PA Department of Human Services
Office of Mental Health and Substance Abuse
Bureau of Children's Behavioral Health Services

Creating Trauma-Informed and Healing Centered Residential Care Environments: An Organizational Assessment Tool for Human Service Providers in Pennsylvania

Organization/Program:_____ Date Completed:_____

Job Title:_____

Introduction and Instructions

In Pennsylvania, the transition of human service organizations to a model of care that seeks to prevent trauma responds effectively to the impact of trauma on youth, families, caregivers and communities, is expected to occur along a continuum whereon the first step is to become "Trauma Aware." Further along this continuum, are levels of knowledge, skill, organizational structure and culture, that represent a level of care meeting the "Trauma Sensitive" standard, and then the "Trauma Informed" standard and finally, the highest level of Trauma-informed Care in which the approach is consistently "Healing Centered." [1] The following assessment form was developed to provide a monitoring tool for use in assessing Pennsylvania's residential care and treatment facilities' progress along the Trauma Informed PA (TIPA) Continuum. Further, it is designed to help monitoring authorities to provide residential care and treatment facilities with feedback, technical assistance, support and guidance as they work to progress along the continuum. This document is a work in process being drafted for review by a range of stakeholders. It is being adapted with permission from similar tools created by authors at the University of South Florida and others cited at the end.

[1] **Trauma Informed Pennsylvania Plan (2020)**

Administration of Organizational Assessment Form

The Organizational Assessment shown below can be used for organizations just beginning or already practicing principles of Trauma-Informed care. The assessment tracks the potential use of one or more sources of data and the extent to which it is occurring in the organization for the purpose of determining existing components of Trauma Informed Care that need further assessment, planning, data collection, and implementation while highlighting those components where progress has been made.

Some organizations may choose to use this document in self-assessment efforts as a way to prepare for an external audit. This tool can be distributed to a task force of staff and key informants (e.g., learning collaborative team, TIC workgroup, etc.) to fill out and return within a short time period (e.g., one week) and the results can be aggregated for the organization as a whole and used to assist in the planning of next steps toward furthering Trauma-Informed Care within the organization.

A Staff interviews
B Resident/Caregiver Interviews
C Review of Policies/Procedures and Training Programs/Plans
D Resident/Client Record Review
E Treatment Team or De-briefing
F Observation
G All of the Above

Results

Specific instructions are located within the margins of the tool below. There are three overall domains with numbered items listed: (1) Organizational structure, finance, and leadership; (2) Developing a Collaborative, Trauma-Informed and Healing-Centered Workforce; (3) Developing Trauma-informed and Healing-Centered Clinical Programs and Practices. Points are assigned to each item on the assessment using the 0-5 scale shown.

This tool may be used to assess progress along the Trauma-Informed/Healing Centered care continuum, and/or to guide an organization in its efforts to become a Trauma-Informed and Healing Centered Residential Care environment. However, it should not be the sole determining factor in a licensing process. Scores on this instrument are highly dependent on the amount and kind of information on which the ratings are made. The more data on which the ratings are based, the more likely that scores will represent a valid measure of the level at which the Organization functions as a Trauma-informed and Healing Centered entity. Preliminary benchmarks for each level on the HEAL PA continuum are noted for consideration and further discussion.

Creating Trauma-Informed Residential Care Environments: Organizational Assessment

Continuum Benchmark Item Key:	**Benchmark Designation score key:**	**(0-49** = "Noticing" **and 50-79=** "contemplating"**)**
✠= Trauma-Aware	"Trauma- Aware: Recognizing and Planning"	**80-159 (82= sum of items marked ✠)**
●= Trauma-Sensitive	"Trauma Sensitive: Planning and Implementing"	**160-239 (179= sum of items marked ●)**
☒= Trauma-Informed	"Trauma Informed: Implementing and Evaluating"	**240-289 (251= sum of items marked ☒)**
☺= Healing-Centered	"Healing Centered: Evaluating & Revising/Sustaining"	**291-320 (305= sum of items marked ☺)**

Section 1: Organizational Structure, Finance, and Leadership

Code the source of the data in the first column with the data source (A-G). Check the box in the appropriate column for the corresponding description of your organization's plan as it relates to the item in each row

