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Trauma-Informed Care and Trauma-Specific Services: A Comprehensive Approach to Trauma Intervention

Carmela J. DeCandia, Psy.D., Kathleen Guarino, L.M.H.C.; and Rose Clervil, M.S.W.

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Contents

Introduction

Historically, health and human service systems have served people who have experienced trauma without acknowledging, understanding, or addressing its impact and the need for tailored responses (Harris & Fallot, 2001). This pattern is embedded in society's long-standing history of alternately denying and prioritizing traumatic stress as a primary cause of human suffering (Bloom, 2000; Herman, 1992; McFarlane, 2000; Ringel, 2012). Why does this occur? To study or treat those affected by traumatic stress entails engaging with the reality and magnitude of interpersonal violence and abuse in our society; the reality is often too much to bear (Ringel, 2012). Denial allows us to distance ourselves from the feelings and moral obligation to act; the consequence is that trauma is often overlooked. Trauma-specific services, or therapies for the treatment of posttraumatic stress disorder (PTSD), have been prioritized in funding, research, and practice over ecological approaches (Bloom, 2000; Herman, 1992; McFarlane, 2000) including trauma-informed care. In fact, both are needed to address the scope of the problem and its potential consequences.

Currently, systems including behavioral health, homelessness, child welfare, education, and justice are recognizing the need to address trauma in the lives of the people they serve. The current socio-political climate—post-911 and military actions Operation Iraqi Freedom and Operation Enduring Freedom in combination with mounting neurodevelopmental research on the prevalence and impact of trauma—has created a context in which trauma can no longer be ignored in public systems of care. This context has begun to unite policymakers, researchers, and service providers, setting the stage for a comprehensive approach to trauma intervention that includes "trauma-specific" clinical services to address posttrauma responses, and universal strategies for creating "trauma-informed" service systems (Report of the Federal Partners Committee on Women and Trauma, 2011; Substance Abuse and Mental Health Services Administration (SAMHSA), 2014).

This brief addresses the need for a comprehensive approach to trauma intervention across service settings. In doing so, we define these complementary approaches, identify core principles and current practice for each, and discuss how both are being integrated across service sectors. Finally, we identify next steps for providers, researchers, and policymakers to ensure that all service systems are prepared to sustain this comprehensive approach to trauma intervention.

Prevalence and Impact of Traumatic Stress

Traumatic experiences are events—a series of events or a set of circumstances—experienced by individuals as emotionally or physically harmful (SAMHSA, 2014). An event becomes traumatic when it overwhelms our neurophysiological system for coping with stress and leaves people feeling unsafe, vulnerable, and out of control (Herman, 1992; Macy, Behar, Paulson, Delman, & Schmid, 2004). These experiences, whether real or perceived, threaten one's life and/or bodily integrity; invoke intense feelings of helplessness, powerlessness, and/or terror; and, in the absence of protective supports, can have lasting and devastating effects on an individual's physical, mental, and spiritual health (American Psychological Association (APA), 2008; SAMHSA, 2014). Exposure to traumatic stress is increasingly understood as a common denominator for children, youth, and adults across social service systems.

Prevalence of Trauma Across Service Systems
Justice
96% of female offenders have experienced trauma, often in the form of sexual abuse and intimate partner violence (Jennings, 2008).
75%–93% of youth involved with juvenile justice have experienced trauma (Justice Policy Institute, 2010).
Homeless
93% of homeless mothers have a lifetime history of interpersonal trauma (Bassuk et. al., 1997; Bassuk, E. L., Buckner, J. C., Perloff, J. N., & Bassuk, S. S. (1998); Hayes, Zonneville, & Bassuk, 2013; Weinreb, Buckner, Williams, & Nicholson, 2006).
83% of homeless children have been exposed to at least one serious violent event by age 12 (Buckner, Beardslee, & Bassuk, 2004).
Mental and Behavioral Health
93% of psychiatrically hospitalized adolescents have histories of physical and/or sexual and emotional trauma (Lipschitz, Winegar, Hartnick, Foote, & Southwick, 1999).
75% of clients in substance abuse treatment settings report histories of significant trauma (Jennings, 2004).
Veterans
81%–93% of women veterans have been exposed to trauma over their lifetimes (Zinzow, H., Grubaugh, A., Monnier, J., Suffoletta-Malerie, S., & Freuh, B. (2007).
Child Welfare
50% of children and youth in the child welfare system have experienced trauma (National Center for Children in Poverty, 2007).
Education
25% of school-aged children have been exposed to a traumatic event (APA, 2008; National Child Traumatic Stress Network, 2008).

Human beings are equipped with a complex neurophysiological system that connects the brain and the body to respond to threats; for children, this system develops over time in the context of secure and appropriate caregiving (Center on the Developing Child at Harvard University, 2010). Reactions to traumatic events vary considerably, ranging from relatively mild disruptions in day-to-day functioning to potentially severe and debilitating chronic conditions including PTSD and depression (International Society for Traumatic Stress Studies (ISTSS), 2014).

