SAMHSA’s Trauma-Informed Approach: Key Assumptions and Principles

WHO IS THIS TRAINING FOR?
This training curriculum provides an introduction to trauma and trauma-informed approaches in behavioral health and human services. No prior knowledge about trauma is necessary. The training is intended for a wide range of potential audiences, including direct service providers, supervisors and administrators, advocates, service recipients, and interested community members. Mixed audiences, with staff from different agencies, roles, or service systems, often work well. Including service recipients or family members along with staff can be especially effective—putting information about trauma directly in the hands of those most affected is empowering, and joint training creates a spirit of collaboration. In addition, the interactions that occur between trainees can lead to the development of new relationships and ultimately to more supportive and healing environments.

This training forms the basis for more advanced work in developing trauma-informed environments and practices. It should be completed prior to embarking on more specialized training.

THE TRAINING TEAM
This curriculum is intended to be taught by a team of at least two Instructors, one of whom would preferably be a trauma survivor. Using a survivor-professional training team is a powerful way of modeling collaboration and empowerment. It can also be used to illustrate how people in different roles may experience the same events and circumstances differently. The training team should spend time getting to know each other before training together. It is helpful to discuss specifics about what role each person will play as well as identifying which sections and exercises each person will lead.

One trainer should have experience working in a setting directly relevant to the audience. People learn best from their peers, and there is no substitute for hands-on experience in making a training program relevant. When possible, at least one trainer should have (and be willing to share) personal experience with trauma and healing in a situation that will resonate with the audience. When possible, try to match the survivor experience to the audience so their words and experience will resonate with attendees, such as using a female survivor of intimate partner violence when presenting to staff at a women’s shelter. However, having experienced personal trauma is not enough to make a good trainer. It takes skill to go beyond simply telling one’s story to use personal experience as a teaching tool. If no experienced survivor is available, video clips included in the curriculum can be used to ensure that this perspective is represented.

TAILORING THE CURRICULUM TO YOUR AUDIENCE
While no training program can be “all things to all people,” this curriculum is designed to allow trainers to tailor content to meet the needs and interests of different audiences. To assist in this process, multiple slides have been provided for several core concepts. The slides present
examples or applications from different service settings (for example, for children and adults, in mental health and corrections, etc.).

We recommend that prior to the training you spend some time thinking about your audience— their backgrounds, level of experience, work settings, and roles at work. Think about ways to tailor the basic information in the curriculum to audience members, and try to share examples/stories that relate to the actual services and settings represented by your audience. Throughout this manual, some examples are given to spur your thinking, but trainers are encouraged to offer examples from their own personal and work experiences. Also think about examples that are relevant to the service setting where the training takes place; for instance examples about trauma-informed changes in residential youth settings may be interesting, but they will not have much relevance to staff at a homeless shelter or adult substance abuse outpatient clinics. Always keep the audience and their work roles in mind when coming up with examples of effective trauma-informed program changes; this way participants will be more motivated to think creatively about organizational changes they can make and individual things they can do differently within their work. When possible, before the training, talk with the organization’s leaders to identify what they are already doing that is trauma-informed and offer those examples as a starting point for audience members to think about additional changes that can be made.

At a minimum, select the specific PowerPoint slides, exercises, and video clips that will be most relevant to the audience’s work and experience. Tailoring the program in advance will eliminate the need to skip over irrelevant slides during the training.

We encourage trainers to use the PowerPoint slides as a flexible framework to be modified as you go. Good trainers draw heavily on their own wisdom, stay closely tuned to the audience, and provide examples “on the fly” based on their own experience.

**PREPARATION FOR TRAINING**

Before presenting this training program for the first time, it is essential that you become thoroughly familiar with all of the materials, including the Instructor’s Guidance, the PowerPoint slides and notes, video clips (if used), and handouts. It is also vital that you have prior experience with and in-depth knowledge about trauma, its prevalence and impact, and trauma-informed practices.

