

Criteria for Building a Trauma-Informed Mental Health Service System

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Adapted from “Developing Trauma-Informed Behavioral Health Systems”
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The following elements should be in place in any public mental health system committed to meeting the needs of clients who have histories of trauma. Trauma is defined here as interpersonal violence, over the life span, including sexual abuse, physical abuse, severe neglect, loss, and/or the witnessing of violence.

Administrative Policies/Guidelines Regarding the System

- 1. Trauma function and focus in state mental health department.** A single, high-level, clearly identified point of responsibility should exist within the state administrative structure charged with and supported in implementing trauma-informed service systems and use of evidence-based and emerging best practices in trauma throughout state supported services. This could be a senior staff, a unit or office within the department, and/or ongoing, high-visibility leadership on the part of the lead system administrator. This person or group should develop a written plan with trauma related goals, objectives and timelines, approved and activated by administration, and should meet regularly with system administrator.
- 2. State trauma policy or position paper.** A written statewide policy or position statement should be adopted and endorsed by administrative leadership, and disseminated to all parts of the service system, stakeholder groups, and other collaborating systems. This document should include a definition of interpersonal violence and trauma, make a clear statement about the relationship between trauma, mental health and recovery, and publicly declare trauma to be a priority health and mental health issue. Ideally, the position statement should commit the state to meeting the essential elements of a trauma-informed service system, and a trauma-specific clinical system. The *NASMHPD Position Statement on Services and Supports to Trauma Survivors* (www.nasmhpd.org) serves as a model of such a position paper.
- 3. Workforce Recruitment, Hiring, and Retention.** The system should prioritize recruitment, hiring, and retention of staff with educational backgrounds, training in and/or lived experience of trauma. This priority should be clearly described in job descriptions and postings. These staff or “trauma-champions” provide needed expertise and an infrastructure to promote trauma-informed policies, training and staff development, and trauma-based treatment and support practices throughout the service system. They advocate for consideration of trauma in all aspects of the system. There should be strategies for outreach to sources of prospective trauma-educated/informed employees (e.g. universities, professional organizations, peer-led and peer support programs,

consumer advocacy groups; other training sites). Professional organizations and universities should be approached to offer curriculums preparing students to work with trauma survivors. Incentives, bonuses, and promotions for staff and supervisors should take into account their role in trauma-related activities. Support and training should be provided for direct care staff to address impacts on staff of trauma work. There should be a written policy and regularly monitored plan for building and supporting workforce trauma-competency in all aspects of the service system.

Policies and procedures to ensure safety from sexual offenders should guide all recruitment, screening and hiring practices of both employees and volunteers, and guidelines should be established to prevent and respond to reported incidents of such abuse.

(Goal 5.3, 5.4: President's New Freedom Commission on Mental Health Final Report)

4. Workforce orientation, training, support, job competencies and standards related to trauma. All human resource development activities should reflect understanding of and sensitivity to issues of violence, trauma and coercion; incorporate relevant skill sets and job standards; and address prevalence and impact of traumatic events. Administrative policy should support accomplishment of the following goals.

All employees, including administration, should receive orientation and basic education about the prevalence and traumatic impacts of sexual and physical abuse and other overwhelming adverse experiences in the lives of service recipients. In order to ensure safety and reduction of harm, curriculums used for orientation and basic training should cover dynamics of retraumatization and how practice can mimic original sexual and physical abuse experiences, trigger trauma responses, and cause further harm to the person. All employees must also be educated about the impacts of culture, race, ethnicity, gender, age, sexual orientation, disability, and socio-economic status on individuals' experiences and perceptions of trauma and their unique ways of coping or healing.

Direct service staff and clinical staff should be educated in a trauma-informed understanding of unusual or difficult behaviors, in the maintenance of personal and professional boundaries, in trauma dynamics and avoidance of iatrogenic retraumatization, in the relationships between trauma, mental health symptoms and other problems and life difficulties, and in vicarious traumatization and self-care. They should learn application of trauma-informed issues and approaches in their specific content areas (including disaster response), and trauma-specific techniques such as grounding and teaching trauma recovery skills to clients. Curriculums and training programs for direct service and clinical staff should cover these issues.