The groundbreaking Adverse Childhood Experiences (ACE) Study and research on the neurobiology of trauma offer compelling evidence of the long-term impact of traumatic stress (Center on the Developing Child at Harvard University, 2010; Felitti & Anda, 2010; Felitti et al., 1998; Shonkoff et al., 2012a, 2012b; Shonkoff & Phillips, 2000; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). For children without adequate parental and other supports, exposure to early and ongoing traumatic stress has profound effects on brain development, including alterations in brain size and structure, difficulties with learning and memory, and diminished self-regulation and coping (Cohen, Perel, DeBellis, Friedman, & Putnam, 2002; National Scientific Council on the Developing Child, 2005; Putnam, F., Olafson, E., Boat, B., & Pearl, E. (2006); Perry, 2001; Perry, Pollard, Blakeley, Baker, & Vigiliante, 1996; Saxe, Ellis, & Kaplow, 2006). The ACE Study identified the relationship between the cumulative impact of adverse childhood experiences (e.g., physical or sexual abuse, witnessing violence) with later social, emotional, and cognitive impairments; high-risk behaviors; severe health problems; and a heightened risk of early death (Felitti & Anda, 2010; Felitti et al., 1998).

In both human and economic terms, the cost of not addressing the traumatic stress associated with these adverse experiences is significant: impacts are seen in the health care, employment, child welfare, homelessness, criminal justice, and education systems. The extraordinary toll that traumatic stress and interpersonal violence can take on individuals and society requires us to address trauma—and its impact—across all service systems.

Trauma-Specific vs. Trauma-Informed

"Trauma-specific services" and "trauma-informed care" are sometimes used interchangeably; both provide care for people exposed to traumatic stress. However, trauma-specific services are clinical interventions, whereas trauma-informed care addresses organizational culture and practice. Trauma-specific services are clinical interventions that are designed to address trauma-related symptoms and PTSD directly in individuals and groups. In contrast, trauma-informed care is defined as a universal framework that requires changes to the practices, policies, and culture of an entire organization, so all staff have the awareness, knowledge, and skills needed to support trauma survivors.

Definitions (SAMHSA, 2014)
Trauma-specific services: The term "trauma-specific services" refers to evidence-based and promising prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders (including substance use and mental disorders) that developed during or after trauma.
Trauma-informed care: Trauma-informed care is a strengths-based service delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper, Bassuk, & Olivet, 2010, p. 82). It also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals who already have histories of trauma, and it upholds the importance of consumer participation in the development, delivery, and evaluation of services.

Trauma-Specific Services

Advances in the science of traumatic stress have enhanced the field's ability to understand, diagnose, and address posttrauma responses in the mental health system. In 1980, the APA first included PTSD in the Diagnostic and Statistical Manual of Mental Disorders– 3rd edition (DSM-III); over the past three decades, PTSD has become a well-established diagnostic category (American Psychiatric Association, 2013). Recent changes in the DSM–5th Edition (DSM-V) (American Psychiatric Association, 2013) further refine how PTSD is understood and diagnosed in the mental health system. These changes include moving away from understanding PTSD as an anxiety disorder and creating the new diagnostic category, Trauma and Stressor-Related Disorders, to further distinguish PTSD from other mental health disorders (Friedman, 2014).

Research has demonstrated that various empirically supported treatment interventions are effective in treating PTSD in children, adolescents, and adults (Cohen, Mannarino & Deblinger, 2006; Harris, 1998; Morrissey et al., 2005; Najavits, 2004). Individual and group interventions to address PTSD show considerable promise with a range of populations and are being used across a number of service settings (see table 1). In addition to the evidence-based practices noted here, many promising approaches for addressing PTSD are being piloted to expand the menu of evidence-based, trauma-specific services. There is a growing need to adapt evidence-based interventions for use with particular populations—considering aspects such as gender and cultural background—and for particular settings (e.g., schools, juvenile justice programs, homeless shelters).

