

# Programs Addressing ACEs and Trauma in Illinois

*In 2016, the Illinois ACEs Response Collaborative conducted an Environmental Scan of programs addressing adverse childhood experiences (ACEs) and trauma in multiple sectors. The Scan yielded information from 339 local, state, national and international programs. This paper identifies successful ACE-related policies, programs, and models utilized by these programs highlighting the essential elements and characteristics needed to foster effective interventions.*

*Findings from the  
Illinois ACEs  
Response  
Collaborative's  
National  
Environmental  
Scan*

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## *Executive Summary*

With support from the Illinois Children's Healthcare Foundation and the Health Federation of Philadelphia, the Illinois ACEs Response Collaborative (the Collaborative) conducted an Environmental Scan of programs addressing ACEs and trauma in multiple sectors. The Scan yielded information from 339 local, state, national and international programs through research and an online survey. The survey was enhanced through 21 in-depth interviews with a subset of participants.

In 1995, the Centers for Disease Control's (CDC's) groundbreaking Adverse Childhood Experiences (ACEs) Study first uncovered the profound connection between ACEs—experiences of abuse, neglect, and household dysfunction before the age of 18—and adults' health and social outcomes. They demonstrated that traumatic childhood experiences are a root cause of many social, emotional, physical and cognitive impairments that lead to increased incidence of health risk behaviors, violence or re-victimization, disease, disability and premature mortality.<sup>1</sup>

As recognition of the impact of trauma increases across social services agencies, educational and justice systems, state and local government, public health entities, health care systems and advocacy groups, the desire to provide trauma-informed care is at the forefront of a movement to build resilience and prevent and mitigate the impact of childhood adversity. At the same time, creation of the knowledge base necessary to build trauma-informed organizational structures to support this movement is ongoing and incomplete with many evidence-based solutions at early phases of development, implementation and evaluation.

Given this growing momentum for change, the goal of this Environmental Scan is to uncover essential characteristics, promising practices, and obstacles that exist for meaningful systems change. We also offer recommendations gleaned from our findings on how to integrate the science of ACEs and resilience into program and systems change efforts.

The Scan uncovered that there is great variance in implementing trauma-informed care as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA). There has been significant progress by those implementing direct behavioral health services to clients already affected by trauma using a wealth of trauma-specific treatment modalities for a variety of populations. The long-term processes of transforming whole organizations or systems to not only respond to but prevent further trauma is less documented. The environmental scan demonstrates that implementing clinical services specific to trauma is more prevalent than utilizing organizational change strategies that incorporate the science of ACEs into the daily operations of all levels of a system to prevent unintended consequences for those who have experienced trauma, including the workforce.

Through the Scan, we learned from organizations that inclusion of on-going, sequential training and peer learning opportunities were critical for success in building trauma-informed organizations.

That said, training budgets are scarce and one-off trainings often have to suffice in place of integrated professional development. While there are training experts in Illinois, often a convener must create pathways for learning and facilitate access to such thought leaders. Learning Collaboratives, peer support groups and increased access to free webinars and trainings can support those gaining momentum in their trauma-informed approaches.

Other barriers to success include insufficient funding and lack of access to training. Those in rural areas often have to travel long distances for training, a time and resource drain for already-stretched professionals. State budget cuts and unpaid contracts have caused nonprofits to work with inadequate funding that does not allow time or money to be allocated to the professional development critical for advancing trauma-informed care. Competition for ever-dwindling funding often reinforces silos and may inhibit peer support and collaboration.

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*A trauma-informed approach recognizes historical trauma, intergenerational issues of trauma and the ways that the transmission of ACEs damages the health of a population in a variety of ways.*

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Inadequate funding for appropriate evaluation has also been identified as a major obstacle, which often hinders programs' abilities to demonstrate effectiveness and, consequently, receive future funding. Great innovation is happening in Illinois, but without proper evaluation, much of it is not being recorded or disseminated in ways that strengthen the knowledge base of the field. In order to effectively measure interruption of the multi-generational transmission of ACEs, paradigm shifts and major systems changes must occur over long periods of time, often decades. The ability to measure such long term changes and their origins remains elusive.

Additionally, silos remain among programs providing similar services. In some settings like hospitals and social service agencies where multiple departments exist, integration of ACEs-informed care is often only carried out in clinical, direct service or behavioral health settings, not across the organization as a whole. There are growing movements, such as trauma-informed schools and hospitals, which seek to foster the whole-system organizational shifts required for integrated approaches which prevent and address trauma, where every employee in the organization shares the responsibility to ensure that such approaches are carried out through policy and practice. Organizational shifts have occurred through the work of "resilience teams," "ambassadors," "champions" and "train-the-trainer" models that build capacity and seed new leaders throughout a system. Success in organizational change strategies is often evidenced when leadership engages in public acts of support of the new paradigm, such as attending trainings and integrating self-care practices for staff into regular operations.

Just as systems are beginning to recognize and address the pervasive impact of ACEs on the populations they serve, they also are growing to understand how their employees are affected by secondary (or vicarious) trauma, the trauma that results from witnessing the suffering of others. Organizations that are able to normalize, prevent and address secondary trauma affecting their workforce offer specific strategies throughout their agencies to incorporate trauma-sensitive

practices such as reflective supervision, flexible schedules, onsite mindfulness practices and generous behavioral health benefits. Investing in staff health and recognizing the needs of the workforce that provides trauma-informed and trauma-specific services is critical to the sustainability of this movement.

Finally, the recognition that a public health approach is essential to move the dial on prevention, mitigation and treatment of the consequences of childhood adversity is just starting to gain traction in Illinois and nationally. A trauma-informed approach recognizes historical trauma, intergenerational issues of trauma and the ways that the transmission of ACEs damages the health of a population in a variety of ways and across generations. A public health approach offers the necessary structure to integrate systems-level changes and provides guidance on how to shift policy and practice proactively to address ACEs and build resilience across communities. Leaders in this public health approach include the Illinois ACEs Response Collaborative, but the acceptance of this upstream strategy is often overshadowed by our collective sense of urgency to address specific trauma as it occurs.

The following recommendations emerged after analysis of lessons learned from this Environmental Scan:

#### **RECOMMENDATIONS**

1. Create learning collaboratives for those doing similar work and/or using similar models.
2. Increase training opportunities, including virtual learning. Utilize local talent whenever possible to provide trainings.
3. Utilize systems-level collaboratives, like the Illinois ACEs Response Collaborative, to connect to local trainers and content experts.
4. Create an Illinois-based training institute for trauma-informed care.
5. Initiate evaluation from the start of training and program development.
6. Acknowledge and normalize the prevalence of secondary trauma and incorporate preventive strategies to keep staff healthy and improve retention.
7. Acknowledge the level of commitment of time, resources and staff required to become trauma-informed and adjust funding and reporting periods to reflect the need to shift culture.
8. Expand trauma-informed practices beyond direct services and behavioral health settings to all systems that interface with children, families and communities.
9. Seed and foster internal champions throughout organizations and communities.
10. Integrate behavioral health with primary health.
11. Incorporate historical trauma into trainings and policy and practice recommendations.
12. Support public health approaches to building resilience and incorporate the power of community building to achieve needed outcomes.

# Introduction











This report is an Environmental Scan of programs addressing ACEs/trauma in the Chicago area, Illinois and nationally, and, to a limited extent, internationally. This paper will first provide an overview of ACEs and trauma followed by SAMHSA’s principles of trauma-informed care and definitions of trauma-informed strategies. Next, we will present results from two phases of analysis, which highlight elements of successful trauma-informed approaches as well as challenges experienced by those working to incorporate these approaches into their organizations. Finally, we will present recommendations gleaned from this research in an effort to move the field forward based on the lessons from the Scan.

## Introduction to ACEs

In 1995, a landmark study by the Centers for Disease Control and Kaiser Permanente first uncovered the profound connection between Adverse Childhood Experiences (ACEs)—experiences of abuse, neglect, and household dysfunction before the age of 18—and adults’ physical, emotional and social health outcomes. The results were striking. The study revealed that ACEs were common: about two thirds of participants had at least one experience of adversity.

These results have subsequently been replicated in thirty states and internationally. The researchers also discovered that as the number of ACEs increased, the likelihood of cancer, diabetes, depression, homelessness, teen pregnancy, school problems, unemployment, justice involvement and a range of other life challenges increased as well. In short, they found that ACEs are the root cause of many of our most pressing health and social challenges from illness to community violence, poverty and other health and social problems. An ACE score of 6 or more can reduce a person’s lifespan by almost 20 years.

