CREATING THE CONDITIONS FOR CHANGE:

Emerging Policies to Promote and Support Trauma-Informed Care

All over the country, across multiple systems serving vulnerable or underserved populations, there is increasing understanding about the long-term impact of adversity on health and well-being. Developments in neuroscience and developmental neurobiology, combined with findings from the seminal Adverse Childhood Experiences study,[1] have heightened awareness of a reality that is no secret to individuals with lived experience and the providers who offer them support: painful, traumatic experiences in childhood and across the lifespan have a powerful impact on life trajectories. Moreover, while adversity is surprisingly common in the general population, this fact pales beside the prevalence among youth and adults in community-based mental health services and certainly among transition-age youth and emerging adults using these services, where estimates of childhood trauma are as high as 94%.[2] This information has been the impetus for a paradigm shift in how we think about mental and behavioral health.

On the ground, however, the real game changer is understanding how the impact of trauma manifests in service settings. We now have evidence for what survivors, advocates, and many providers have been saying all along: our service systems have frequently re-traumatized those we are trying to help, making it difficult or impossible for individuals to engage in and benefit from services. This more widespread understanding has resulted in an explosion in demand for training, resources, and technical assistance to transform programs and agencies to be more responsive to trauma survivors.

WHAT HAS BEEN THE ROLE OF POLICY IN THIS TRANSFORMATION?

The term *policy* is used in different ways, but fundamentally refers to a course of actions or a set of decisions that is designed to shape what happens in the future. Often, policy establishes principles or guidelines as well as actions, and this has been very much the case with Trauma-Informed Care (TIC). Policy occurs at the macro level when government (whether federal, state, or local) creates policies to influence large spheres of activity. Policy can also be created across systems; for example, when state agencies co-create policies for children or adults they serve in common (such as county-wide housing systems that agree to common criteria for entry) or when a consortium of local providers decides on a common referral and intake process. Policy, of course, also occurs at the agency and even program level, directly affecting employees, service provision, and the individuals receiving services. Policy can be written into federal or state law through legislative action, formally written in agency policy manuals, or – particularly at the agency level – understood and operationalized in practice, but not necessarily documented.

Federal policy is critical because it brings funding. Federal priorities are reflected in the allocation of grant dollars that drive research and stimulate new programming and innovation in the field. For example, the Children's Health Act of 2000 established the National Child Traumatic Stress Network (NCTSN).[3] This critical policy decision created regional trauma initiatives all over the country. NCTSN efforts have directly fostered

training, inter-agency collaboration, learning collaboratives, and, in some cases, statewide efforts to ensure that all services to vulnerable children and families are informed by an understanding of TIC.

More recently states have come forward to establish policies that set broad expectations for how providers will operate, and in some cases, offer incentives or resources for implementation. These are some examples of what state policy can do:

- Convey a commitment to TIC. Connecticut wrote a set of guiding principles into policy for the Department of Mental Health and Addiction Services.[4] These include a mix of specifics (universal screening, for example) and broader principles such as collaboration and client-centered care.
- Establish an office or project coordinator for Trauma-Informed Care within health or behavioral health divisions that is charged with creating a strategic plan, developing regional learning collaboratives, or providing technical assistance (for examples, see Ohio[5] and Wisconsin[6,7]). A number of states, including Wisconsin[6,7] and Nebraska,[8] have created state TIC advisory workgroups to ensure sustained commitment and action or have established public-private partnerships.
- Require contracted providers to demonstrate their commitment to TIC. Oregon's new trauma policy[9] in the Addiction and Mental Health Division of the state's Health Authority sets overall guidelines but also an expectation that funded and/or licensed services and supports will outline a process to become trauma-informed, ensure the availability of trauma specific services, and follow specified implementation plan guidelines.
- Offer incentives or support for implementation efforts. Nebraska's Region V has offered mini-grants for agencies participating in the statewide workgroup to "promote and support efforts in creating agency cultures of trauma-informed service delivery and enhance the trauma specific service options available".[8] Suggested activities for these mini grants cover a wide range of possible ways that an organization might choose to move forward.[8] Oregon's policy specifies that the state will provide resources for education, technical assistance, toolkits and other supports.[9]
- Build trauma-informed care into health care transformation. With the emphasis on integrating mental and behavioral health into a *medical home* – combined with the compelling evidence from the Adverse Childhood Experiences study[10] – some state legislatures, notably Vermont, have grappled with whether to institutionalize the routine screening of children and/or parents for ACEs in pediatric care.[11]

In Oregon, renewed advocacy for trauma-informed care took root in the Children's System Advisory Council (CSAC) and with other key partners at the Oregon Health Authority Addiction and Mental Health Division, but it was 10 long years before it resulted in legislative action. When it did, in 2014, a comprehensive policy was passed and Trauma Informed Oregon (TIO) was established.[12] TIO is a partnership between the state and two universities that brings social work and health care together. TIO is charged with coordinating and disseminating resources and information, providing training across the state, increasing training capacity and sustainability, providing technical assistance and evaluation, and bringing the voice of providers, youth, families, persons with lived experience, and diverse communities into policy decisions.