Table 1. Evidenced-Based, Trauma-Specific Services

Intervention	Description	Populations
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) *(Cohen, Mannarino, & Deblinger, 2006)*	TF-CBT is a psychosocial treatment of 8–24 sessions designed to treat PTSD and related emotional and behavioral problems in adults, children, and adolescents.	▪ Male and female ▪ Children and youth aged 3–21 ▪ Black or African American ▪ White ▪ Race/ethnicity unspecified Adapted for: ▪ Transition-age youth aged 18–25 ▪ Latino and tribal populations ▪ Children from outside the United States
Child–Parent Psychotherapy (CPP) *(Liebermann, Ghosh Ippen, & Van Horn, 2006; Lieberman, Van Horn, & Ippen, 2005)*	CPP is a relational treatment for parents and their very young children who have experienced at least one traumatic event and, as a result, are experiencing developmental, behavioral, attachment, and/or mental health problems, including PTSD.	▪ Male and Female ▪ Ages 0–5 (Early childhood) 　Ages 18–25 (Young adult parents) 　Ages 26–55 (Adult parents) ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ White ▪ Race/ethnicity unspecified Adapted for: ▪ Latino immigrant mothers and their infants
Seeking Safety (SS) *(Najavits, 2004)*	SS is a present-focused treatment for clients with a history of trauma and substance abuse. The treatment was designed for flexible use, including group or individual formats.	▪ Male and female ▪ Ages 13–17 (Adolescent) ▪ Ages 18–25 (Young adult) ▪ Ages 26–55 (Adult) ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ White ▪ Race/ethnicity unspecified Adapted for: ▪ Homeless ▪ Veterans ▪ Prisoners ▪ Outpatient, inpatient, and residential settings

Intervention	Description	Populations
Prolonged Exposure (PE) **Therapy** *(Foa, E. B., & Kozak, M. J., 1986)*	PE is a cognitive-behavioral treatment program for adults who have experienced single or multiple/continuous traumas and have PTSD.	▪ Male and female ▪ Ages 18–25 (Young adult) ▪ Ages 26–55 (Adult) ▪ Ages 55+ (Older adult) ▪ Black or African American ▪ White ▪ Race/ethnicity unspecified ▪ Non-U.S. population Curriculum translated into Hebrew, Japanese, and Spanish.
Cognitive Processing Therapy (CPT) *(Monson et al., 2006)*	CPT is an adaptation of the evidence-based therapy known as cognitive behavioral therapy (CBT) used by clinicians to help clients explore recovery from PTSD and related conditions. CPT is a manualized, 12-session cognitive behavioral treatment for PTSD that offers an alternative to purely exposure-based interventions.	▪ Adults, male and female ▪ Survivors of rape and sexual assault Adapted for: ▪ Veterans ▪ Refugees
Eye Movement Desensitization and Reprocessing (EMDR) *(Shapiro, 1995)*	EMDR is a one-on-one form of psychotherapy designed to reduce trauma-related stress, anxiety, and the depression symptoms associated with PTSD and to improve overall mental health functioning for adults.	▪ Male and female ▪ Ages 18–25 (Young adult) ▪ Ages 26–55 (Adult) ▪ Ages 55+ (Older adult) ▪ American Indian or Alaska Native ▪ Black or African American ▪ Hispanic or Latino ▪ White ▪ Race/ethnicity unspecified Adapted for: ▪ Children ▪ Adolescents

In adults, the most successful interventions include a combination of cognitive behavioral therapies, such as Prolonged Exposure (PE) Therapy and Cognitive Processing Therapy (CPT), and medication, including the antidepressants Zoloft® and Paxil®—the first medications to receive APA approval as treatment for PTSD (Friedman, 2014). Eye Movement Desensitization and Reprocessing (EMDR) is also an effective, evidence-based treatment for PTSD in adults (Friedman, 2014; Foa, Keane, Friedman, Cohen, & ISTSS, 2009). Seeking Safety, a group or individual intervention for addressing PTSD and substance abuse, has demonstrated consistently

positive outcomes (Foa, E. B., Keane, T. M., Friedman, M. J., Cohen, J. A., & International Society for Traumatic Stress Studies, 2009) and is one of the few promising practices that has been adapted to nonclinical service sectors, including homeless shelters and criminal justice settings.

For children, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) shows the strongest evidence of success. Drawing on this evidence base, variations of cognitive behavioral therapy have been adapted for particular settings, including the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) (Foa et al., 2009). Child–Parent Psychotherapy (CPP), a relational approach to addressing trauma that includes children aged birth through 5 and their caregivers, also shows positive effects for reducing PTSD symptoms (Foa et al., 2009).

The growing science related to the impact of trauma at the neurobiological level has led to a greater need for therapeutic interventions that address the body-based symptoms associated with PTSD. People who have experienced trauma sometimes disconnect from emotions and physical sensations in an attempt to cope. Body-oriented, nonverbal activities serve as a way for trauma survivors to reconnect to their bodies, manage their feelings, and communicate in nontraditional ways. For younger children, who have fewer words to express how they feel, the use of play and body-based activities helps manage stress and strengthen coping skills. Creative Arts Therapies (CATs) such as art, movement, dance, and music, hold promise; however, additional research is needed to support the evidence base for these therapies as effective treatments for PTSD.