Data Source	**Status**					
Enter all that Apply **A** Staff interviews **B** Resident/Caregiver Interviews **C** Review of Policies/Procedures and Training Programs/Plans **D** Resident/Client Record Review **E** Treatment Team or De-briefing **F** Observation **G** All of the Above	**0** **Missing:** Little to no Awareness of the need for a plan	1 **Recognizing:** Need for plan is recognized No plan yet developed	2 **Planning:** Plan has been developed but not yet implemented	3 **Implementing**: Plan is being actively implemented	4 **Evaluating**: Plan is in full implementation and data is being gathered to evaluate impact	5 **Revising/Sustaining**: Implementation strategies are revised as necessary based on analyses of outcome data and feedback

Objective	Data Source	Status					
1. Governance, Leadership, Infrastructure, and Finance	**Enter all that Apply A B C D E F G**	**0 Missing**	**1 Recognizing**	**2 Planning**	**3 Implementing**	**4 Evaluating**	**5 Revising/ Sustaining**
A. Leaders understand how knowledge about the impact of trauma, gained along the HEAL PA continuum, can enhance the organization's ability to fulfill its mission, and they seek to implement Trauma Informed approaches relevant to fulfilling the organization's mission.		Leaders seem unaware of the impact and importance of trauma awareness, and the potential of TIC	Leaders are aware that the general topic of trauma and trauma informed care needs attention, but have not made a plan to get any training for themselves in an effort to lead the organization in the development of Trauma informed care	Leaders have not yet received training, but there are specific plans for leaders to become trained and able to lead the organization's efforts to develop trauma informed/healing centered care approaches to the fulfillment of its mission.	Most or all organizational Leaders have been, or are currently being, trained to understand how knowledge about the impact of trauma, gained along the HEAL PA continuum, can enhance the organization's ability to fulfill its mission.	✠ All leaders have been trained and are monitoring the growth of trauma knowledge and TIC approaches throughout the organization. They are aware of their own and other's needs for additional training, coaching and collaboration regarding TIC implementation	Leaders are using what they have learned through personal training, organizational self-assessment and feedback to implement a plan to ensure that they remain up to date and engaged in the ongoing organizational process of becoming and sustaining a Trauma informed/healing centered organization.

B. Leadership has identified and addressed cultural and policy barriers, externally and internally, that may impede implementation of trauma-informed/healing centered care.			✠				
C. Incentives are in place to support staff as changes in organizational policies and expectations are made.			✠				
D. The organization's mission statement and/or written strategic goals, express a commitment to providing trauma-informed/Healing Centered services and supports			✠				
E. The organization's formal policies and procedures reflect language and practice of trauma-informed care & demonstrate a commitment to reducing the potential for re-traumatization through an explicit emphasis on safety, respect, & confidentiality.			✠				
F. The organization has incorporated trauma-informed practices into the list of qualifications and competencies for various levels of residential staff. These identified trauma-informed practices and competences are evaluated as part of the			✠				

routine performance review process.							
G. The organization provides the necessary financial and other resources for implementation of Trauma Informed/Healing-Centered Care				✠			
H. The organization provides financial and other resources (technology, staffing, training) for the collection of information and data necessary to evaluate the effectiveness of the organization's efforts to implement trauma informed care.			✠				
I. The organization has developed a formal ready response for crisis/disaster/emergency management that reflects trauma informed values.			✠				
2. Progress Monitoring and Quality Assurance	**Enter all that Apply**	**0 Missing**	**1 Recognizing**	**2 Planning**	**3 Implementing**	**4 Evaluating**	**5 Revising/ Sustaining**

