challenges: • There is no designated trauma specialist or trauma-focused workgroup • The Clinic offers no substance abuse treatment • The Clinic is unable to provide childcare or childcare referrals to those in need • The Clinic does not gather trauma-related data from clients	

Domain 5: Staff Trauma Training, Education, and Support	**Rating**
Domain subtotal	**4.0**
Strengths: • The clinic offered a weekly, staff-led "Burnout Group" to support workplace wellness	

Challenges: • The "Burnout Group" has disbanded as the leader recently left the organization

Domain 6: Human Resources Practices	**Rating**
Domain subtotal	**4.0**
Strengths: • The Clinic maintains a staff appreciation budget used for events like staff lunches and social events • The Clinic sends monthly "Shout-Outs" to recognize notable performance by individual staff members	
Challenges: • The Clinic does not routinely assess staff knowledge of trauma	

Overall Rating Mean	**4.0**