### The Three Types of ACEs

ABUSE	NEGLECT	HOUSEHOLD DYSFUNCTION	
 Physical	 Physical	 Mental Illness	 Incarcerated Relative
 Emotional	 Emotional	 Mother treated violently	 Substance Abuse
 Sexual		 Divorce	

Source: Centers for Disease Control and Prevention

The original 1998 study chose 10 aspects of adverse childhood experience to study. Since then, the definition of adverse experience has been expanded to emphasize the embodiment of a range of traumatic experience including, but not limited to, being a victim of extreme discrimination (racism, homophobia); a victim of or witness to community violence or war; being a refugee; or experiencing severe social deprivation including poverty, hunger and homelessness). Trauma result from an event, series of events or set of circumstances that is experienced as physically and/or emotionally harmful or threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, and/or spiritual well-being.<sup>2</sup>

ACEs are such a powerful determinant of health because they affect us at critical moments of physiologic development, altering the structure of our growing brains and the brain's ability to signal other organs. This derailment of normal brain development can impact us across the lifespan by affecting a child's ability to pay attention in school, a teen's capacity to control their temper or a young parent's success holding a job.

Moreover, without adequate family intervention and support, ACEs often are transmitted from one generation to the next. In addition to their human toll, the CDC estimates that the financial cost of child abuse and maltreatment is \$124 billion annually. In order to create and sustain healthy communities, we must look upstream and address the root causes of poor health and suffering. By targeting ACEs, there is potential not only for profound health improvements but also for progress in educational outcomes, violence prevention, community wellbeing, and reduction of health, criminal justice and other social expenditures.

Although the frequency and impact of ACEs is shocking, there is great reason for hope. Trauma-informed programs are being developed across the country in the education, justice, health and other sectors to prevent childhood adversity. By learning about ACEs and taking action in our homes, communities and workplaces, we can treat and beat the staggering problems we face as a nation.

## The Illinois ACEs Response Collaborative

The Illinois ACE Response Collaborative (the Collaborative) represents a broad range of community and academic organizations, thought and practice leaders and public agencies committed to expanding understanding of the impact of childhood trauma and ACEs on the health and well-being of Illinois residents and communities. Collaborative members were instrumental in supporting Illinois to include an 11 question ACE Module in the 2013 Illinois Behavioral Risk Factor Surveillance System (BRFSS), a national health telephone survey which provided key data about ACE exposure in Illinois. The Collaborative has also convened large groups of professionals and community members to raise awareness about ACEs and has consulted to hospitals and civic leaders about trauma and trauma-informed practices.

While we are proud of our accomplishments, in Illinois we are still in the early stages of mitigating the impact of ACEs on our population's health and are just beginning to identify promising practices that work to address ACEs in different sectors. Our role—one the Collaborative is uniquely suited for—is to share what is working and how it can be applied across systems to improve individual health and well-being, as well as strengthen families and communities. We have the expertise, policy development knowledge, and relationships to advance the work of educating healthcare providers, health systems, policy makers, and others to create change and address childhood trauma and its harmful impact on health.

While ACEs research emphasizes how deeply trauma impacts health outcomes, it also offers a powerful lens to guide the development of solutions to our most pressing public health problems. The Collaborative illustrates the power of systems-level cooperation to address the transmission of ACEs from one generation to the next. The successes of the Collaborative are grounded in a commitment to a collective impact framework, recognizing that no single organization or sector can build community resilience alone. By expanding ACEs research in Illinois, learning from effective interventions in other states and communities and strengthening the relationships among the



groups in our state working to address ACEs, we can develop the policies and interventions we need to reduce ACEs and their harmful impact on our health.

## *Trauma-Informed Care and the Context of the Environmental Scan*

The following definitions, principles, and domains are provided by SAMHSA and are being used consistently throughout the field—as well as in our sample—as a uniform way to convey such concepts. SAMHSA is an agency in the U.S. Department of Health and Human Services that “leads public health efforts to advance the behavioral health of the nation. The agency’s “mission is to reduce the impact of substance abuse and mental illness on America's communities.”<sup>3</sup> The definitions, principles and domains below will be referenced throughout this report and are sourced from “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach” prepared by SAMHSA’s Trauma and Justice Strategic Initiative in July 2014.<sup>4</sup> SAMHSA has been a leader and supporter of spreading trauma-informed care work and, therefore, is regarded as the most respected resource and its terminology is utilized consistently in this report.

### SAMHSA’s Definitions, Principles and Domains

#### Trauma

“Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.”<sup>1</sup>

#### Trauma-Informed Approach<sup>5</sup>

“A program, organization, or system that is trauma-informed:

- **Realizes** the widespread impact of trauma and understands potential paths for recovery;
- **Recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
- **Responds** by fully integrating knowledge about trauma into policies, procedures, and practices; and
- Seeks to actively **resist re-traumatization**.

A trauma-informed approach can be implemented in any type of service setting or organization and **is distinct from trauma-specific interventions** or treatments that are designed specifically to address the consequences of trauma and to facilitate healing.”

## Trauma-Specific Interventions

**Trauma-specific** interventions generally recognize the following:

- The survivor's need to be respected, informed, connected and hopeful regarding their own recovery
- The interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression and anxiety
- The need to work in a collaborative way with survivors, family and friends of the survivor and other human services agencies in a manner that will empower survivors and consumers

Therefore, trauma-informed care (TIC) is a framework that any person can implement, regardless of discipline or education level. Trauma-specific services are more targeted interventions employed by a person specifically trained to treat and transform trauma. Trauma-specific approaches are usually clinical and ideally evidence-based. They follow a specific trauma treatment model that takes into account the client's cultural and gender-specific needs.

## SAMHSA's Six Key Principles of a Trauma-Informed Approach<sup>6</sup>

Rather than a prescribed set of practices or procedures, a trauma-informed approach reflects adherence to six key principles. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific:

### **1. Safety**

Throughout the organization, staff and the people they serve feel physically and psychologically safe.

### **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 those receiving services.

### **3. Peer support and Mutual Self-Help**

These are integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety and empowerment.

### **4. 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. 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.

### **5. Empowerment, Voice and Choice**

Throughout the organization and among the clients served, individuals' strengths are recognized, built on and validated and new skills developed as necessary. 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. This includes a belief in resilience and in the ability of individuals, organizations and communities to heal and

promote recovery from trauma. This builds on what clients, staff and communities have to offer, rather than responding to perceived deficits.

## **6. Cultural, Historical and Gender Issues**

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

## Ten Implementation Domains<sup>7</sup>

*“While it is recognized that not all public institutions and service sectors attend to trauma as an aspect of how they conduct business, understanding the role of trauma and a trauma-informed approach may help them meet their goals and objectives. Organizations, across service-sectors and systems, are encouraged to examine how a trauma-informed approach will benefit all stakeholders; to conduct a trauma-informed organizational assessment and change process; and to involve clients and staff at all levels in the organizational development process.”<sup>8</sup> - SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach*

The domains below, built upon the work of Harris and Fallot<sup>9</sup>, are intended to intersect with the six principles labeled above to create more effective organizations. Per SAMHSA, the ten domains below should not be seen as areas that can be mastered definitely. They also are not stages of implementation. Rather, they are groupings of areas where an organization can analyze its efforts and intersect with institutional change strategies in order to encourage a more healthy and responsive workplace.

Below each domain are sample questions to consider when implementing a trauma-informed approach. These questions were derived from SAMHSA’s Guidance for Implementing a Trauma-Informed Approach. The entire list of questions and full definitions of the domains are attached in the appendix.

### **1. Governance and Leadership**

- How does agency leadership communicate its support and guidance for implementing a trauma-informed approach?
- How do the agency’s mission statement and/or written policies and procedures include a commitment to providing trauma-informed services and supports?

### **2. Policy**

- Do the agency’s written policies and procedures include a focus on trauma and issues of safety and confidentiality?
- How do the agency’s written policies and procedures recognize the pervasiveness of trauma in the lives of people using services, and express a commitment to reducing re-traumatization and promoting well-being and recovery?

### **3. Physical Environment**

- How does the physical environment promote a sense of safety, calm and de-escalation for clients and staff?
- In what ways do staff members recognize and address aspects of the physical environment that may be re-traumatizing, and work with people on developing strategies to deal with this?

### **4. Engagement and Involvement**

- How do people with lived experience have the opportunity to provide feedback to the organization on quality improvement processes for better engagement and services?
- How do staff members keep people fully informed of rules, procedures, activities and schedules, while being mindful that people who are frightened or overwhelmed may have difficulty processing information?

#### **5. *Cross-Sector Collaboration***

- Is there a system of communication in place with other partner agencies working with the individual receiving services to facilitate making trauma-informed decisions?
- Are collaborative partners trauma-informed?

#### **6. *Screening, Assessment, Treatment Services***

- Is an individual's own definition of emotional safety included in treatment plans?
- Is timely trauma-informed screening and assessment available and accessible to individuals receiving services?