Within the field, there is continued interest in understanding more about the complex manifestations of PTSD and its relationship to individual and external factors (e.g., age of onset, number and type of traumatic experiences, social supports, family and cultural context) (Cook et al., 2005). Of particular concern is ensuring that the Western-based PTSD diagnosis is applicable to individuals from non-Western cultures, where symptom expression may not match the diagnostic criteria in the DSM-V (Witzum & Kotler, 2000). For example, symptoms of PTSD among displaced populations and refugees often involve severe loss and grief, which are not necessarily seen as central components of treatments that focus on anxiety reduction and the regulation of arousal. Physical or "somatic" responses to traumatic experiences are also common in many non-Western cultures, and suffering is sometimes described in spiritual versus medical terms (Argenti-Pillen, 2000). However, these issues are often overlooked in Western therapies and may contribute to high drop-out rates or poor response to treatment (Cook Ross Inc, 2010; Nicolas, DeSilva, Grey & Gonzalez-Eastep, 2006; World Health Organization, 2010). Additional research on cultural adaptations to evidence-based, trauma-specific treatments is critical to provide culturally and linguistically competent treatment for diverse populations.

Trauma-Informed Care
As the field of traumatic stress has developed, so too has our understanding of the complexity involved in addressing its impact. Consensus is growing that, in addition to evidence-based treatment for PTSD, universal, systemic approaches are needed to address the magnitude of trauma and violence affecting children and adults across service systems. Health is, at least in part, socially determined (Bronfenbrenner & Morris, 1998; Masten, 2011). To be successful and meet the needs of the millions affected by traumatic stress, interventions that address traumatic stress must target individual, interpersonal, and environmental factors (Bloom, 2000; Bronfenbrenner & Morris, 1998; SAMHSA, 2014; Saxe et al., 2006).

From an ecological perspective, organizations and systems are seen as critical targets for trauma intervention. As such, the focus of interventions expands beyond the individual therapy hour into the larger environment. Trauma-informed care can be viewed as a "universal design" for serving trauma survivors, provided to all, by all. The entire system is used as a vehicle for intervention (Bloom, 1997; Clervil & DeCandia, 2013; Guarino, 2014; Guarino, Soares, Konnath, Clervil, & Bassuk, 2009; Harris & Fallot, 2001; Hopper, Bassuk, & Olivet, 2010; SAMHSA, 2014). Providing trauma-informed care requires an organizational commitment to building employees' awareness, knowledge, and skills to support recovery. At a minimum, trauma-informed organizations endeavor to do no further harm and avoid retraumatizing children, youth, or adults receiving services (Moses, Reed, Mazelis, & D'Ambrosio, 2003). Regardless of the services an agency provides, organizations across systems can adopt the core trauma-informed principles shown in table 2.

Table 2. Core Principles of Trauma-Informed Care

Core Principles	Examples
Understanding Trauma and Its Impact	Understanding traumatic stress and recognizing that many current behaviors and responses are ways of adapting to and coping with past traumatic experiences.
Promoting Safety	Establishing a safe physical and emotional environment where basic needs are met; safety measures are in place; and provider responses are consistent, predictable, and respectful.
Supporting Consumer Control, Choice, and Autonomy	Helping people regain a sense of control over their daily lives. Keeping people informed about all aspects of the system and allowing them to drive goal planning and decisionmaking.
Sharing Power and Governance	Sharing power and decisionmaking across all levels of an organization, whether related to daily decisions or when reviewing and establishing policies and procedures.
Ensuring Cultural Competence	Respecting diversity within the program, providing opportunities for consumers to engage in cultural rituals, and using interventions specific to cultural backgrounds.
Integrating Care	Maintaining a holistic view of consumers that acknowledges the interrelated nature of emotional, physical, relational, and spiritual health and facilitates communication within and among service providers and systems.
Healing Happens in Relationships	Believing that establishing safe, authentic, and positive relationships can be corrective and restorative to trauma survivors.
Understanding That Recovery Is Possible	Understanding that recovery is possible for everyone regardless of how vulnerable he or she may appear, instilling hope by providing opportunities for consumer involvement at all levels of the system, and establishing future-oriented goals.

Source: Guarino, Soares, Konnath, Clervil, & Bassuk, 2009.

A range of established models and tools has been developed to help organizations become trauma-informed across service settings. Harris and Fallot (2001) were among the first to articulate a comprehensive array of strategies that organizations can use to adopt trauma-informed care. Community Connections developed "Creating Cultures of Trauma-Informed Care" and Sandra Bloom created the Sanctuary Model, which offers organizations concrete tools for implementing the model's core principles in milieu settings (Bloom, 1997).

In addition to these models, a number of organizational self-assessments can guide agencies through the change process. Assessment tools include concrete benchmarks of trauma-informed care for daily practice. Although they are not formal measures of the extent to which an organization is trauma-informed, these tools provide a valuable roadmap and process for organization-wide, trauma-informed change. Maine's System of Care Trauma-Informed Agency Assessment was designed for child-serving agencies (Yoe, Hornby, Goan, & Tiernan, 2012). Other tools include the National Council for Behavioral Health's Trauma-Informed Care Organizational Self-Assessment, used as part of their consultation services to organizations, and the Chadwick Center's Trauma System Readiness Tool for child welfare agencies (Chadwick Center for Children & Families, 2013). The National Center on Family Homelessness at American Institutes for Research developed the Trauma-Informed Organizational Self-Assessment (Guarino et al., 2009) for homeless service settings. It has since been adapted for agencies that serve women veterans and community-based organizations serving displaced children and families (Clervil, Guarino, DeCandia, & Beach, 2013; Guarino, 2011).