	A B C D E F G						
A. The organization has a "trauma-informed care initiative" (e.g., workgroup/ taskforce, trauma champion or specialist) endorsed by the chief administrator		Leaders show little or no interest or awareness of the need for an organized approach to ensuring sustained progress towards trauma-informed and healing centered care.	Leaders acknowledge there is a need to develop a plan for promoting trauma informed and healing centered care but have not yet acted on this knowledge to develop a formal plan	Leaders have developed a formal plan for how they want to work towards TI/HC Care but have not yet initiated a workgroup or endorsed a taskforce to create and carry out any action steps.	✠ The chief administrator has endorsed a formal plan or initiative that is currently being championed by at least one leader (clinical director or other appropriate leader) assigned to initiate a Trauma-Informed Care Workgroup or taskforce to facilitate implementation.	A workgroup, taskforce, or team responsible for planning and executing action steps is actively implementing a Trauma-Informed/ Healing Centered Care (TI/HC) Initiative and is collecting information about the results of any changes related to the initiative	Information and data collected to assess the effectiveness of the TI/HC initiative is reviewed and used to modify plans as needed to facilitate further attainment of improved and sustained TI/HC care.
B. A formal self-assessment has been completed to identify organizational strengths and needs for progress along the HEAL PA continuum.						✠	
C. The organization identifies and monitors core Trauma Informed Care values (i.e., safety, trustworthiness/transparency, empowerment/choice, collaboration/mutuality, peer support, and cultural competency).			✠				

D. The organization has standardized and systematic approaches for compiling quantitative and qualitative data and information for monitoring outcomes to improve their level of trauma-informed/healing centered care.			✠				
E. The organization has standardized and systematic approaches for compiling data for monitoring outcomes related to *the use of seclusion and restraint in the facility*.					✠		
F. The organization solicits anonymous and confidential feedback from residents and their families.					✠		
G. The organization seeks and utilizes the perspectives of trauma-impacted individuals in assessing organizational performance beyond the resident satisfaction survey.			✠				

Section 2: Developing a Collaborative, Trauma-informed, Healing-Centered Workforce

Code the source of the data in the first column with the data source (A-G). Check the box in the appropriate column for the corresponding description of your organization's plan as it relates to the item in each row

Data Source	Status					
Enter all that Apply **A** Staff interviews **B** Resident/Caregiver Interviews **C** Review of Policies/Procedures and Training Programs/Plans **D** Resident/Client Record Review **E** Treatment Team or De-briefing **F** Observation **G** All of the Above	**0** **Missing:** Little to no Awareness of the need for a plan	1 **Recognizing:** Need for plan is recognized No plan yet developed	2 **Planning:** Plan has been developed but not yet implemented	3 **Implementing**: Plan is being actively implemented	4 **Evaluating**: Plan is in full implementation and data is being gathered to evaluate impact	5 **Revising/Sustaining**: Implementation strategies are revised as necessary based on analyses of outcome data and feedback

Objective	Data Source	Status					
3. **Training, Supervision, and Workforce Development**	**Enter all that Apply A B C D E F G**	**0 Missing**	**1 Recognizing**	**2 Planning**	**3 Implementing**	**4 Evaluating**	**5 Revising/ Sustaining**
A. All staff at all levels of the organization have participated in an initial 2 (for adjunct staff who do not work directly with residents) and 4 hours of Trauma-related training (for any staff providing direct care, education or clinical intervention) to gain foundational information about trauma, basic brain function, impact of trauma on brain and behavior, and models of trauma-informed and healing centered care		There is little to no data available regarding the degree to which staff are aware of and informed about trauma and its impact. AND/OR There is little to no	There is a general recognition of the need for trauma-related training but no identifiable plan for obtaining training resources and providing the training to all staff. Some staff may have some documented	✠ There is full recognition that a minimum of 2 or 4 hours of training (depending on position) is necessary for all staff and there is a clear and specific plan for ensuring that each staff member receives at least the minimum hours	A plan for ensuring each staff member in the organization receives at either at least 2 hours or at least 4 hours (depending on position) of trauma-informed care training is well established and being	At least 90% of staff has received either a minimum of 2 hours training, or a minimum of 4 hours of trauma-informed care training (depending on position) and there is consistent progress towards achieving a 100% trauma informed care training completion rate, as evidenced by	The documentation and data show that there has been a successful effort to provide a minimum of either 2 or 4 hours trauma-informed care training for each staff member in the organization, and the data is regularly evaluated to determine how