#### **7. *Training and Workforce Development***

- How does the agency address the emotional stress that can arise when working with individuals who have had traumatic experiences?
- How does the agency support training and workforce development for staff to understand and increase their trauma knowledge and interventions?

#### **8. *Progress Monitoring and Quality Assurance***

- Is there a system in place that monitors the agency's progress in being trauma-informed?
- Does the agency solicit feedback from both staff and individuals receiving services?

#### **9. *Financing***

- How does the agency's budget include funding support for ongoing training on trauma and trauma-informed approaches for leadership and staff development?
- What funding exists for cross-sector training on trauma and trauma-informed approaches?

#### **10. *Evaluation***

- How does the agency conduct a trauma-informed organizational assessment or have measures or indicators in place that show their level of trauma-informed approach?
- How does the perspective of people who have experienced trauma inform the agency's performance beyond consumer satisfaction surveys?

## **Disclaimer Regarding the Environmental Scan**

The following is the most comprehensive Environmental Scan done in Illinois to-date, but it is not an exhaustive representation of all work in Illinois and beyond to address ACEs. Our sample size was very large (339 programs) and included national and international best practices research, but the task of including and analyzing every program addressing trauma, ACEs and toxic stress and/or building resilience in Illinois is beyond the scope of our current capacity. As shown in the methods section, we utilized a variety of strategies to include as many programs as possible. Other efforts to uncover lessons in this area have been provided by the Illinois Chapter of the American Academy of Pediatrics' (ICAAP's) PROTECT (Promoting Resiliency of Trauma-Exposed Communities Together) Initiative, which includes a status report on the origins and vision of the PROTECT Initiative and includes factors that informed their work, their leadership and their operating structure for decision-making; what they have learned; and next steps for their project.



# Goals

## Expanding the Knowledge Base of ACEs for Illinois

This Environmental Scan represents the Collaborative’s first effort to expand knowledge regarding ACEs and trauma-sensitive practice and is a response to a gap in knowledge, identified by the Collaborative and our colleagues, of program information that illuminated promising practices, policies and pathways to becoming trauma-informed. We found that this lack of information stymied attempts to address ACEs and trauma through policy and practice decisions. Increasingly, service providers, systems leaders and policymakers have recognized that becoming trauma-informed and implementing trauma-informed practices and policies are important, but the steps required to shift policy and practice have remained unclear.

We found that in many settings, while awareness of trauma and ACEs is high, people are stuck when it comes to deciding how to move forward in the education of staff, the development of policy and the implementation of trauma-informed practices. Furthermore, there is recognition that doing it “wrong” can have significant unintended consequences for patients, providers and systems. However, implementation based on promising elements, proven practice and the work of local and national leaders holds the potential to improve the health and wellbeing of families and communities, as well as reduce costs to the health, justice, educational and other systems.

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*We found that in many settings, while awareness of trauma and ACEs is high, people are stuck when it comes to deciding how to move forward in the education of staff, the development of policy and the implementation of trauma-informed practices.*

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Therefore, to highlight these promising practices, the first step in the Environmental Scan was to identify activities around ACEs and trauma in Illinois and in the rest of the country. Through an examination of our findings, we distilled what we saw in successful ACE-related policies, programs and models in order to define the essential elements and characteristics necessary to foster effective interventions and improve outcomes.

Our goal is to make this data available to health providers, health and social services systems, social service agencies, educators, justice system leaders, policymakers and others interested in effectively addressing ACEs in their respective sectors and collaboratively, whether that be at the community, organizational, systems or policy level, to provide guidance and support as we move along the continuum from awareness to full implementation of trauma-informed practices.

# Methodology

## Phase One: Data Collection

The data collection process of this Scan was multi-pronged and designed to obtain as much information as possible. Our first step was to engage our partners across the country who are leading community-level efforts to address childhood trauma. This process was informed by those partners who had completed scans within their communities and could act as consultants about methodology and content. While not originally a priority, we realized that in the process of building our data repository, we could also focus on building partnerships to strengthen the Collaborative and support other organizations in our shared goal to break down the silos separating work on ACEs across Illinois. Our intent was not to judge the ways different groups defined being trauma-informed. Instead, we viewed data collection as a process of discovery and a basis for future advocacy efforts on behalf of all those striving to become or sustain being trauma-informed, no matter how far along they were on the continuum of implementation.

Our next step was to engage our stakeholders within the Collaborative to determine the key elements of data collection. The Collaborative held several meetings of our Steering Committee, as well as our Education, Health and Justice Work Groups, to discuss how to identify trauma-informed programs and organizations and which program elements to examine. These factors became the *Data Elements*. The data collected in the first round of the scan included the following Data Elements:

- Program Name
- Website
- Primary Program Focus
- Target Audience
- Program Goals
- Program Description
- Any indication of whether or not there have been steps to become trauma-informed
- Open-ended responses about the ways programs have become trauma-informed
- Desired or measured outcomes of the program
- Funding sources
- Geographic Area
- Models used
- Partners
- Contact Information

These Data Elements were collected in two ways:

- An **online questionnaire** was created and distributed to several large listservs, newsletters and mailing lists, reaching thousands of program representatives. The survey was distributed to:
  - Health & Medicine Policy Research Group stakeholders
  - United Way of Metropolitan Chicago grantee list
  - Strengthening Chicago's Youth newsletter audience
  - Evanston Cradle to Career Network
  - Blue Cross Blue Shield of Illinois grantee list
  - Illinois Children's Trauma Coalition listserv
  - Personal invitation and mass emailings from Collaborative members
- Collaborative members **identified** noteworthy programs locally, nationally and internationally and researched these programs.

These two strategies yielded information from approximately 339 programs and organizations working to address ACEs and build resilience in a variety of ways. These programs and their descriptions are included in the appendix.

## Phase Two: Qualitative Interviews

After analysis of the initial data set described above, we realized that qualitative interviews were necessary in order to deepen our understanding of the fundamental steps required to become trauma-informed, the successful elements of trauma-informed programming and the challenges that arise when implementing trauma-informed care. While the survey data was useful in developing a broad baseline understanding of the breadth and scope of trauma-informed practices across the state, qualitative data provided a more nuanced understanding of processes and phenomena. Thus, conducting individual interviews was identified as an important method for understanding the experience of implementing trauma-informed practices at organizations identified through the questionnaire.

Two members of the Illinois ACEs Response Collaborative and an outside qualitative research consultant from the University of Illinois at Chicago worked together to create an interview guide which included open-ended questions intended to gather information related to the specific research questions of this project. In particular, the team focused questions on the organizational process of becoming trauma-informed, including successes and challenges during implementation and staff training, the impact on clients and planned next-steps towards incorporating or sustaining trauma-informed practices. The three primary interviewers created a systematic plan for collecting the data prior to the first interview. Working with a qualitative researcher, we developed a series of questions that would more fully elucidate promising practices and obstacles. All interviews were transcribed to aid in analysis.

Approximately 50 representatives from organizations were invited to participate in one-hour phone interviews to discuss their organization's progress towards becoming trauma-informed. We began by looking at the raw data from the original Scan questionnaire. Organizations that noted that they were working towards becoming trauma-informed were highlighted. Fifty programs were selected that were at various stages of implementing SAMHSA's definition of a trauma-informed organization or program. The selection of programs at various stages of implementation was intentional to highlight the steps necessary to move from one stage to another so that lessons could be gleaned from various stages of such efforts. In total, 21 individuals participated in the interviews, each lasting between 30 and 60 minutes. Interviewers wrote notes during and after the interviews to summarize their overall impressions of the interview and to highlight the key points from the conversation. The primary interviewers engaged in analytical debriefs at two points during data collection. During debriefs, each interviewer discussed their key "takeaways" from the interviews and identified emerging patterns across their interviews and notes.

The interviewer notes and summaries of interview debriefing sessions were reviewed and annotated by a qualitative researcher. The audio recordings (interviewees gave permission to be recorded) were used to verify and supplement the written data, as well as to provide direct quotes where relevant. Although the depth of written data was insufficient for a full qualitative analysis, a summary of major themes and their implications were identified by the qualitative researcher and are discussed below.