One of the primary messages of training about trauma-related topics is that trauma can impact us in strong and enduring ways. So in addition to having robust training skills, it is important that you have both a solid knowledge of trauma-related topics and that you have self-awareness about trauma’s impact on your own mind, body, and spirit. During training, both trainers and participants may become emotionally affected by the material, so it is helpful to train in teams of two, both to support each other and to have a trainer available to assist participants if needed. By using techniques such as modeling trauma-Informed practices during the training process, it is possible to minimize or mitigate the negative impact of trauma during training.
A Note About Language

In keeping with the values and principles of trauma-informed approaches, the authors of this curriculum deliberately avoided using clinical language to the extent possible. In recognition of the understanding that trauma responses are natural human responses to extreme circumstances, not “illnesses,” the curriculum does not focus on diagnostic terms such as PTSD (post-traumatic stress disorder) or borderline personality disorder. In addition, the curriculum does not use terms like “vicarious trauma” or “secondary trauma,” because the authors do not believe that there is a hierarchy of traumatic experiences. The focus is on using everyday language to talk about people’s experiences.

We also refrain from talking about “triggering” or “triggers.” We think these can be experienced as violent terms and that they don’t accurately describe what happens when people are emphatically reminded of traumatic events by certain words, sounds, smells, attitudes, behaviors, or other’s experiences, etc. Instead, we refer to “hot button issues,” or “things that push your buttons,” “things that bring up big emotions,” “trauma reminders,” or similar non-clinical phrases.

Trauma-informed practices are based on the universal expectation that trauma has occurred. This is sometimes referred to in literature as “universal precautions.” Many trauma survivors have found this term to be offensive, as it implies they “have” something to be feared or is contagious. "Universal expectation" conveys the message that anyone in any system or program, no matter their position, whether they are people who use services or staff, can be a trauma survivor.

MODELING TRAUMA-INFORMED PRACTICES IN TRAINING

When training on topics related to trauma, it is crucial to use training approaches that are rooted in our understanding of trauma-informed practices. In “Walking the Walk: Modeling Trauma Informed Practice in the Training Environment,” Leslie Lieberman identifies the following principles and discusses how to demonstrate them in training:

- Creating safety
  - Have participants create a self-care plan to use during the training
  - When discussing traumatic events, give enough information to convey the idea but omit graphic details

- Maximizing opportunities for choice and control
  - Let participants know they are free to choose not to participate in any activity
  - Remind participants that they are free to leave the room if they wish

- Fostering Connections

1 [http://www.multiplyingconnections.org/become-trauma-informed/walking-walk-trauma-informed-training](http://www.multiplyingconnections.org/become-trauma-informed/walking-walk-trauma-informed-training)
Provide opportunities for participants to interact with one another through small group or dyad discussions

- Self-reflection and managing emotions
  - Offer activities that ask participants to reflect on what they have learned in pairs or on their own
  - Build in opportunities to ask the group how an activity made them feel.

Liebman’s full article offers additional suggestions and detail, and it will be helpful to read it before conducting the training program.

SELF-AWARENESS

As a trainer, it is important that you have an understanding of your personal values, your biases, and your own “hot spots” related to potentially traumatic material. This kind of self-awareness is invaluable in training and facilitating group discussion about sensitive material. To be an effective trainer, it is crucial that you:

- Identify how your own values, biases, and “hot spots” affect your behavior and communication;
- Manage your own biases and emotional responses in the training environment;
- Model respect and inclusion throughout the session;
- Identify, use and adapt your interpersonal skills to model Trauma-Informed practices for participants.

ADULT AS LEARNERS

Adults learn differently than children and teen-agers do, and it is important that trainers understand these differences in order to be effective. The field of adult learning was pioneered by Malcolm Knowles, who identified the following characteristics of adult learners.

- **Adults are autonomous and self-directed.** They need to be free to direct themselves, and trainers must actively involve them in the learning process. Trainers must be sure to act as facilitators, guiding participants to their own knowledge, rather than simply supplying them with facts.

- **Adults have accumulated a foundation of life experiences and knowledge that may include work-related activities, family responsibilities, and previous education.** Relevance is key to adult learning. Adults need to connect learning to their own knowledge and experience base. To help facilitate this process, trainers should draw out participants’ experience and knowledge so they can relate theories and concepts to their relevant experience.

- **Adults are goal-oriented.** They appreciate a program that is organized and has clearly defined elements. It is important to demonstrate to participants how the training will help
them attain their goals. Clear communication of goals and learning objectives must be done early in the session.