In 2010, Hopper, Bassuk, and Olivet conducted a comprehensive review of the field to assess the level of trauma-informed care as an emerging, promising practice. Although research on the effectiveness of trauma-informed care is in its infancy, preliminary outcomes include a decrease in program participants' emotional reactions,s a decrease in crises in programs, an enhanced sense of safety, and greater collaboration among service providers (Cocozza et al., 2005; Community Connections, 2002; Morrissey, Ellis, & Gatz, 2005; Noether et al., 2007). A few pilot programs have demonstrated some improvement in client functioning in trauma-informed service settings (Morrissey et al., 2005; Kramer, unpublished), suggesting that trauma-informed care is a cost-effective approach to addressing trauma compared to standard or traditional programming (Domino et al., 2005).

Trauma-Informed Care and Trauma-Specific Services: Why Both Are Needed

Historically, treatment for trauma and PTSD has been focused on the individual and delivered by clinicians in one-on-one therapies—often in the mental health system. However, an increasing number of evidenced-based, trauma-specific services treat PTSD in various populations. These services are essential to advance the science and treatment of PTSD and improve outcomes for children and adults. However, there are challenges to relying exclusively on mental health interventions to prevent, address, and mitigate the impact of trauma. Challenges include (1) treatment limitations; (2) issues of availability, access, and quality; and (3) lack of attention to contextual factors.

Despite recent advances, all treatments have their limitations (Foa, Keane, Friedman, & Cohen, 2008). Drop-out rates for patients with PTSD are as high as 50 percent (Schottenbauer, Glass, Arnkoff, Tendick, & Gray, 2008). Some treatments show limited efficacy (Foa et al., 2008) or have not been tested with particular populations (e.g., homeless) or cultural groups, raising concerns about their generalizability (Kazdin, 2008). Although evidence-based treatments demonstrate improved outcomes, research indicates that regardless of technique, the client–therapist relationship is a key factor affecting the outcome (Kelley, S. D., & Bickman, L. (2009). In addition, most clinicians do not use them in practice and rely instead on clinical judgment (Drake et al., 2001; Kelley & Bickman, 2009; Kazdin, 2010). In some circumstances, people receiving services may not be ready to address their traumatic experiences in a clinical setting, or they may prefer faith-based or alternative healing approaches. Finally, many people served in public systems of care may not be properly assessed for PTSD and thus may never be referred for treatment. Many present with posttrauma responses that do not meet the threshold for diagnosis, making them ineligible for such services.

Currently, the availability of and access to evidence-based treatments in mainstream service systems is inadequate to meet the need. For example, there are too few licensed mental health providers for maltreated youth involved with child welfare, and many of them do not use effective, evidence-based, empirically supported practices (Stagman & Cooper, 2010). Exacerbating the problem is the lack of evidence-based mental health treatment available in the community; even among children and youth who have access to mental health services, quality of care is often deficient (Shipman & Taussig, 2009). Similarly, among homeless families, despite severe trauma histories and associated mental health problems, mothers' utilization of mental health services tends to be infrequent and extremely rare for the children (Hayes & DeCandia, 2012).

Finally, organizational climate studies and resiliency research support a move away from a strictly medical model of individual illness toward a broader understanding of how social context and environmental factors impact functioning and resilience. The context of any environment has important effects on individual and group behavior (Bronfenbrenner & Morris, 1998). Factors such as organizational culture, structures (policies and practices), provider and consumer characteristics, and physical space have been studied for their relative effect on human behavior and treatment outcomes (Insel & Moos, 1974; Moos, 1973; Rivard et al., 2003; Rivard et al., 2004; Rivard, Bloom, McCorkle & Abromovitz, 2005). In addition, resiliency research

highlights the importance of factors beyond individual traits (e.g., social support) in the human response to traumatic experiences (Bonanno, 2004, 2014; Bonanno, Keltner, Holen, & Horowitz, 1995; Bonanno, Keltner, Knoll, & Putnam, 2002; Cutuli, & Herbers, 2014; Masten, 2011; Masten & Coatsworth, 1995, 1998; Masten et al., 1999; Masten, Herbers, Cutuli, & Lafavor, 2008). These contextual factors are especially relevant to the treatment and care of traumatized groups from diverse cultural backgrounds (Mollica, 2006).