		awareness or interest in providing trauma-related training for all staff.	training, but there is not yet a plan for making sure staff at all levels of the organization receive the 2 or 4 hours that meet the criteria for this item.	of training that meets the criteria listed for this item, but the implementation process has not begun or is in the very early stages. Less than 30% of staff have been trained	actively implemented so that 30% or more of the staff have been trained according to the plan.	data that is collected and evaluated to determine how well the implementation plan is working.	best to revise the plan in an effort to close any training gaps and continue to ensure that all new staff continue to the appropriate number of hours of trauma-informed care training for their position as part of the onboarding process.
B. Staff at all levels of the organization can explain the basics of what it means to be trauma-informed.				✠			
C. Use of the "Trauma lens" has become institutionalized as represented by the yearly availability and use of advanced follow up and refresher trainings, and the requirement that staff at all levels receive at least one hour of refresher training each year.			✠				

D. Staff who work directly with children and families are expected to complete additional hours of trauma-related training (beyond the yearly refreshers) over time to achieve trauma sensitivity and the capacity for trauma-informed and healing centered care.			✠				
E. Staff who provide clinical intervention and clinical supervision are expected to complete advanced trauma-focused and trauma-specific therapy trainings (e.g., TF-CBT, EMDR, or others) in order to be able to provide effective treatment for trauma related symptoms and disorders .			✠				
F. Leaders and supervisors are provided training and resources for incorporating trauma-informed principles in their interactions with staff members and they regularly incorporate trauma related knowledge and					✠		

practices into supervisory discussions.							
G. Supervisory support is accessible and readily available to staff (in person for accredited RTF).						✠	
H. Leaders and supervisors recognize and respond to compassion fatigue and vicarious trauma in staff.			✠				
I. Leaders and supervisors encourage staff members to recognize, acknowledge and find ways to address the personal impact of working with trauma-impacted people.			✠				
J. There are systematic opportunities for staff to recognize, acknowledge, and address their personal life stress and trauma impact, as well as the stress and vicarious or secondary trauma that can develop in working with trauma impacted people.			✠				
K. Staff have systematic opportunities to seek support, or assistance from their peers to help limit the impact of			✠				

vicarious trauma, compassion fatigue, burnout etc.							
L. Staff training regularly includes instruction on the ways that identity, culture, community, and oppression can affect a person's experience of trauma, access to supports and resources, and opportunities for safety.					✠		
M. The organization regularly trains all staff on how to better engage known trauma survivors, as well as other individuals and families in a trauma sensitive manner, and monitors extent and success of that engagement.				✠			
N. There is an organization wide cultural competency expectation that includes being sensitive and strengths-based in the way language is used.				✠			
O. All levels of leadership and management model trauma			✠				

informed approaches and self-care.							
P. Ongoing coaching and consultation in the implementation of trauma-informed care is part of the supervision of all staff.			✠				
Q. A process is in place to address unprofessional or trauma- insensitive words or actions by staff members (The process should also apply to racially or culturally insensitive (etc.) words or actions)				✠			
4. Cross Sector Collaboration	**Enter all that Apply**	**0 Missing**	**1 Recognizing**	**2 Planning**	**3 Implementing**	**4 Evaluating**	**5 Revising/ Sustaining**

	A B C D E F G						
A. The organization identifies discharge resources, community providers, and referral agencies that have experience delivering evidence-based and/or evidence informed trauma-specific interventions and services.		There is little to no information gathered about the trauma informed status of discharge resources and little or no recognition or commitment to developing a plan to gather and use such information.	✠ Organizational leaders and/ or a trauma-informed care implementation team expresses awareness of the importance of identifying trauma informed discharge resources but do not yet have a specific plan for collecting and using relevant information about these resources.	If little or no information relevant to the Trauma informed/Healing centered status of discharge resources is being collected, there is a specific plan (to be implemented in the near future) for how it will be gathered and by whom.	A formal plan for gathering information about the availability of trauma-informed and trauma-specific, evidence-informed discharge resources isbeing implemented with the intention of using the information to encourage ongoing access to trauma informed and healing centered care.	The plan has been implemented and there is information about the trauma-informed/healing centered status of most discharge resources and these are being used to help plan trauma informed aftercare services for residents to the extent these are available. There is also an attempt to track whether or not the discharge services are being accessed and utilized.	Information about the use of trauma-informed discharge resources is collected and included in ongoing assessment of the degree to which existing resources offer trauma-informed and trauma specific services, along with ongoing monitoring of the availability of new or improved discharge resources over time.
B. The organization promotes or seeks and utilizes available cross-sector (public/private,			✠	●	☒	☺	