- **Adults are practical.** They focus on the aspects of a lesson that will be most useful to them in their work or life. They may not necessarily be interested in knowledge for its own sake. Trainers must tell participants explicitly how the training will be useful to them.

- **Adults need to be shown respect** (like all learners!). It is important for trainers to acknowledge the wealth of experiences that adult participants bring with them when they participate in training. Adult participants should be treated as equals in experience and knowledge and encouraged to voice their opinions freely.

**TRAINING TIPS**

Here are some things to consider before delivering this training for the first time.

1) **Know the difference between "listening" and "learning."**
   Listening is passive, which means that lecture is the least efficient, least effective form of learning. Listening alone requires very little engagement on the learner’s part. Therefore, don’t talk more than 10-15 minutes without doing something interactive that stimulates discussion. Offer opportunities for audience interaction when possible, such as by asking questions, including role playing exercises, or breaking into small discussion groups. The level of interaction will need to be based on audience size, the time allotted for the course, and the skill level of the trainer, but even in large groups, trainers should encourage some forms of audience interaction to maintain interest and reinforce the concepts being taught.

2) **Emotions provide the information for building memories.**
   Feelings are the tags that determine how important a particular experience is and whether the learner understands it as a memory worth saving. People remember what they feel far more than what they simply hear or see.

3) **Acknowledge the power of feelings.**
   Use the activities in the curriculum to elicit participants’ emotions. Modulate your tone of voice to accentuate the experience. Allow participants to feel their way through an exercise. Do not tell them what they feel—ask them!

4) **Vary your training methods to address the wide variety of learning styles.**
   The curriculum incorporates a number of learning techniques; use all of them. Remember to keep lecture to a minimum and allow the process to work.

5) **Use stories to engage people in learning.**
   People don’t always remember statistics, but stories are powerful because they engage the participants’ emotions. Stories speak directly to the heart and the imagination, so people tend to pay more attention to them. You can connect with the group by strategically sharing personal experiences, one of the personal stories available on video as part of the curriculum, or stories you have heard from others that relate to the topic you are discussing.
When you share something that others can relate to, you help develop a rapport with the group and engage their emotions, which support the formation of new memories.

6) **It is more important to ask good questions than to supply all the answers.**
   Trainers often fail to ask enough questions. Instead, they present solutions, which can leave participants feeling frustrated and interfere with learning. After you ask questions, restate what you have learned from the responses and ensure that you understood correctly. You can do this by simply restating two or three of the key points you heard from participants.

7) **Keep your training skills and your knowledge base of the subject matter sharp and up to date.**
   Good presenters keep abreast of the newest training techniques and tools. You should improve upon your skills through reading on the topic, attending seminars, and seeking coaching from other facilitators. It is equally important that you keep your knowledge of trauma-related topics up to date as well.

8) **Establish your credibility in a low-key way.**
   Participants do not care about your degrees, how smart you are, or what you have accomplished. While it's important to establish a baseline level of credibility, it is far more important that you care about how smart they are, what they know (and will know, thanks to this learning experience) and what they have done. Your job is to know far more about them than they know about you.
   
   At the beginning of the session, you can quietly establish your credibility in an understated way (i.e., “We've done this training for 10 other peer-run programs across the country”). As a trainer, you nearly always come with a certain amount of credibility, even if the participants have never heard of you. It may be is helpful to provide a brief statement—a couple of sentences—about the work and history of your organization to support understanding the passion behind why you do what you do.

9) **Have a quick start and a big finish.**
   Give participants the opportunity to do something active and interesting very early. Do not bog them down with a long introduction. The faster they are engaged, the better. Don't let the class fizzle out at the end. Try to end on a high note. Ask yourself, "What were the participants feeling when they left?"

10) **Don't assume that just because you said it, they got it.**
    Good trainers know how to slip in repetition in a stealthy way, where the material is presented again, but from a different angle.

11) **Be passionate and participants will respond in kind.**
    Be honest, be authentic, and, especially, be passionate about your message. Your passion will keep them awake. Your passion will be infectious, and it will provide the emotional hook to help people remember the content.
12) *Don't think of yourself as the expert.*

It's not about what you do or about what you know; it's about how participants feel about what they can do as a result of the learning experience you created. Rather than think of yourself as the expert, try thinking of yourself as "a person who creates learning experiences ... a person who helps others learn."