POLICY AT THE PRACTICE LEVEL

Within community-based organizations providing direct services, policy to support trauma-informed care is relatively new but emerging rapidly. Practice level policy change is likely to be the fastest growing aspect of transformation across mental and behavioral health-care systems over the next few years. Why is this so? In some cases, state policies require contracted agencies to incorporate TIC into their mission and programming. However, local policy is also emerging in response to the groundswell in the workforce and among advocates, youth, adults, and families who "get it" and are asking for meaningful and sustained change. As little as five years ago, champions for TIC were focused on building awareness, and educating and convincing others. This is still the case in some of our service systems but in others, little convincing is needed. It is rapidly becoming a question of not whether it's important, but of what to do about it. Policy is both leading and following the charge, supported by a growing body of knowledge and resources; for example, see SAMHSA's "Concept of Trauma and Guidance for a Trauma-Informed Approach."[13]

The deputy director and senior colleagues at Impact Northwest, a multi-service organization in Portland, OR, implemented an agency-wide self-assessment process developed by Community Connections in Washington, DC (see http://www.communityconnectionsdc.org). They also created a multi-level workgroup, and developed a strategic plan to address key findings from the assessment. This included making significant shifts in staff training, supervision, and practice as well

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as rewriting the manual on Standard Operating Procedures to reflect the principles of TIC. At Clackamas Behavioral Health Care (see http://www.clackamas.us/behavioralhealth), also in Oregon, the executive director wanted to set a standard for the agency. In addition to supporting a workgroup to prioritize and address issues affecting staff and clients, she created an agency-wide TIC policy that includes guiding principles; such as client-centered, culturally responsive, and collaborative planning, as well as specifics such as education and training for staff and expectations for screening and assessment of clients.

Sometimes, however, change comes from the bottom up. At Human Solutions, a large housing and anti-poverty agency in the Portland area, resident services staff joined a county-wide Trauma-Informed Care Learning Community and subsequently created a small support group to talk about what they could do in their own work that would make a difference. The group created and delivered a presentation to the agency's board of directors (with permission). It was not difficult to get buy-in at that level, and an expanded workgroup developed and delivered training modules to each department. What started as a very small effort has resulted in policy changes that are accumulating across the entire system:

- Trauma-informed care has been incorporated into hiring and onboarding for all staff, with special orientation for new supervisors.
- A skills survey that is part of annual employee reviews includes TIC goals for the coming year and reflection on how TIC was incorporated in the previous year.
- Forms and procedures that affect staff and clients are reviewed through a lens of trauma-informed care before they are implemented.

Policy changes also include care of the workforce and and should involve program participants as well. This was the case, for example, in a women's residential treatment program, where the program director established a resident council that meets weekly. These local policy actions cluster into three important categories:

- Agencies can *ADD* critical policies, as in some of the examples noted above, to reflect a commitment to TIC and the principles that are needed to implement it.
- Agencies can also reflect their commitment to TIC by *DROPPING* policies that, upon review, are recognized as *not* trauma-informed and unnecessary, such as intake procedures that require answering intrusive questions likely to activate a trauma response with no real purpose. Other examples include unexamined rules in residential facilities regarding "lights out," cell phones, cigarette breaks, or computer or television use that have an historical basis but may have no current value and have not been reconsidered in decades.
- Some policies cannot be eliminated – either because they serve a legitimate purpose (e.g., keeping everyone safe) or because they are required by law and are beyond the agency's control. Frequently, TIC workgroups can *AMEND* these necessary policies, changing the provisions and/or the wording to be more respectful and sensitive to the needs of trauma survivors. The TIC Workgroup from the Homeless Youth Continuum, in Multnomah County, OR, for example, reviewed and made substantial changes in the joint *exclusion policy* that specifies whether a youth might or might not be allowed to return for services after termination.

WHAT'S NEXT?

These examples are a tiny fraction of all that is happening as more states, health and behavioral health systems, providers, and advocates come on board every day. As this transformation continues to unfold and gain momentum in systems that are newer to trauma-informed care, there are several areas where thoughtful policy development will be greatly needed. They include:

- Integration of principles of equity and empowerment into TIC training and implementation. The impact of historical trauma, community and system oppression, and micro-aggression cannot be overstated.

- Inclusion of individuals with lived experience, youth, families, diverse communities, and populations in every aspect of policy development at all levels.
- Inclusion of parallel process in policy;[16] i.e., the understanding that TIC cannot be implemented unless it addresses the experience of the workforce along with the experience of the individuals seeking services or supports.
- Standards of practice for trauma-informed care. Much progress is being made to operationalize the principles of TIC, but concrete measures of implementation are lacking.
- Evidence for the impact of TIC. Along with assessing implementation, we need to demonstrate that it makes a difference in the engagement, retention, and outcomes for individuals seeking services, and for the health and well-being of the workforce.

Policy to support TIC is emerging and changing so rapidly that this article will be outdated well before it goes to press. Some of that policy will be effective and some may not be, but the movement to better address the needs of trauma survivors is here to stay. Whether policy change happens at the federal, state, or agency level – and whether it happens from the top down or the bottom up – if it acknowledges the impact of trauma on survivors and their support networks, it will help improve the quality of care.

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AUTHOR

Diane K. Yatchmenoff is Adjunct Research Faculty at the School of Social Work, Portland State University, and Director of Trauma Informed Oregon, a partnership between the Oregon Health Authority, Portland State University, and the Oregon Health Sciences University.

Regional Research Institute for Human Services, Portland State University.
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