health/education/justice etc.) training opportunities involving trauma and trauma-informed practices							
C. There is a system of communication in place with partner agencies for making trauma-informed decisions when working with the resident.			✠				
D. There is a system for ensuring that the community partners with whom the organization collaborates are also trauma informed			✠				

Section 3: Developing Trauma-Informed/Healing Centered Programs and Practices

Code the source of the data in the first column with the data source (A-G). Check the box in the appropriate column for the corresponding description of your organization's plan as it relates to the item in each row

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Objective	**Data Source**	**Status**					
5. Environment	**Enter all that Apply A B C D E F G**	**0** **Missing**	**1** **Recognizing**	**2** **Planning**	**3** **Implementing**	**4** **Evaluating**	**5** **Revising/Sustaining**
A. The physical and social environment is attuned to safety, calming, and de-escalation. (e.g., removing unnecessary emotionally triggering items from physical spaces, modeling the provision of trigger warnings where necessary, posting youth and family "rights" and "trauma awareness" related posters, etc.)		There is little to no awareness of how the physical and social environment can impact how safe residents and others feel, and no evidence from interviews, observation, etc. that the physical and social environment is being	Staff express some knowledge or awareness of how the physical and social environment can impact the felt sense of safety of residents and others; There may be some informal attention paid to physical and social environmental factors that impact the felt sense of safety, but there is not yet any formal plan for assessing	Those responsible have developed an evidence informed plan for assessing and monitoring physical and social environmental factors affecting the felt sense of safety in the residential program; however, the plan has not been implemented or is in the very early stages such no significant action	✠ There is currently being implemented a formal plan for assessing and changing features of the physical and social environment that are potentially triggering, re-traumatizing or unsafe.	A plan (as described for a score of 3) has been implemented and data is being collected to assess how well changes to the environment are having the desired impact on the felt sense of safety (for example, through resident and family surveys or other means).	Data collected regarding the effectiveness of the plan for changing physical and social environmental factors affecting the felt sense of safety in the residential program is fed back into ongoing efforts to monitor and sustain a trauma sensitive, informed and healing centered residential environment.

		monitored or assessed for traumatic content or process and no apparent plans for making such an assessment.	and adjusting features of the physical and social environments to ensure they are trauma-sensitive, free of unnecessary triggers, etc.	steps have yet been taken.			
B. There are mechanisms or policies in place to address gender related physical and emotional safety concerns (e.g., gender specific spaces and activities).			✠				
C. The agency provides space that both staff and people receiving services use to practice self-care.			✠				
D. The organization has a process for systematic review of the physical and social environment as it may be perceived by those who			✠				

have experienced trauma.							
E. Staff members recognize & work to remediate aspects of the physical and social environment that may be re-traumatizing for specific residents or their families.				✠			
F. Staff at all levels avoid intimidation of and coercive responses to residents, including threats of punishment and the unnecessary use of restraint as well as more subtle, triggering verbal cues (e.g., language) and nonverbal cues such as tone and physical proximity					✠		
G. Implementation of physical restraint is always done safely and					✠		

appropriately -- e.g., only when necessary to ensure the safety of the individual and others on an emergency basis, after prior interventions have been ineffective; only when the restraint involves approved techniques that are applied safely and as intended; and only after ensuring that restraint is not used with those residents for whom the use of restraint is contraindicated.							
6. Engagement and Involvement	**Enter all that Apply A B C D E F G**	**0 Missing**	**1 Recognizing**	**2 Planning**	**3 Implementing**	**4 Evaluating**	**5 Revising/Sustaining**