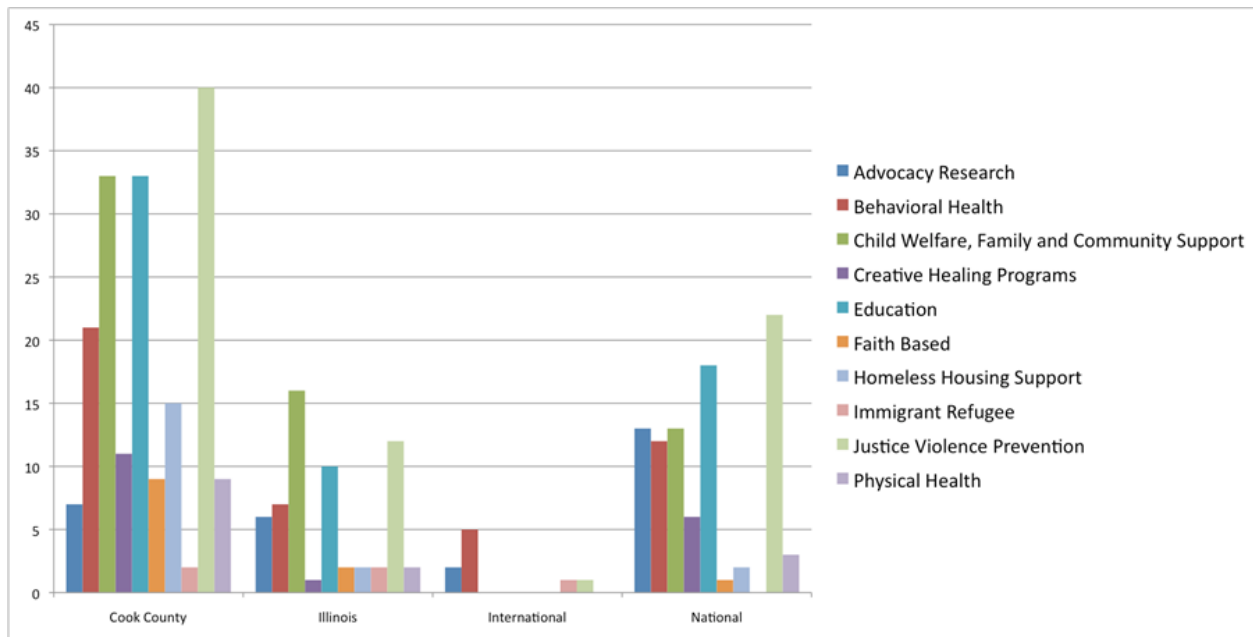
# Findings

## Phase One: Results and Findings from the Survey

### The Respondents

The Environmental Scan includes 339 organizations, at the county, state, national and international level. (A complete list of the programs, along with their website and description may be found in the appendix.) For descriptive purposes, below is a chart and pivot table of organizations organized by geographic area and program focus. Also included are charts showing the percentage/number of programs in each geographic area and each area of program focus.

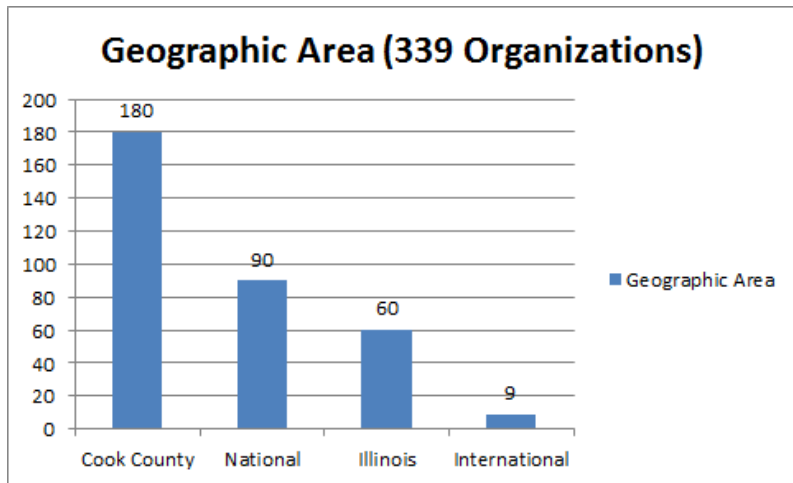
PRIMARY FOCUS	GEOGRAPHIC AREA				Grand Total
	Cook County	Illinois	International	National	
Advocacy Research	7	6	2	13	28
Behavioral Health	21	7	5	12	45
Child Welfare, Family and Community Support	33	16		13	62
Creative Healing Programs	11	1		6	18
Education	33	10		18	61
Faith Based	9	2		1	12
Homeless Housing Support	15	2		2	19
Immigrant Refugee	2	2	1		5
Justice Violence Prevention	40	12	1	22	75
Physical Health	9	2		3	14
<b>Grand Total</b>	<b>180</b>	<b>60</b>	<b>9</b>	<b>90</b>	<b>339</b>



There was a wide variety in types of organizations included in the sample. Some are social service agencies with long histories of providing services to clients who have suffered great hardship, but may have just begun to implement trauma-informed concepts. At the other end of the spectrum,

some programs (including the Illinois ACEs Response Collaborative) are grounded in advanced theory but do not provide direct service. Education sector programs, for instance, run the gamut from early childhood education, where the focus is on the parent, through K-12 programs focusing on the child, to university-graduate schools where the focus is on the student as future care provider. Justice sector initiatives included in the scan tended to be advocacy

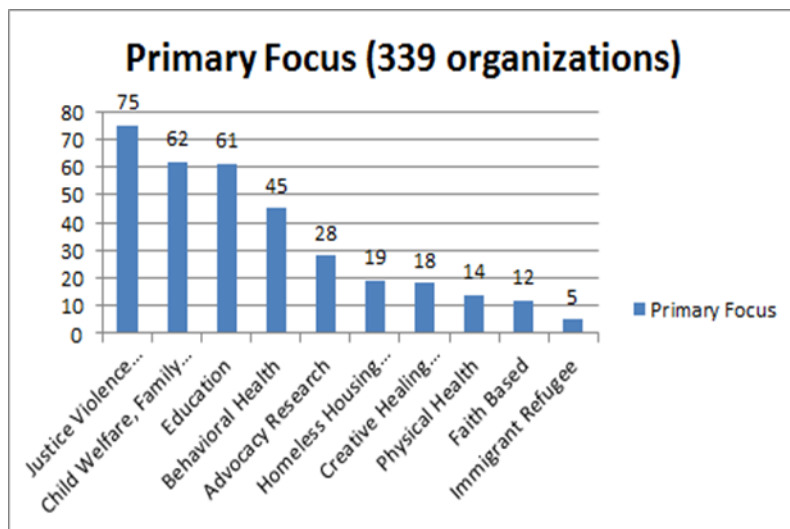
groups working to reform the criminal justice system while promoting practices like restorative justice. Representation from people/organizations within the justice system itself was very limited in our sample. The health care field was largely represented by programs providing various crisis services to people in the emergency department as well as behavioral health departments within major hospital systems.



It is clear from the providers surveyed that there has been an explosion of awareness among their staff about the prevalence of trauma in the populations they serve. At the same time, the use of "trauma-informed" language is becoming widely accepted across education, justice and behavioral health. However, an exception to this is that there is minimal awareness or application of such concepts in medical care systems outside of behavioral health. Interestingly, while programs acknowledged the trauma experienced by the populations they served, it was rare to find discussion of organizational transformation towards becoming fully trauma-informed, and secondary trauma and historical trauma were rarely mentioned in the survey results.

One of the major goals of this scan was to uncover the key elements of trauma-informed programming and the extent to which true trauma-informed care (per SAMSHA's framework described above) is being practiced. Of those who completed the survey and indicated their programs/organizations were taking steps to become trauma-

informed, only 21% of those respondents were incorporating SAMHSA's principles of trauma-informed care or addressing more than one of the Ten Implementation Domains. Seventy-nine



percent of respondents either gave no concrete examples of incorporating elements of trauma-informed care or only indicated receiving “training” as evidence of being trauma-informed.

One hundred and four organizations answered “yes” to the question, “Has the program taken steps to become Trauma-Informed?” Of those, 22 organizations provided specific examples of the way they are trauma informed, for example:

- *“Becoming more trauma-informed is a part of our agency’s strategic plan. All new staff get a basic training and we are implementing specific models in various ways across our agency. Our board will be trained soon.”*
- *“Our staff have attended numerous presentations and courses on trauma. We have incorporated information from these educational experiences, along with the latest in research, into our agency philosophy. We have also revised all of our programs from a trauma-informed perspective. Remaining trauma-informed, compared to trauma-focused, is a regular dialogue in supervision and team meetings.”*

The remaining 82 organizations either did not elaborate on training or could only identify training as a tactic in becoming trauma-informed.

- *“All the therapists on staff have had some training in working with trauma.”*
- *“Staff are trained to consider trauma in assessment and intervention.”*

In program descriptions, the overwhelming focus was on understanding what the “client” or “child” had been through—it was rare to find an emphasis on resilience skills or recovery from trauma. Programs in the data set focused their interventions on the individual child/client rather than the family unit as a whole. Our sample programs also did not identify issues of “historical trauma” or multigenerational trauma experienced by a specific cultural group<sup>10</sup>—to e.g. experience of systemic discrimination such as the Holocaust, etc. Historical trauma can be experienced by “anyone living in families at one time marked by severe levels of trauma, poverty, dislocation, war, etc., and who are still suffering as a result.”<sup>11</sup> There was also minimal data provided about the impact of homophobia as trauma.