Trauma survivors are being served in all service sectors. Some are not intended to be treatment settings, nor do they have the capacity to provide mental health services; however, they still have a significant impact on participants' recovery and well-being. Comprehensive care for trauma survivors from all cultural backgrounds, in all service settings, requires systems to provide both trauma-specific services *and* trauma-informed care. Individual and organization-wide approaches are viewed as complementary and not exclusive; one supports the efficacy of the other.

Trauma Intervention Across Service Systems

Systems at various stages of implementing trauma-informed care and trauma-specific services include behavioral health and health care; justice; child welfare; education; and homeless services. Federal agencies are partnering to address trauma, fostering a cross-system vision for trauma intervention and recovery. To gain a more complete picture of these efforts, we highlight examples of how systems are adopting trauma-informed care and trauma-specific services to support children and adults.

Behavioral Health and Health Care

The U.S. Department of Health and Human Services' (HHS) SAMHSA has led the call for trauma-informed care in behavioral health. The seminal Women Co-Occurring Disorders and Violence Study, a 5-year multisite study that began in 1998, was the first federal effort to address the service needs of women with co-occurring substance use and mental health disorders who experienced trauma, and helped establish the federal direction around trauma-informed care and trauma-specific services for adult trauma survivors (Moses et al., 2003). SAMHSA continues to lead the field in defining and integrating trauma-informed care with efforts including (1) supporting the National Child Traumatic Stress Network (NCTSN); (2) launching its National Center for Trauma-Informed Care (NCTIC); (3) leading the charge to minimize retraumatizing practices in behavioral health settings and beyond, including alternatives to seclusion and restraint; and (4) most recently, developing a comprehensive "Treatment Improvement Protocol" number 57 (TIP 57) to set the standard for trauma-informed care with integrated trauma-specific services in behavioral health (SAMHSA, 2014).

Veterans' Administration (VA)

The VA is also a leader in addressing trauma in behavioral health settings. For the past 25 years, the VA's National Center for PTSD has led the trauma field in researching, implementing, and disseminating evidence-based practices for treating PTSD, and educating the public and mental health professionals about trauma and trauma-specific interventions. The VA's focus is on providing veterans with access to high-quality, trauma-specific clinical services to address PTSD, including PE therapy and CPT—both evidence-based practices.

Justice

SAMHSA's Trauma and Justice Strategic Initiative addresses the intersection between criminal justice and trauma, bringing trauma-informed care and trauma-specific services to targeted aspects of the criminal justice system (e.g., law enforcement, courts, jails, and community corrections). SAMHSA's GAINS Center for Behavioral Health and Justice Transformation developed a training curriculum, How Being Trauma-Informed Improves Criminal Justice System Responses. Training is designed for criminal justice professionals, including police, community corrections, and court personnel.

Juvenile Justice

The U.S. Department of Justice (DOJ) Office of Juvenile Justice and Delinquency Prevention (OJJDP) has led several initiatives to address the impact of violence and trauma on children. Since 2000, OJJDP's Safe Start Initiative has been supporting communities to pilot best practices to mitigate the impact of violence on children, including implementing trauma-specific

interventions and trauma-informed care. Launched by Attorney General Eric Holder in 2010, the DOJ's Defending Childhood Initiative seeks to prevent children's exposure to violence, mitigate the impact of exposure, and raise public awareness. The 2012 Report of the Attorney General's Task Force on Children Exposed to Violence included key recommendations to support trauma-informed practices. In addition, the DOJ Office of Justice Programs highlights evidence-based or promising trauma-specific services for this population, including Trauma Affect Regulation: Guide for Education and Therapy (TARGET), an intervention used with youth in juvenile detention facilities.

SAMHSA's National Child Traumatic Stress Network (NCTSN) is also supporting the emerging focus on trauma-informed care in juvenile justice. Efforts include (1) establishing a juvenile justice work group and learning collaborative across NCTSN sites piloting trauma intervention in justice settings or with justice-involved children and youth; (2) holding a Trauma-Informed Juvenile Justice Roundtable in 2013 to discuss next steps for creating trauma-informed juvenile justice systems; and (3) developing resources, including the NCTSN Bench Card for the Trauma-Informed Judge to support criminal justice professionals in adopting trauma-informed care.

Child Welfare

HHS's Administration for Children and Families (ACF) Children's Bureau awarded five 5-year cooperative agreements to create trauma-informed child welfare systems. Grantees from Massachusetts, North Carolina, Connecticut, Montana, and Colorado will build the capacity of the child welfare system to provide trauma-specific interventions and trauma-informed care across the system. In 2012, the ACF issued an Information Memorandum that required state, tribal, and territorial child welfare agencies to describe how they will screen for and treat emotional trauma in their state plans. The ACF Child Welfare Information Gateway provides resources on trauma and trauma-informed care for child welfare systems, and secondary traumatic stress among child welfare professionals. In 2013, the ACF, SAMHSA, and Centers for Medicare & Medicaid Services issued a joint letter to state child welfare agency directors to incorporate trauma-focused screening, trauma-specific interventions, and approaches to trauma services reimbursement. Currently, the ACF Children's Bureau is funding a 5-year demonstration project across five communities nationally, representing a complex merger of two systems—child welfare and housing—to serve some of the highest need families. Trauma-informed care and the use of evidence-based, trauma-specific services are hallmarks of this initiative.