Input from and involvement of persons (consumers and staff) with lived experience of trauma should be a part of all employee and staff trauma trainings.

Staff whose clinical work includes assessment and treatment, including those involved in disaster response, should be required and supported to implement evidence-based and promising practices for the treatment of trauma, and to attend ongoing advanced trauma trainings .

Disaster responders should be trained in trauma issues from the initial assessment through the intervention process, and disaster planning, policy and curriculums must include this.

Whenever possible, trainings and training programs should be multi-service system, inclusive of staff in mental health and substance abuse, disaster planning, health care,

educational, criminal justice, social services systems and agencies, and promoting systems integration and coordination.

(Goals 3.1, 3.2, 4.2, 4.3, 4.4, 5.3, 5.4: President's New Freedom Commission on Mental Health Final Report)

5. **Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.** The voice and participation of consumers who have lived experiences of trauma should be actively involved in all aspects of systems planning, oversight, and evaluation. Trauma-informed individualized plans of care should be developed in collaboration with every adult and child and child's family or caregivers receiving mental health system services. Consumers with trauma histories should be significantly involved in staff orientation, training and curriculum development and play a lead role in the creation of State Mental Health Plans, the improvement of access and accountability for mental health services, and in orienting the mental health system toward trauma and recovery. Special attention should also be paid to the rights of people with trauma histories (e.g. right to trauma treatment, freedom from re-traumatization, and rights to maximum choice, collaboration and empowerment) and to the ways in which these rights may be systematically violated. Administrative level policy or position statement should support these goals. *(Goals 2.1, 2.2, 2.3, 2.4, 2.5: President's New Freedom Commission on Mental Health Final Report)*

Administrative Policies/Guidelines Regarding Services

6. **Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.** Funding strategies for trauma-specific services should be clearly identified, and should eliminate disparities in mental health services by improving access to evidence-based and promising practices in trauma treatment. Existing exclusions and barriers to reimbursement should be eliminated. Although new funds are not necessarily critical to developing a trauma-informed system, the development of sufficient trauma-specific services to meet the treatment needs of the high percentage of clients with histories of unaddressed sexual and/or physical abuse and trauma may require creative fiscal reimbursement strategies. Attention to reimbursement and funding issues is key to a successful change strategy. *(Goal 3: President's New Freedom Commission on Mental Health Final Report)*
7. **Clinical practice guidelines for working with children and adults with trauma histories.** Findings from studies, including SAMHSA's Women, Co-Occurring Disorders, and Violence study and more recently studies involving traumatized children, increasingly provide evidence that trauma treatment is effective. Numerous clinical approaches have been manualized and guidelines have been developed. Clinical approaches to trauma treatment should clearly identify trauma as the issue being treated, promote recovery, allow for survivors to tell their stories, include trauma-sensitive training and supervision, address secondary trauma and self-care for the caregiver, respect cultural diversity, and be experienced as empowering by consumer/survivors.

8. **Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.** Policies and regulations that guide system-wide practices are central to ensuring that trauma-informed and trauma-specific assessment and services are adopted consistently. Trauma-informed policies and procedures are crucial to reducing or eliminating potentially harmful practices such as seclusion and restraint, involuntary medication, etc. They therefore must be carefully reviewed, revised, monitored and enforced to take into account the needs of trauma survivors. Licensing, regulations, certification, quality improvement tools and contracting mechanisms should all reflect a consistent focus on trauma. Policies and regulations addressing confidentiality, involuntary hospitalization and coercive practices, consumer preferences and choice, privacy, human resources, rights and grievances for employees are also key. They should be modified periodically to conform to developments in knowledge of evidence-based and emerging best practice and to promote provision of and access to trauma-informed and trauma-specific services. *(Goal 3: President's New Freedom Commission on Mental Health Final Report)*