## Models Used

The survey asked if programs subscribed to a certain model either to change the entire organization to be trauma-informed or for direct service delivery. Since the majority of the online surveys went to those providing direct services, models included were largely *trauma-specific*. Qualitative interviews helped to extract information about models used for organizational efforts to become trauma-informed. Respondents in Phase One identified several different models, including ARC (Attachment, Regulation and Competency), Sanctuary, SELF (Safety, Emotions, Loss and Future), Therapeutic Crisis Intervention (TCI), The Relational Re-Enactment Systems Approach to Treatment (REStArT), Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), The Collaborative Stage Model (CSM), Urie Bronfrenbrenner's Bioecological Model and EMDR (Eye Movement Desensitization and Reprocessing).

## Phase Two: Results and Findings from Qualitative Interviews

### The Process of Becoming Trauma Informed

Interviewees discussed a variety of approaches to becoming trauma-informed or incorporating the science of ACEs into their work or the work of the organization. Some described a strategic approach to becoming trauma-informed, indicating that specific models were used or adapted to guide the process. One interviewee representing an organization which provides residential services described a *10-year journey* incorporating trauma-informed strategies into their work. This organization in particular utilized a number of different teachings and models to transform their practices. Other organizations were on more organic, less strategic paths towards becoming trauma-informed. One interviewee, representing a small organization with only one full-time staff member described updating the volunteer training to discuss the science of ACEs and trauma as their first effort at becoming trauma-informed.

These two organizations represent very different ends on a continuum of trauma-informed organizational practice, one far along in its journey and another just beginning. This illustrates the potential role of organizational age, size and funding in the successful and strategic implementation of robust efforts to incorporate trauma-informed practices. While a number of interviewees reported significant progress towards a trauma-informed approach, many indicated that there is much more work to be done within their system. Unsurprisingly, those interviewees who were able to articulate the steps which their organization has taken to become trauma-informed appear to be furthest along and most strategic in their processes.

There was a wide variance in reported elements employed to become trauma-informed. The majority of respondents only indicated participation in trainings as an indication of trauma-informed services. Of the 10 SAMHSA domains, Training and Workforce Development was the most noted. The second most common Implementation Domain was “Screening, Assessment, and Treatment Services.” The more frequent implementation of this domain highlights that programs focus on using trauma-specific strategies to clinically treat and transform trauma. Other organizations could cite specific evidence-based models they used, and how they incorporated the core principles of trauma-informed practice throughout the organization in several domains. Far fewer organizations were in this group, and reported requiring significant dedication from all levels of staff as well as resources.

### Motivation to Become Trauma-Informed

Among organizations, there were different motivations to become trauma-informed. Some organizations, like Thresholds and National Runaway Safeline have been incorporating true trauma-informed care for at least a decade. The elements of client choice, client empowerment and safety were historically essential to the values of these organizations. Therefore, the principles of trauma-informed care aligned squarely with their values and this framework aligned well with the ways they were already interacting with their clients. These organizations were clear that trauma was the root cause of many of their clients’ behaviors and challenges. Using a trauma-informed framework to educate rather than shame clients was of paramount importance.

Other organizations learned to become trauma-informed when their usual treatment modalities were not effective and, at times, were retraumatizing. Programs that treated substance use in a

wide vary of populations started to understand that trauma was the unifying element of those who relapsed more often and had a more difficult road to recovery.

- *"I have worked in community mental health for 20+ years and with refugee populations. Became interested in trauma-informed work in order to meet the needs of my clients who were not being served with more traditional forms of treatment."*
- *"I was motivated by observing how powerful trauma-informed practices can be in helping folks and by how retraumatized clients can get in more traditional settings."*
- *"We saw a growing need in the population we serve. Many individuals...reported a history of traumatic experiences in their childhood, adolescence and adult life. These same clients had a high rate of continue (substance) use and relapse. We determined that clients who reported or displayed traumatic stress needed to be counseled and supported in a different way."*
- *"The (TIC) trainings have been very useful for staff and clients. After providing these trainings the clinical staff is better equipped to recognize and address traumatic stress at all levels; from our receptionist to the management team."*

While these organizations have already shifted to meet the needs of their populations, others are just starting to become aware of how large the impact of trauma is on their individual, community- and system level clients. There is an increased understanding within many organizations that trauma is the root of many of the issues people face as research starts to uncover the profound impact of childhood trauma on the life course. In this light, organizations are seeking guidance on how to best serve their populations. That said, trauma-specific services require the right environment in order to be effective. Therefore, the use of direct evidence-based practices also requires an organizational change wherein those services are administered for optimal outcomes. Per Sandra Bloom, "Trying to implement trauma-specific clinical practices without first implementing trauma-informed organizational culture is like throwing seeds on dry land."<sup>12</sup>

- *"Trauma-informed care is the backbone of our crisis intervention training. It provides structure, definitions and examples for working with runaway youth both on the phone and online."*

### Training- Individual and Organizational

Interviewees described varying levels of individual and organizational-level training. Some interviewees described formal training during master's programs, followed by supplemental training in the form of conferences and continuing education opportunities.

- *"[M]y masters in social work is really where I started [learning about trauma-informed practices] and I've just consistently tried to pursue continuing education opportunities and read books about it and really keep, you know, myself updated."*

Others described a less formal pathway to learning about trauma-informed practices, especially those who were trained in fields other than behavioral health and social work.

- *"[My journey has been] less formal. [After my initial training in ACEs] I started seeing ACEs everywhere and then I started RSVPing for every training everywhere. I'd say it's very much a*

*patchwork. Loyola has a training here, [another organization] has a training there, it's very much about being on the right list serves [...] and piecing it together."*

Some interviewees, for reasons of insufficient capacity, funding or similar issues, described small planned steps to becoming more trauma-informed, such as going to a single training on the topic.

- *"We've got [expert speaker] coming in [to train our volunteers]. I would love to be able to get to a conference."*

**A lack of training among external partners was described as a barrier to the progress for some.**

For example, an interviewee representing a child advocacy center discussed the difficulty of getting law enforcement and legal professionals to understand the need to explicitly incorporate trauma-informed practices into their work with children and families. The interviewee also mentioned that physicians and medical professionals "get it", while colleagues in other disciplines often do not.

This finding highlights the importance of inter-disciplinary training, especially in settings where children and families are often interfacing with professionals from a variety of fields, such as medicine, education and child welfare.

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*"[Our goal is to] strengthen the network. The bottom line is, we're not trying to compete with providers. We are trying to give providers the tools, the information, the support so that they can produce better outputs."*

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A number of interviewees are charged with providing training to others on trauma, ACEs and strategies for becoming trauma-informed. Train-the-trainer models were popular among the interviewees, as they allow for rapid dissemination of information within, by an internal employee rather than an outsider. These interviewees described training individuals in a variety of settings, including hospitals--particularly emergency rooms--as well as correctional facilities. One interviewee who had been hired to work with women's prisons for two to three years in a training and consulting capacity noted that true systems-level culture changes take much longer than a couple of years, alluding to the limitations of individual training sessions. Another interviewee, who provides training and technical assistance to other organizations, described the role of training and support in creating trauma-informed practices and settings,

- *"[Our goal is to] strengthen the network. The bottom line is, we're not trying to compete with providers. We are trying to give providers the tools, the information, the support so that they can produce better outputs."*

Even though training was the most frequently noted strategy for becoming trauma-informed, interviewees often mentioned lack of resources within Illinois to provide such trainings. Most of the trainings that were available were clinical in nature and not about organizational shifts to become trauma-informed. Organizations in Chicago utilized several of the same trainers to teach their direct service staff to provide trauma-specific services. Groups consistently asked to be linked to trainings, toolkits, or webinars that the Collaborative could provide or facilitate. In Illinois, those outside of Chicago were particularly eager for webinars and toolkits that could increase their capacity to provide trauma-sensitive services without the need to travel or invest limited program dollars, specifically citing the budget impasse and the added stresses on the organization.

## Models Used for Organizational Change

The smaller pool of respondents who were creating a trauma-informed organization relied on an evidence-based model like ARC (Attachment, Regulation and Competency) or the Sanctuary Model. Interestingly, those who chose these models and those who are trying to change school climates in Illinois have brought in experts from outside of the state like Bruce Perry and Jim Sporleder, to name a few.

Experts agree, and participants in the scan acknowledge, that training is a starting point rather than the endpoint of becoming trauma-informed. Often, people are mobilized to administer the ACEs questionnaire to clients after having been exposed to it even just once at a training. This can be problematic as implementing the screening is a nuanced activity, can have unintended re-traumatizing consequences, and can create a need for trauma-specific interventions not provided by those administering the survey. While it is encouraging to see providers incorporate ACEs into their work, this must be done with sensitivity, adequate provider training, access to additional services and using evidence-based practices. These practices must be incorporated and implemented with the awareness of both the potential positive and negative impacts on those completing the questionnaire. Such sensitive and nuanced practices usually cannot be mastered within a single training.