SAMSHA's NCTSN's Child Welfare Trauma Training Toolkit is used to educate professionals on trauma and trauma-informed practice. The Chadwick Trauma-Informed Systems Project, part of the NCTSN, has led a national effort to develop a new resource to help child welfare professionals, "Creating Trauma-Informed Child Welfare Systems: A Guide for Administrators," which contains guidelines for trauma-informed care in child welfare systems, including trauma-specific services and system-wide practices.

Education

Efforts in schools to address trauma are largely targeted to providing intensive, specialized, trauma-specific interventions for students with the most significant challenges. Three trauma-specific interventions have been developed specifically for use in schools and have empirical

support for reducing trauma-related symptoms: cognitive behavioral intervention for trauma in schools (CBITS), the multimodality trauma treatment (MMTT), and the UCLA Trauma/Grief Program (Foa et al., 2009).

In addition to trauma-specific services, there is a movement to adopt trauma-informed care as a universal, school-wide framework for preventing and addressing trauma in school settings. Tools and strategies for creating trauma-sensitive schools include Massachusetts Advocates for Children's seminal Helping Traumatized Children Learn; Washington State's Compassionate Schools curriculum; Sandra Bloom's Creating Sanctuary in the School; and the National Child Traumatic Stress Network's Child Trauma Toolkit for Educators. Although all of these efforts have raised awareness about the impact of trauma and the need for trauma-informed care in educational settings, none has been formally systematized or evaluated for feasibility, fidelity, and benefits to school climates or student performance. Even though additional research is needed, some states are making gains in bringing trauma-informed care to school settings.

> **State Spotlight:**
> **Massachusetts Safe and Supportive Schools**
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> On August 13, 2014, Massachusetts Governor Deval Patrick signed the Safe and Supportive Schools provisions into law. This groundbreaking legislation lays the foundation for integrating trauma-specific services and trauma-informed care into educational settings to benefit all students, particularly children and youth exposed to and impacted by traumatic stress. This legislation defines safe and supportive schools as:
>
> *"… schools that foster a safe, positive, healthy and inclusive whole-school learning environment that (i) enables students to develop positive relationships with adults and peers, regulate their emotions and behavior, achieve academic and non-academic success in school and maintain physical and psychological health and well-being and (ii) integrates services and aligns initiatives that promote students' behavioral health, including social and emotional learning, bullying prevention, trauma sensitivity, dropout prevention, truancy reduction, children's mental health, foster care and homeless youth education, inclusion of students with disabilities, positive behavioral approaches that reduce suspensions and expulsions and other similar initiatives."*

Homeless Services

Often individuals and families who experience homelessness have had multiple, ongoing traumatic exposures throughout their lives in the form of childhood abuse and neglect; domestic and community violence; and the significant stress associated with poverty and the loss of home, safety, and sense of security (Hopper et al., 2010). Launched in 1992, the Worcester Family Research Project was the first longitudinal study to examine the lives of homeless families to understand the correlates, causes, and consequences of family homelessness (Bassuk et al., 1997). Among the landmark findings were extraordinarily high rates of violent victimization among homeless mothers; rates of lifetime trauma exceeded 90 percent. Two decades later, the prevalence of trauma remains constant. The SHIFT (Service and Housing Interventions for Families in Transition) Study found that 93 percent of mothers had a history of trauma, and 81 percent had experienced multiple traumas (Hayes et al., 2013). Approximately half of the mothers met the diagnostic criteria for PTSD.

In response to high rates of violence and trauma in the lives of individuals and families who are homeless, trauma-informed care has emerged as a best practice in homeless service settings (United States Interagency Council on Homelessness (USICH), 2010). Although not a clinical

system, homeless service providers often serve people with significant trauma histories. Supporting homeless service settings to become trauma-informed, The National Center on Family Homelessness at AIR has led the field in creating trauma-informed assessment tools and models for implementation in the homeless service sector (Hopper et al., 2010; Guarino et al., 2009). In February 2014, the USICH and federal partners released "Family Connections: Building Systems to End Family Homelessness." Key strategies for addressing family homelessness were outlined, including "the use of trauma-informed services in every intervention" (USICH, 2014).

Spotlight:
Trauma Intervention in Homeless Services

The National Center on Family Homelessness at American Institutes for Research is building the capacity of the homeless service system to integrate trauma-informed care and trauma-specific services to meet the needs of trauma survivors in shelter settings.