A. All staff who interact with people using services are a part of a team that allows for integrated training, supervision, and peer review in Trauma-informed/Healing Centered Care practices and principles		There is little to no evidence to suggest staff are aware of themselves as part of a team in which the intent is to collaborate to promote trauma-informed interactions with residents, families or between staff members, and there is no person or group assigned to begin the process of assessing and developing a plan to improve such collaboration	Organizational leaders and some supervisors clearly understand the need for a collaborative team approach to promote trauma-informed care throughout the organization, and are aware of the importance of peer support and organizational integration of trauma concepts into supervision, etc. However, there is not yet a formal plan for creating and sustaining such integration and collaboration.	✠There has been developed a plan for establishing a collaborative team approach that allows integrated training, supervision, and peer review/support in the application of trauma informed practices throughout the organization. However, the plan has not been implemented or it is in the very early stages such that no significant action steps have yet occurred.	There are active, organized efforts to implement the plan for creating and sustaining collaborative teams in which trauma-informed practices, training, supervision and peer review and support are integrated. There has not yet been any opportunity or effort to assess how effective the efforts have been or to collect data that would provide information with which to make adjustments and improvements to the	Staff are consistently aware of being part of a team that is collaborating to engage in trauma informed practices across the organization, and there is an integration of training, supervision, and peer review/support built into the team approach to trauma-informed/healing centered care. Data is being gathered regarding the success and sustainability of this team approach and includes feedback from staff involved.	Feedback from staff and other sources of outcome data are reviewed in order to determine best ways to enhance and sustain the integrated approach to providing trauma informed care, supervision and collaboration within and across teams at the organization.

					organization's team approach.		
B. Staff use a strengths-based, person-centered approach in their interactions with residents and their families.					✠		
C. The organization demonstrates in philosophy and practice, the intent to increase the comfort, involvement, and collaboration of residents & their families.				✠			
D. Residents and their families are engaged and helped to identify strategies to help them feel comforted and empowered in relationships characterized by trust and transparency with staff members.					✠		
E. The organization has, and makes use of, one or					✠		

more methods for de-briefing incidents that may have posed a physical or psychological safety threat or risk of re-traumatization (including any incidence of seclusion or restraint) to residents and their family members.							
F. Residents and their families are actively involved in treatment and discharge planning and decisions regarding the transition to the next placement or level of care.						✠	
G. Staff members keep residents and their families fully informed of rules, procedures, activities, and schedules while being mindful that people who are frightened or					✠		

overwhelmed may have difficulty processing information							
H. There are systematic opportunities for those using services and their families to discuss core TIC values (Safety, Transparency/ Trustworthiness, Choice, etc.) in interactions with staff and leadership.			✠				
I. Individuals using services and their families are invited to serve in planning and advisory roles within the organization.			✠				
J. People with lived experience of trauma impact provide feedback to the organization on quality improvement processes for better			✠				

engagement and services.							
7. Screening, Assessment, and Treatment Services	**Enter all that Apply A B C D E F G**	**0 Missing**	**1 Recognizing**	**2 Planning**	**3 Implementing**	**4 Evaluating**	**5 Revising/Sustaining**
A. Trauma-screening and trauma-informed assessment of needs are available and accessible in a timely manner to residents.		There is no discernable or organized effort to screen and assess trauma history and impact for the people receiving services, and no identifiable plan for developing trauma screening and assessment procedures	Leaders express an educated awareness of the need and importance of trauma screening and assessment to developing effective treatment plans and programs for providing individualized and trauma-informed residential care. However, there is not yet a formal plan in place to identify and implement effective trauma screening and assessment procedures.	✠ Those tasked with identifying and developing effective trauma screening and assessment procedures are in the process of selecting screening procedures, policies, and tools to be implemented. Some piloting of assessment procedures may be taking place; however, the plan is not being formally implemented yet	An official plan for implementing effective trauma screening and assessment procedures is being actively implemented, but it is too early to gather or analyze any data regarding the impact that the change in screening and assessment procedures may have had on treatment processes or outcomes	There is an organized effort to look at the results of plan implementation both in terms of whether it is being implemented consistently and effectively, and in terms of whether the information gathered in the screening and assessment process is being used to effectively guide treatment planning, intervention, and residential care.	Data gathered about the implementation and effectiveness of the trauma screening and assessment procedures implemented are analyzed to explore ways in which the screening and assessment processes can be improved and used more effectively in providing trauma-informed/healing centered services.
B. Treatment (or service) planning and interventions							✠