## Collaboration

Qualitative interviews yielded evidence that programs doing very similar work were siloed even when located in the same hospital or schools. For instance, programs that build social emotional learning in schools are often not coordinated by the school system. One respondent noted that the exact same social and emotional learning (SEL) program was provided to the same classroom by two different social service agencies two days in a row. Other organizations that provide advocacy within hospital settings to address a wide variety of needs within the emergency department often have to advocate for clients when law enforcement is present. Creating a united front to train law enforcement on how to deal with people recently traumatized could be a shared goal of such groups, but there is no indication that this is happening currently. Other organizations/respondents noted that even when working within a hospital system, it was difficult to train doctors.

Even programs that co-locate other necessary supports in order to meet the comprehensive needs of clients (such as housing supports, job training, and childcare) find it difficult to fully engage those offering these wraparound services as part of their strategies for trauma-informed care. Often there is a lack of understanding, for example, of how providing housing supports requires a trauma-informed lens. Awareness of the advantage of using trauma-informed approaches for service providers who are not directly providing trauma-specific services is just starting to emerge in the field. For instance, interviews with a lawyer providing trauma-informed legal services included feedback that client engagement and compliance increased with the adoption of trauma-informed policies leading to a greater ability to work towards longer-term goals.

- *“One of our challenges has been intersecting with other systems that are not trauma-informed. We see many folks with chronic pain who have been traumatized by the medical system or folks with legal difficulties who have been traumatized by the criminal justice system. When we interface with these systems we often feel that we are speaking different languages.”*

- *“We also feel our culture wants to deny the effects of trauma so that we feel we need to continue to advocate. This can feel discouraging and overwhelming at times.”*

Other programs were quite strategic in their collaborative initiatives. They shared training resources, often pulling experts from within partnered organizations. This way, each organization could contribute some expertise without incurring the full cost of training. This also created an overarching framework that ACEs cut through all services and that addressing them in a coordinated fashion requires different perspectives. By partnering and building trust among staff at different agencies, these organizations eventually created linkage agreements and were able to work more cohesively, creating the conditions for better, more integrated client services.

Ripple-effect analysis and evaluation of the Collaborative show the power of connecting with like-minded colleagues outside of one’s organization. Collaboration is particularly vital for people providing trauma-informed services within a larger organization that does not recognize or understand trauma. This peer support allows employees to feel less isolated in their jobs and more connected to a larger movement. One interviewee highlighted the importance of knowing that others are also taking on efforts to improve organizational practices, given the complexity of incorporating trauma-informed principles into an organization.

- *“It’s amazing to think about one’s own successes, but also the work colleagues have done, to know we are not out here floating by ourselves.”*

It is important to note that in order to address trauma in students, patients, those involved in the justice system and clients in other sectors, it takes a coordinated, integrated effort by all staff involved in all systems. Relying solely on staff within an individual system or service to be trauma-informed will not be sufficient to address the sequelae of childhood trauma. Efforts must be made to engage whole communities and to create the widespread cultural change required to move the dial on ACEs.

### Staff Needs

A focus on staff needs yielded important findings. The link between secondary trauma and working with trauma survivors is well-known. Trauma-informed care stresses the need to prevent retraumatization of clients as well as staff. Those organizations who understand this phenomenon mentioned specific tactics to mitigate the impact of this work on staff including:

- Flexible work schedules
- Mental health days
- Manageable caseloads
- Balanced caseloads<sup>†</sup>
- Commitment to reflective supervision at least weekly
- Group consultation that includes discussion of vicarious trauma
- Yoga and meditation provided on-site

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<sup>†</sup> *Balanced caseloads were described as caseloads that consisted of a mixture of types of trauma experienced by their clients. For example, one respondent noted that clients who had visible physical wounds in addition to other types of trauma (i.e. sexual abuse) affected clinicians more negatively and caused more secondary trauma than serving someone who experienced sexual abuse but whose physical wounds were not visible or were already healed. In this type of environment, supervisors audited staff caseloads each week to ensure that visible physical abuse cases were spread evenly throughout the department. For the multiple organizations interviewed who operated from an on-call, crisis counseling model, supervisors noted the need to keep track of the number, length and severity of each encounter with a client or family in crisis.*



- Generous benefits, including substantial behavioral health plans
- Multidisciplinary teams for case review
- Debriefing and peer support after the death of patients
- Per the Sanctuary Model, every staff person in the organization has a written plan about how they de-escalate stress in everyday work environments. These plans are shared at meetings to support behaviors that proactively prevent and deal with stress.

It is important to recognize the stress that builds in workers and ignites the sympathetic (“fight or flight”) nervous system. Just like their clients, workers may have increased heart rates and become more reactionary in this state. Systems that are trauma-informed attempt to incorporate everyday tactics that stimulate the parasympathetic (“rest and digest”) system, like breathing techniques, taking a walk or meditation. Laughter and camaraderie among staff are key components for reducing stress in the workplace.

*“Laughter is the quickest way to access the parasympathetic nervous system.” – Sandra Bloom, MD in Caretakers (movie)*

Using non-work hours to take a break from work and to connect with what is nourishing for each worker is of critical importance. Some workers note that they have found it successful to avoid talking about their careers when they are not at work.

One organization that was particularly aware of the need for staff safety and self-care noted that there was a threshold for delivering crisis services and that when a staff person was responding to an increased number of crisis interventions, that staff person was offered a break from providing direct services. Usually this required supervisors to increase their own clinical caseloads to remove cases from their direct

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*ACEs and trauma impact clients in all programs, not exclusively trauma-specific programs, and the organization as a whole was responsible to shift the culture to become trauma-informed.*

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reports. It also required an environment of teamwork and mutual responsibility to ensure colleagues felt a collective responsibility to each other and remained open to shifting caseloads (sometimes taking on more clients when a co-worker required a break). This also required open communication and constant check-ins so that all employees felt that there was a fair distribution of labor. Staff needed to feel safe to admit when they needed additional support from their supervisors and colleagues without it being seen as a sign of weakness or inability to perform at work. When this wasn’t done in some of the organizations interviewed, resentment built up among staff resulting in a feeling of competitiveness regarding whose job was the most challenging. In those environments, peer support decreased and job satisfaction plummeted.

Supervisors who were committed to preventing secondary trauma in their staff also intentionally reduced the time that staff were providing direct trauma-specific services and incorporated organizational administrative duties into their work plans so that time was not spent exclusively in trauma-heavy interactions. Additionally, these supervisors empowered their clinical staff to incorporate institutional advocacy into their roles. Institutional advocacy includes working to improve systems (i.e., police, healthcare and justice systems) that impact clients but are outside their direct responsibilities. The addition of adding upstream, prevention-based work to direct service work often helps employees feel like they are making an impact at systemic, levels rather than merely constantly reacting to trauma.

Interestingly, one agency that has implemented the Sanctuary model- one that integrates the principles of trauma-informed care within all levels of the agency- lost several staff once the model was implemented over several years. This was the only example in our sample in which the executive director was spearheading the efforts to be trauma-informed. Staff who had been employed before the use of the model and who did not feel comfortable with the culture change ultimately left. This example illustrates how transformational the implementation of true trauma-informed care throughout an organization can be and how much commitment is required from all staff. When we practice the principles of trauma-informed care, we realize that each interaction with staff and clients must be intentional and requires effort to ensure safety, transparency, respect and choice. This level of attention to the subtle ways that we can encourage healing or increase trauma requires energy as well as a belief that the trauma-informed care model is worth the additional effort. Through this lens, it is understandable how such a culture change may be problematic for some and lead to staff turnover.

One large, statewide organization interviewed noticed the positive impact of providing leadership opportunities to staff who showed interest in resilience and trauma and who may not otherwise have had a substantive way to contribute to larger organizational change efforts. By seeding these staff as leaders, the buy-in for the model grew and the employees recruited noted greater job satisfaction. This organization, which trained over 80 staff in the ARC model, was intentional in its recruitment of particular staff to be trained and would then become the champions of the model. Since this organization is so large with multiple lines of service, it chose staff from all service areas. This plan underscored their knowledge that ACEs and trauma impact clients in all programs, not exclusively trauma-specific programs, and that the organization as a whole was responsible for shifting the culture to become trauma-informed. This organization also chose staff from multiple offices across the state.

Once all of the trainees were gathered, staff from different programs and different offices were grouped together so that implementation of the model in various environments and different populations encouraged a deeper understanding of the impact of the model. This decision also emphasized the different ways trauma appears within organizations from multiple perspectives. An unintended positive consequence of this strategy of mixing diverse staff together was an increased feeling of camaraderie among staff who previously rarely made connections with workers from other offices/departments. The integration of staff was a visible example of the importance of trauma across all programs and the requirement for a comprehensive, cohesive approach to service delivery where each interaction, no matter where in the agency, was trauma-informed and safe for clients and staff.