START With Kids

Funded by the DOJ's OJJDP as part of its Safe Start Initiative, START With Kids (**S**helter-based, **T**rauma-Informed **A**ssessment, **R**eferral, and **T**reatment) provides trauma-informed, clinically driven care to children and families in emergency shelters. Intervention components include (1) comprehensive child assessments to identify needs; (2) child-specific service plans to address needs; and (3) Strengthening Family Coping Resources, a multifamily group implemented in shelters to build safety, connection, and ritual for families exposed to violence and trauma.

Trauma-Informed Care for Women Veterans Experiencing Homelessness

Funded by the Bristol-Myers Squibb Foundation as part of its Mental Health & Well-Being initiative, Trauma-Informed Care for Women Veterans Experiencing Homelessness is a multisite demonstration project to address the need for an organization-wide approach to understanding and responding to trauma in veteran-serving agencies and to build the capacity of community-based organizations to adopt trauma-informed care.

Next Steps for the Field

The study of psychological trauma has a curious history … periods of active investigation have alternated with periods of oblivion. Repeatedly, in the past century, similar lines of inquiry have been taken up and abruptly abandoned, only to be rediscovered much later… it (the field) has been periodically forgotten and must be periodically reclaimed (Herman, 1992, p. 7).

Given the prevalence of trauma in the lives of children and youth, civilians, and veterans, the need for a comprehensive approach to addressing traumatic stress across service sectors is greater than ever. Providers, policymakers, funders, and researchers vary in their understanding and prioritization of trauma-specific services and trauma-informed care. Sometimes these terms are used interchangeably, which confounds the evidence base and polarizes the approach. What is needed to advance the field? Foremost, a clear consensus on the terminology is needed to guide effective research and practice. Resources must be made available to study the effectiveness of both approaches, and to support implementation. Policymakers can support these efforts by prioritizing comprehensive trauma intervention across all public systems of care.

A commitment by all leaders, and public and private support—at the federal, state, and local levels—are needed to fund research and the resources aimed at effective implementation. Methodologically rigorous studies are required to continue to build the evidence base of trauma-informed care as a framework and complement to trauma-specific services. Training the health and human service workforce represents a critical step in this evolution. Compared to the enormous human and economic toll that unaddressed trauma takes on individuals and communities, workforce development represents a relatively low-cost, high-yield investment.

Building trauma-informed systems requires a commitment to the ongoing training and support of providers and organizations to transform their practices and incorporate appropriate treatments for the populations served. One-shot trainings are not enough and will ultimately fail. The most successful method to transfer knowledge effectively is an empirically based systematic process through which skills, techniques, models, and approaches are delivered to, and applied by, providers (Backer, David, & Soucy, 1995). Active learning has been shown to be far more effective than passive learning (Barwick, Boydell, & Omrin, 2002; King, Hawe, & Wise, 1998; Lomas, 2000; Wilkes, 1997). Adults in particular have been found to learn more effectively when actively engaged in the learning process (Kolb, 1984). In addition, systems change takes time; leaders of organizations and their staff require ongoing technical assistance to realize sustainable systems change.

In 2001, the Institute of Medicine reported on the "quality chasm" between research and practice. Building relationships is the "most efficient way to transfer research knowledge to the field" (Barwick et al., 2002; Lomas, 2000). As such, funding agencies, leaders, and policymakers can support relationships between the research and practice communities in developing trauma-informed systems and evidence-based practices. Currently, there is not one standard of measurement to assess the degree to which an organization is trauma-informed, and whether organizations that provide comprehensive trauma-informed care produce better outcomes than traditional systems. Measurement tools with valid and reliable psychometric properties are

needed to advance the field and study the effectiveness of organizational approaches to trauma intervention for diverse populations across and within different settings. The heterogeneity of traumatic experiences and individual variables results in a heterogeneity of symptom expression (Bonanno, 2004, 2014), and, thus, a variety of responses to treatment. Ongoing research is needed to study the effect of a host of individual and cultural variables in the treatment of PTSD as well as the influence of environmental factors; both influence the outcome.

We all have a role to play in addressing the scope and potentially devastating impact of traumatic stress. Addressing trauma is not the purview of the mental health system alone. Nonclinical settings (e.g., homeless, child welfare, criminal, and juvenile justice) that do not see themselves as having the capacity to provide trauma-specific services can adopt trauma-informed care to support the people they serve. Conversely, even in settings where trauma-specific services are prominent (e.g., mental health, VA), a trauma-informed organizational structure is recommended and could even support the efficacy of individual treatments.

Conclusion

We can no longer ignore the impact of trauma. All of society's service settings have the potential to support recovery and mitigate the consequences of unaddressed trauma on health and well-being. History has revealed our tendency to alternately reject or accept the centrality of trauma in the lives of those who are suffering. Investing in research and building workforce knowledge and skills can safeguard us against repeating the pitfalls of the past and send a message to all who have experienced trauma that recovery is possible and that they are not alone.

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