are individualized, safe, and developmentally suited to each resident.							
C. Adverse Childhood Experiences and subsequent trauma impact are recognized and meaningfully integrated into the construction of a) A clinical formulation and treatment Plan (for PRTFs), or b) an integrated case summary and service plan (for 3800 programs under OCYF) that helps to explain the current struggles and strengths of the resident from multiple perspectives, including, at a minimum, social, psychological, and biological factors.				✠			

D. Each resident and staff member has a personal coping plan (which includes the individual's own definition of emotional safety) in which individualized choices for calming and de-escalation are identified.				✠			
E. Staff members providing direct care acknowledge and talk with people about a range of trauma reactions and work to minimize feelings of stigma, fear, and shame to increase self-understanding and acceptance			✠				
F. If the residential program offers clinical mental health services on site, then trauma-specific, evidenced-based and/or evidence-informed Trauma Treatments (e.g.,				✠			

TF-CBT, EMDR, etc.) are available, or- if the organization does not provide direct mental health services- it makes referrals to evidence-informed trauma-specific services.							
G. Peer or Family Peer Support programs are integrated into the service delivery approach.			✠				
H. Gender-specific services and supports screenings, assessments, treatments are available and accessible			✠				
I. All staff demonstrate skill and effective use of trauma informed/ healing centered practice with residents, visitors, and co-workers regardless of their			✠				

assigned job duties							
J. If appropriate to the mission of the organization, evidence-informed Trauma-specific programs are incorporated into the organization's ongoing operations (e.g., programs or units for survivors of sexual abuse, human trafficking, complex trauma related to parental addiction, etc.).			✠				

Glossary of Terms

Caregiver: Identified family member, relative or non-relative responsible for resident's care while in the community. Primary contact for residential treatment facility.

Choice (as TI Care principle): Residents are offered opportunities for daily decision-making, and they actively participate in key decisions.

Collaboration (as TI Care principle): Residents and staff make day to day and treatment decisions together through planning and discussion.

Data: Information gathered regarding resident demographics, treatment, and outcomes, or organizational programming, trends, outcomes, and resident/family satisfaction for purposes of planning, implementation, and quality improvement.

Debriefing: Systematic and in-depth discussion of a critical or "unsafe" incident, and of any use of seclusion or restraint, with those involved directly, including staff, the resident, and the family. Debriefing often occurs at many levels of the organization for purpose of ensuring safety, improving an individual's treatment, and for organizational quality improvement.

Direct Care Staff: Staff who work directly with resident within the group setting of the program. Often referred to as frontline staff, milieu staff, mental or behavioral health technicians, or unit staff; and typically, are not trained to provide clinical trauma-specific treatment.

Discharge Planning: Planning for discharge that begins at the time of admission and intensifies approximately one month prior to a planned discharge which involves the resident, family, and systems representatives within the organization and community.

Empowerment (as TI Care principle): Allowing individual residents and residents as a group to generate and participate in ideas, processes, and experiences that affirm their strengths, priorities, self-expression, and self-advocacy.

Evidenced-Based and Evidence-Informed Practices: Evidence-based practices are well-supported by research and identified as best practices in the field. Evidence informed practices are those for which there is a growing base of evidence suggesting a promising practice that may eventually be designated as "evidence-based."

Family Engagement: Strategies and practices that are successful in involving families as partners and active participants in treatment.

Healing-Centered Practices Healing-centered practices incorporate trauma-informed approaches and identify strengths inherent to an individual or community as the foundation for healing. They focus on the fundamental belief that the person who has survived trauma is not broken or needing to be fixed but is already whole and has the capacity to grow from what happened to them.

Plan of Action: A plan created to address a particular outcome, feedback, data, goal, or process.

Qualitative Data: Information that can be captured that is not numerical, such as data through interviews, observation or review of policies or records.