**PLANNING FOR THE TRAINING EVENT**

Each training is tailored to the specific audience—advance planning with the host organization should therefore, clarify the following issues:

- The organization’s goals for the training
- The extent of leadership’s commitment to trauma-informed practices
- Any issues or incidents that prompted the need for training or focusing on trauma
- Any previous staff training on trauma-related issues
- The length of training desired (i.e., half-day, full day; for residential facilities, whether training sessions are needed for all shifts)
- The estimated number of participants
- The size and set-up of the training facility (i.e., auditorium, large room with participants sitting at tables). It is important that the training environment is set up in a way that reinforces Trauma-Informed practices by considering individual vulnerability, safety, comfort, and ease of exit.
- Whether the host organization or the trainer will supply and set up:
  - Projector and screen
  - Laptop
  - Internet access
  - Speakers (needed if using video clips)
  - Handouts

**LOGISTICS FOR THE DAY OF THE TRAINING**

Plan to arrive at least 45 minutes before the presentation to ensure that:

- Your laptop is connected to the projector (if you are using your own) or the PowerPoint is loaded and the system is working properly
- If using speakers for video, ensure that they are working properly
- Handouts are available in a convenient location
The room temperature is comfortable, lighting is adequate, and seating is arranged so people are not cramped and have easy access to exists.

Opening Slide
Slide 1

INSTRUCTOR GUIDANCE
Display this slide as participants arrive for the day’s training. It should show on your screen after you finish setting up and until you begin the training.

In the opening, Instructors introduce themselves very briefly and conduct a brief poll as a quick way to gauge who is in the room. Possible poll questions include asking about job titles, length of time in the agency, working with adults or children, etc. You can also ask about personal interest like who has pets, has seen a recent movie, etc., as an icebreaker.

Before concluding the introductory section, Tell participants where the restrooms are, review the schedule for the day (preferably provided as a handout) including when breaks and lunch will be taken, and point out the emergency evacuation route.

Disclaimer
Slide 2

The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS) or the Center for Substance Abuse Treatment (CSAT), the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services (HHS).
Section 1: Understanding Trauma

Slide 3

TALKING POINTS

- The first section of today’s training is Understanding Trauma and Its Impact.
- We’ll talk about what trauma is and how it affects people.
- Self Care: At times the material presented is difficult to hear. It might bring back memories of painful times in our past. Please feel free to take a break at any time and speak to instructors or colleagues when you need support.

Slide 4

Learning Objectives

- Shared understanding
- Identification of trauma
- Awareness of prevalence

TALKING POINTS

After completing this section, you will:
• Have a shared understanding of trauma
• Be able to identify examples of traumatic event
• Understand how prevalent trauma histories are among the people you serve

Slide 5

**Things to Remember**

- **Underlying question =** "What happened to you?"
- **Symptoms =** Adaptations to traumatic events
- **Healing happens =** In relationships

**TALKING POINTS**

- The underlying question is not “What's wrong with you?” but “What happened to you?”
- What are often called symptoms are actually adaptations to traumatic events.
- Healing happens in relationships.

*Power of Empathy (Video - Brene Brown) available at [https://www.youtube.com/watch?v=1Evwgu369Jw](https://www.youtube.com/watch?v=1Evwgu369Jw)*

Slide 6

**What is 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.*
TALKING POINTS

- This framework for understanding trauma was developed by a working group of researchers, practitioners, trauma survivors, and family members convened by SAMHSA.

- It is important because it creates a framework for understanding the complex nature of trauma.

INSTRUCTOR GUIDANCE

Some people prefer to use a simpler definition – something like “trauma is anything that overwhelms a person’s ability to cope.” It’s fine to use a shorthand definition for ease of communication. SAMHSA’s framework provides a way to go deeper, as discussed on the next slide.

Slide 7

The Three Es in Trauma

- **Events**: Events/circumstances cause trauma.
- **Experience**: An individual's experience of the event determines whether it is traumatic.
- **Effects**: Effects of trauma include adverse physical, social, emotional, or spiritual consequences.