9. **Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.** Data on trauma prevalence, trauma impacts, effectiveness of trauma services and consumer satisfaction can provide rationale for support/funding of such services and the training necessary for their implementation. Such data should be regularly collected and used as part of ongoing quality improvement and planning processes. Evaluation and research activities should be carried out through internal staffing or through liaison with external evaluators and researchers, to determine the effectiveness of systems change to a trauma-informed system, and to identify outcomes of trauma-related services. These findings are incorporated into ongoing services modifications and planning. *(Goals 5.1, 5.4: President's New Freedom Commission on Mental Health Final Report)*

Trauma Services

10. **Universal trauma screening and assessment.** All adults and children who enter the system of care, regardless of which “door” they enter, should be screened for abuse and trauma at or close to admission. At a minimum, questions should include histories of physical and sexual abuse, domestic violence, and witnessed violence. Individuals with a positive response to the screen should have a trauma assessment as an integral part of the clinical picture, to be revisited periodically and used as a part of all treatment, rehabilitation, and discharge planning. Clients with trauma histories should be informed about and referred to quality, trauma-informed and trauma specific services and supports.

11. **Trauma-informed services and service systems.** A “trauma-informed” service system and/or organization is one in which all components of the system have been reconsidered and evaluated in the light of a basic understanding of the role that violence and trauma play in the lives of people seeking mental health and addictions services. A “trauma-informed” organizational environment is capable of supporting and sustaining “trauma-specific” services as they develop. A trauma-informed system recognizes that trauma results in multiple vulnerabilities and affects many aspects of a survivor’s life over the

lifespan, and therefore coordinates and integrates trauma-related activities and trainings with other systems of care serving trauma survivors. A basic understanding of trauma and trauma dynamics, including that caused by childhood or adult sexual and/or physical abuse shown to be prevalent in the histories of mental health consumers, should be held by all staff and should be used to design systems of services in a manner that accommodates the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid retraumatization and facilitate consumer participation in treatment. A trauma-informed service system is knowledgeable and competent to recognize and respond effectively to adults and children traumatically impacted by any of a range of overwhelming adverse experiences, both interpersonal in nature and caused by natural events and disasters. There should be written plans and procedures to develop a trauma-informed service system and/or trauma-informed organizations and facilities with methods to identify and monitor progress. Training programs for this purpose should be implemented. *(Trauma-informed service systems increase capacity to address Goals 2, 3, 4 and 5 in the President's New Freedom Commission on Mental Health Final Report)*

- 12. Trauma-specific services, including evidence-based and promising practice treatment models.** Services designed specifically to treat the actual sequelae of sexual or physical abuse and other psychological trauma should be available in adequate numbers to serve the population and should be accessible to all consumers, including adults, adolescents, and children and their families. As part of national research initiatives including the SAMHSA *Women, Co-Occurring Disorders, and Violence* study and SAMHSA's *National Child Traumatic Stress Network*, numerous evidence-based and promising practice trauma treatment models appropriate for adults or children and applicable in public sector service systems, have been manualized and in many cases proven to be effective in reducing symptoms. Many of these evidence based and promising practice models have been identified in the SAMHSA publication "Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services". Selected models should be implemented by state mental health systems to treat trauma. Health technology and telehealth should be used to make these programs accessible for individuals in remote areas or in underserved populations. Although program models may vary widely, all should be recovery-oriented, emphasize consumer voice and consumer choice, and be fully trauma-informed. In addition, because of the numbers of adult and adolescent trauma survivors with co-occurring disorders, and given significant positive findings from studies such as the WCDVS, trauma treatment programs should provide integrated trauma, mental health and substance abuse services and counseling designed to address all three issues simultaneously. *(Goals 2.1; 3; 4.3; 5.2; 6.1 President's New Freedom Commission on Mental Health Final Report)*