- *“One of the things that has affected staff the most is the knowledge that we must work on our own inner experience and our reactions to our own trauma and the stories we hear with our clients to be most effective in this work.”*
- *“We have also acknowledged that this work must be done in community in order to hold the feelings and sensations that arise when working with those who have traumatic stress histories.”*

Other examples of incorporating support for staff were specific to the profession of the helper. For instance, when there is a death of a patient in the hospital or other medical settings, a deliberate debrief and targeted support for the staff effected is increased. This not only provides critical support to staff, it also destigmatizes the affects the job has on the worker and opens up the dialogue needed to address the impact of secondary trauma on staff. Additionally, child welfare

workers require more supports when a child who was referred to that agency dies. Similarly, nurses in the NICU (neonatal intensive care unit) who witness the death of infants in their care must take additional precautions to safeguard their own well-being.

Cultures of certain professions create resistance to discussing the emotional toll of their work. Stress First Aid (SFA) was created in response to this resistance and is “a set of supportive actions designed to help emergency responders assist each other in reducing the negative impacts of stress. SFA was designed specifically to support firefighters, EMS and rescue personnel. This model teaches SFA at the awareness level, focusing on:

- Understanding stress
- Recognizing how stress manifests in thoughts, words and actions
- Delivering the "Seven C's" of Stress First Aid (Check, Coordinate, Cover, Calm, Connect, Competence, Confidence) to each other<sup>13</sup>



## 7 Cs Of Stress First Aid

### Continuous Aid

1. **Check**  
Assess, observe and listen
2. **Coordinate**  
Get help, refer as needed

### Primary Aid

3. **Cover**  
Get to safety ASAP
4. **Calm**  
Relax, slow down, refocus

### Secondary Aid

5. **Connect**  
Get support from others
6. **Competence**  
Restore effectiveness
7. **Confidence**  
Restore self-esteem and hope

Stress First Aid is also being used with people in combat and in various sections of the military.

## Leadership

Qualitative interviews yielded insight about the ways that the likelihood of becoming interested in and implementing trauma-informed care rely on an internal ambassador or pioneer within the organization to stimulate the momentum required to take on such a task. Interviewees also discussed the important role of “champions”, those who lead and/or promote efforts related to trauma-informed practices, in organizational efforts. The process of identifying “champions”, however, was sometimes challenging.

Although most of these trauma-informed care models require training, and therefore funding, an important factor for success seems to be commitment to change and commitment of effort. A common theme among these different treatment models is that they are time-intensive for clients and staff, not only for training but also when implemented. They all also require a commitment on

the part of leadership to support organizational change. Many of the models discussed require a systematic, responsive approach that asks both staff and clients to actively participate and communicate. This is not “business as usual”; it is a change in organizational culture. Thus, inconsistency or lack of support from leadership is often the biggest barrier to success. In-depth follow up interviews after the initial environmental scan validated this conclusion.

One of the challenges in implementing training and models of care at various levels was the reality of staff turnover. Training staff and moving the workplace to embrace a new culture requires investment in and from employees. Many of the organizations surveyed are fast-paced, stressful, and consequently, high-turnover work environments. Those supervisors who had taken the initiative to invest in training and support strategies for staff mentioned an understandable frustration at losing that investment once staff left their positions to take on new roles elsewhere. Because turnover seemed inevitable in those environments (until the culture became more stabilized), supervisors found it difficult to make true change “stick,” given the cyclical nature of staffing.

According to the Center for Healthcare Strategies, Inc.’s “Key Ingredients for Successful Trauma-Informed Care Implementation, steady support from senior leaders in an organization is critical not only to guide the change process but also to communicate regularly about the changes underway. Part of this leadership includes empowerment of the workforce to guide these changes and to ensure buy-in at all levels.

*“A successful transformation will likely require significant investments — to continuously train staff, hire consultants, and make physical modifications to the facility — and senior leaders are typically responsible for identifying the resources needed to do so, often through outside funding. At the same time, leadership must also consider how designating time for staff training, rather than billable clinical activities, could influence the financial health of the organization.”<sup>14</sup>*

## Funding

Funding was consistently highlighted as the largest barrier to providing the comprehensive services people need as well as for training staff and creating the organizational climate to sustain real change related to trauma and resilience. Qualified clinicians often used their time trying to raise critical funds rather than ensuring that services were appropriately delivered and staff were adequately supported.

- *“We are living paycheck to paycheck, just like our clients are.”*

This level of unpredictability in funding streams, the constant shifting of program priorities to meet funders’ needs over clients, and multiple (often non-congruent) reporting requirements stymied those in a position to do the most impactful work with clients. Of all the organizations surveyed, only one noted that their extensive ARC training of 50 employees and long-term plans of incorporating the model through several strategies was being financed through general operating funds.

Another structural barrier to funding identified by some working in hospitals and universities is the significant institutional overhead costs, which limit available programmatic resources. When direct service programs are located in hospitals or universities, indirect costs for the institution can be up to 50% of the total funds. In the case of one program we interviewed, this arrangement significantly

reduced program services. One respondent noted that hospitals should support the services that are provided on-site by outside organizations, either completely or with a dollar-to-dollar match of grant funding brought into the hospital setting by that organization's clinical services.

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- *“The investment in resources and time for TIC training has been very fruitful to staff’s personal and professional development. It has helped us to recognize the emotional and psychological impact on youth who contact us for services.”*
- *“We wish to incorporate more physical activity in our treatment. We know that physical activity such as walking, swimming, art lessons, and yoga helps to reduce the symptoms of traumatic stress. However, how to fund these activities is a challenge.”*

## Pace

For those few organizations working to incorporate full system-level change, a complete culture change is required, which takes several years. While specific models are very useful in guiding these processes (i.e. ARC and Sanctuary), there still must be room for some organic iterative processes as well as time for reflection, building on successes and learning from failures, and shifting to accommodate specific organizational needs. One interviewee who is incorporating ARC in a large organization reaches out to other organizations that are further along in implementing the model in order to receive support. This interviewee noted that the best guidance she received from these partners was to take the time necessary and to not rush the process. Other respondents noted that when they tried to incorporate too much too soon, they were unable to get traction and had to slow down implementation so that the organization had time to adjust to the changes and intentionally build on their successes.

# Key Learnings

## Promising Elements

The intent of this environmental scan was to highlight the key elements of programs that are successfully implementing trauma-informed practices. The following strategies emerged from our research:

### *Organizational Integration*

- Investment from all levels of staff within an organization
- An understanding that every position and department in an organization is responsible for providing a safe environment for all who interface with that organization, i.e. “you don’t have to be a therapist to be therapeutic”
- An understanding that every position and department in an organization is responsible for providing a safe environment for all who work within that organization
- Inclusion of elements of trauma-informed care in job descriptions
- Public presentation of a commitment to change by leadership through being present at trainings and incorporating trauma-informed care principles into their own work
- Dedicating funding to the organizational change strategies necessary to implement trauma-informed care, i.e. training, consultation, staff time, etc.
- Considering skills related to trauma-informed care when hiring new staff (i.e. empathy, non-judgment, collaboration)

### *Building and Supporting Leaders*

- Seeding “Resilience Champions” who shepherd the principles of trauma-informed care, lead by example and provide peer support to colleagues
- “Train the trainer” models that increase the reach and capacity of large organizations
- Leadership opportunities for staff with an interest in trauma even if trauma-specific services are not part of their job responsibilities

### *Implementing Techniques to Reduce Secondary Trauma and Increase Self-Care Among Staff*

- Understanding and normalizing that secondary trauma is a consequence of working with traumatized populations
- Open conversation by supervisors about secondary trauma to reduce the stigma surrounding it
- Flexible work schedules
- Mental health days for staff
- Manageable caseloads
- Balanced caseloads
- Commitment to reflective supervision at least once weekly
- Group consultation that includes discussion of vicarious trauma
- Yoga and meditation provided on-site
- Generous benefits, including behavioral health plans
- Institutional advocacy and system change efforts being incorporated into direct service staff responsibilities to limit exposure to trauma and diversify staff skills

### *Peer Support*

- Links with other organizations doing similar work to facilitate learning, support and reduce competitiveness and “turf” issues
- Strategies to break down silos between those doing similar work to increase effectiveness of services and reduce feelings of professional isolation
- Building learning communities and collaboratives to reduce isolation, increase peer support and build new skills without the need to bring in trainers

### *Comprehensive Care Models*

- Resources linked seamlessly with an understanding that integrated services are imperative for whole person care
- Reduced silos between systems that interact with clients

### *Safe Environments*

- Physical environments are well lit
- Security is visible inside and outside the building
- Each person is greeted and feels welcomed
- Noise levels are kept to a minimum in waiting areas
- Clients have clear access to the door in exam rooms and can easily exit if desired
- There is an understanding and use of culturally competent services that take into account how a person’s culture affects how they perceive trauma, safety, and privacy<sup>16</sup>
- *“We have designed our space to have light and openness. Our music and art choices are all designed to facilitate a sense of safety in the present moment.”*
- *“We make personal safety a priority.”*

## Barriers to Success

The environmental scan also surfaced the following barriers to providing trauma-informed care:

### *Funding*

- The time and resources required to submit applications and reports often distracted direct service staff from their clients.
- Budgets that do not incorporate the full amount of resources needed to transform whole organizations increase pressure on staff.
- Large medical systems benefit from services provided on-site by outside organizations but do not help fund those organizations work, suggesting that they do not perceive or support the organization’s value.
- Funding was difficult to obtain for system change efforts due to the time frame and scale of activities required to achieve culture change.
- Private therapists often struggle to assist those who do not have financial means to access their services.