Quantitative Data: Information that is numerical in nature, such as frequencies and outcomes, which can then be analyzed through a variety of research methods.

Safety (as TI Care principle): First principle of trauma-informed care involving the establishment of physical, psychological, and emotional safety within the person's environment.

Strengths-Based, Person-Centered: The individual and their strengths are the central focus of all policies & practices.

Systematic Review: A pre-defined process of reviewing a practice, policy, or process

Trauma/ Traumatic Event: Trauma results from an event, series of events or a set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's cognitive functioning and physical , social, emotional, mental or spiritual well-being. – A traumatic response is individualized or in the "eye of the beholder." Individuals who experience the same event may not have the same trauma related responses.

Trauma Champion: A resident, family/caregiver, staff, administrator or board member who wholly understands, endorses, and practices standards of trauma-informed care and who serves as a trauma advocate in the organization.

Trauma-Informed: Specific policies and practices that identify, incorporate and remain sensitive to an individual and/or family's trauma history, symptoms, strengths and coping with overwhelming emotion, and which promote resilience and healthy functioning.

Trauma-Informed Care is a strengths-based approach to service delivery and organizational structure grounded in an understanding of and responsiveness to the widespread impact of trauma, including historical and identity-based trauma, that:

- recognizes the symptoms of trauma and its effects on individuals, families, communities, and those who provide services or work in care settings,
- understands multiple, complex paths to recovery,
- emphasizes physical, psychological, and emotional safety for providers, survivors, and their families.
- creates opportunities for survivors to rebuild a sense of safety, control, and empowerment,
- prioritizes the use of positive relationships to help the survivor regain a sense of safety, control, and empowerment.
- responds by fully integrating knowledge about trauma and recovery into policies, procedures, and practices, and
- seeks to actively prevent re-traumatization.

"Trauma Lens": Perspective in which one considers "what has happened to" a person (or family, or organization) that is having symptoms or problems rather than focusing on "what is wrong with" them.

Trauma-Specific: Refers to clinical treatment interventions designed to focus on individual trauma symptoms and trauma-related diagnoses.

Treatment Plan/Service Plan- Treatment plans outline an individual resident's goals and objectives to be achieved during admission to a residential treatment facility. The plan is individualized based on the resident's unique strengths and challenges, includes information about through what efforts and with what help and on what timeline the goals and objectives will be achieved. Goals and objectives may be categorized as psychological/behavioral, educational, medical, and so on, depending on the specific needs of the resident. The plan is typically reviewed by a multidisciplinary team that includes the

resident their family. A "Service" plan is a similar plan and process initiated in residential settings that are primarily for child welfare rather than focused on health care.

Trustworthiness (as a TI Care principle): Resident and family's ability to trust and experience safety with staff and program, based on interactions, guidelines, and practices that are clear, positive, consistent and honest.

Vicarious Traumatization: A shift in our worldview and core beliefs in the therapist or other staff and administrators as a result of repeated exposure to traumatic imagery and empathic engagement with trauma victims/ survivors.

Significant aspects of this assessment are based on the following instruments with permission from the authors:

Hummer, V. & Dollard, N. (2010). *Creating Trauma-Informed Care Environments: An Organizational Self-Assessment. Creating Trauma-Informed Care Environments curriculum)* Tampa FL: University of South Florida. The Department of Child & Family Studies within the College of Behavioral and Community Sciences

Additional Credits:

1. Fallot, R. D., & Harris, M. (2006). *Trauma-informed services: A self-assessment and planning protocol, version 1.4*. Community Connections: Washington, D.C. (202-608-4796).
2. Traumatic Stress Institute of Klingberg Family Centers (2008).*Trauma-Informed Care in Youth Serving Settings: Organizational Self Assessment*. 370 Linwood Ave., New Britain, CT. 06052. (860-832-5507).
3. Substance Abuse and Mental Health Services Administration. *SAMSHSA's Concept of Trauma and Guidance fir a Trauma Informed Approach.* HHS Publication No, (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
4. **For more information, please contact:**
5. questions about this draft adaptation, please contact Caren Rosser-Morris, PhD at c-crosserm@pa.gov.