### *Training*

- There is a lack of intensive, integrated training that supports staff in incorporating trauma-informed and trauma-specific interventions--most organizations rely on short trainings during orientation or one-off, piecemeal “Trauma 101” trainings.

- Those who are creating innovative models in trauma-informed schools are enlisting national experts to help in the creation of curricula or as consultants rather than hiring local experts who could provide services at a fraction of the cost.

#### *Staff Turnover*

- Implementing a trauma-informed approach requires a major investment in staff. When staff leave, this investment in training and momentum for change may leave with that employee
- Because becoming a trauma-informed organization exposes staff to more secondary trauma, some staff left because the job became too damaging for them.

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*Lack of intensive, integrated training that supports staff to incorporate trauma-informed and trauma-specific interventions--most organizations rely on short training during orientation or one-off, piecemeal "Trauma 101" trainings.*

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#### *Limited Use of a Public Health Approach*

- Most respondents were providing direct services. Rather than a public health approach, which is critical to align policy and practice with upstream interventions that prevent the intergenerational transmission of trauma. While direct services for trauma survivors are necessary, there needs to be an increased understanding that addressing ACEs is not solely through clinical interventions. Building resilience at micro, mezzo and macro levels is required as well as having a prevention-oriented approach to support overall population health.
- Building community capacity and resilience is just beginning take root in the Chicago area. Residents who are not interfacing with social service agencies have not been engaged in a significant way to lead neighborhood efforts to build social cohesion that is critical for public safety and thriving communities.
- While trauma is pervasive among individuals and in communities, services tend to be centered on the individual and be specific to the actual trauma experienced. Building resilience was not a major theme of the programs included in the scan as their missions and funding drive them towards individual service models.
- There was little mention of historical trauma and its impact on whole communities. This framework is required to fully address the breadth of trauma.



# Recommendations and Next Steps

The following recommendations emerged from the lessons of this environmental scan:

**1. *Create learning collaboratives for those doing similar work and/or using similar models.***

This is a cost-effective way for staff to incorporate peer learning and support. It expands the reach and quality of models while illuminating pitfalls for others to avoid, thereby saving time and resources.

**2. *Increase training opportunities, including virtual learning. Utilize local talent whenever possible to provide trainings.***

There was a very clear message from our interviewees: people recognize that trauma impacts their clients in a pervasive way. They see the need for training, but they do not access it because it is either cost-prohibitive, they are unaware of opportunities or they do not have time to travel to trainings.

**3. *Utilize systems-level collaboratives, like the Illinois ACEs Response Collaborative, to connect to local trainers and content experts.***

It is obvious from the Environmental Scan that additional and comprehensive training about ACEs is desired throughout Illinois. It was also clear that organizations were creative in sharing resources and utilizing partnerships to create piecemeal trainings when possible. A clearinghouse of available trainers is something that a convener with a birds-eye view of the field can provide.

**4. *Create an Illinois-based training institute for trauma-informed care.***

While existing local trainers have been invaluable in moving the state forward towards providing trauma-informed care; a training institute that offers accredited and customized trainings for staff in various settings would add great value to the field. It would create a common language for the state as well as a professional development hub for those in the field. While a cost-for-service model could sustain such an institute, it would be more advantageous to be able to provide these trainings for free or at reduced cost to organizations whose budgets cannot support professional development.

**5. *Initiate evaluation from the start of training and program development.***

Many lessons of systems change have been lost due either to waiting too long to begin an evaluation or lack of funding for evaluation.

**6. *Acknowledge and normalize the prevalence of secondary trauma and incorporate preventive strategies to keep staff healthy and reduce turnover.***

Increase research about secondary trauma and how staff can be best supported in their work. Incorporate institutional policies and practices that support staff and ensure supervisors are monitoring staff trauma and burnout. Provide opportunities for self-care in and outside of the workplace.

**7. *Acknowledge the level of commitment of time, resources and staff required to become trauma-informed and adjust funding and reporting periods to reflect the real needs of a culture shift.***

Trauma-informed care requires a paradigm and culture shift. The magnitude of this shift must be acknowledged for successful planning and implementation of trauma-informed care.

**8. *Expand trauma-informed practices beyond direct services and behavioral health settings.***

Utilize SAMHSA's ten domains to highlight the areas within an organization that often are not targeted for improvements. Start in the domain where there is momentum and build out from past successes.

**9. *Seed internal champions throughout organizations and communities.***

Empowering employees and community members is critical in making the culture shifts required to become trauma-informed.

**10. *Integrate behavioral health with primary health.***

The science of ACEs and its impact on physical health throughout the lifetime shows that mind and body are deeply integrated. Primary care physicians should not only gain additional understanding of how experiences in youth impact health across the lifespan, they should also learn how to adjust their practices to be trauma-informed. While it may not be recommended or feasible to administer ACE screenings in all primary care settings, taking a "universal precautions" approach is recommended. By assuming all patients may have trauma and potential triggers, practice sites can be improved with simple environmental changes as well as through more sensitive ways that physicians may interface with patients- i.e. explain procedures before they happen, create additional safety mechanisms and realize the power of language and the subtle ways physicians can be supportive rather than victim-blaming.

**11. *Support public health approaches to building resiliency and incorporate the power of community building to achieve needed outcomes.***

Most past ACEs and trauma interventions have been focused on direct social services. Research supporting a public health approach as well as community-building models that create social cohesion and collective responsibility to create safe spaces is growing, providing critical strategies for an upstream approach to building resilience and preventing intergenerational transmission of trauma.<sup>17</sup>

**12. *Incorporate historical trauma into trainings and policy and practice recommendations.***

When the Illinois ACEs Response Collaborative brought in national expert Laura Porter to Chicago to discuss moving from knowledge to action related to ACEs, our evaluation showed that new knowledge gained about historical trauma from her presentation changed the way people approached their jobs and their clients'/communities' experiences. One respondent wrote that "After learning about historical trauma, we now have a better understanding of how it affects the individual and community as a whole. We are using this information to provide trauma-informed family therapy." Another respondent stated that she is now incorporating this information into all trainings she provides about ACEs. Therefore, we know that utilizing the science of ACEs and neurobiology resonates with those in Illinois and is imperative to further expanding the knowledge base of ACEs. We also know from this Environmental Scan that there is not enough emphasis on the critical concept of historical trauma in the field as a whole.

## Conclusion

There is varied understanding of how to fully integrate trauma-informed care principles into their systems among the 339 respondents to the Illinois ACE Response Collaborative survey. Most interventions and trainings identified by respondents focused on trauma-specific, clinical interventions required by people who have experienced trauma. These trainings, and even the rare organizational shifts demonstrated in the data, were located within behavioral health settings, suggesting that addressing trauma is perceived to be the responsibility of behavioral health staff.

True trauma-informed care assumes that all clients interfacing with child- and family-serving organizations and systems have the potential to be impacted by trauma experienced at any point in their life. This trauma can influence the ways that people feel safe in certain environments and therefore may predict their success in building healthy relationships with such systems, which is necessary for them to access supports. Trauma-informed systems incorporate SAMHSA's Six Key Principles for every person walking through the door, not just those there specifically for trauma services. Additionally, systems must incorporate these same six principles into internal operations, specifically with staff support and intramural staff interactions. SAMHSA's Ten Implementation Domains show the breadth of the organizational accountability that must take place. Finally, organizations across Illinois are recognizing the importance of becoming trauma-informed but are at very different stages along the continuum of learning and integration. Fortunately, successful strategies and elements have emerged alongside barriers to transformation. This report can serve as the beginning of a roadmap to investments of money, time and human resources to help Illinois become a leader in trauma-informed care.

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## Appendix

- One: Participant Overview
- Two: SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach
- Three: Quantitative Interview Questions

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