TALKING POINTS

- The focus on **events** places the cause of trauma in the environment not in some defect of the individual. This is what underlies the basic credo of trauma-informed approaches: “It’s not what’s wrong with you, but what happened to you.”

- The focus on **experience** highlights the fact that not every child or adult will experience the same events as traumatic.

- The identification of a broad range of potential **effects** reminds us that our response must be holistic—it’s not enough to focus on symptoms or behaviors. Our goal is to support a child to learn and grow or an adult to live a satisfying life.
TALKING POINTS

There is a very wide range of events that can potentially cause trauma.

- Trauma can be caused by events that the individual doesn’t remember, such as events that occurred in early childhood.
- Trauma can be caused by events that are well-intentioned and necessary, such as medical procedures.
- Trauma can be caused by an event that didn’t happen to the person but to a group that he or she identifies closely with—as in slavery or the Holocaust or the genocide of the Native American people.
- Over time, chronic stressors can accumulate to cause trauma.

INSTRUCTOR GUIDANCE

It is particularly important to emphasize that many people experience multiple traumatic experiences over the lifespan. While the immediate focus might be on a recent event, the individual’s reaction to that event may be affected by earlier experiences.

Ask participants for an example describing how people they serve may experience multiple sources of trauma, or the following example can be offered:

A veteran who has intrusive war-related memories who comes for support or treatment may have experienced neglect or abuse at home, lived in multiple foster care settings, and witnessed the impact of Hurricane Katrina while in the Reserves, all before being deployed and experiencing the military sexual trauma that brought her in for support or treatment.

A note about language: As discussed in the curriculum introduction, we are deliberately not using the terms vicarious trauma and secondary trauma. This section offers a good opportunity to explain.
Experience of Trauma

Experience of trauma affected by:

- How
- When
- Where
- How Often

**TALKING POINTS**

- The individual’s *experience* of trauma may be profoundly affected by when, how, where and how often it occurs.

- Trauma can result from a single devastating event, called *single-episode trauma* (sometimes called *acute trauma*), or it can result from multiple traumatic events over time.

- Most individuals served in the public system have complex trauma, which comes from experiencing multiple sources of trauma over a lifetime.

- Trauma can be totally unintentional, as when an organization does harm through its procedures. For example, the routine practice of undressing for a medical exam can re-traumatize a person.

- Systems can also unintentionally replicate the dynamics of an earlier trauma, causing re-traumatization.

- Trauma can occur from hearing about, watching, or interacting with others who have had traumatic experiences.

- The context, expectations, and meaning assigned to an event or circumstance may determine how it is experienced.

- Trauma often includes a threat to life, bodily integrity or sanity and/or the feeling of being overwhelmed and unable to cope.

- Even interventions that are necessary or life-saving may be experienced as traumatic (e.g., medical interventions or removal from an abusive home).

- Humiliation, betrayal, or silencing may compound the traumatic experience.
• The individual experience of trauma is not necessarily conscious or recognized either by the individual or by others, and it may include physiological as well as cognitive experience.

Slide 10

Discussion Question

How can the same event be traumatic for one person and not for another?

INSTRUCTOR GUIDANCE

Ask participants to discuss why some events may be traumatic for one person but not for another.

Slide 11

Effect of Trauma

The effect of trauma on an individual can be conceptualized as a normal response to an abnormal situation.

TALKING POINTS

The effect of trauma on an individual can be conceptualized as a normal response to an abnormal situation.
Slide 12

**Effect (con.)**

- Trauma can:
  - Cause short and long-term effects.
  - Affect coping responses, relationships, or developmental tasks.
  - Impact physiological responses, well-being, social relationships, and/or spiritual beliefs.

**TALKING POINTS**

- Trauma can have both short- and long-term effects, and impact may not be immediately recognized.

- Trauma can affect an individual's coping responses or ability to engage in relationships, or it can interfere with mastery of developmental tasks.

- Trauma may affect an individual's physiological responses, psychological well-being, social relationships, and/or spiritual beliefs.

Slide 13

**Signs of Trauma Responses**

- Behavioral: Blow-up when being corrected, fighting when criticized or teased, resisting transitions or change, very protective of personal space, reckless or self-destructive behavior, frequently seeking attention, reverting to younger behaviors.

- Emotional/Physical: Nightmares or sleep problems, sensitive to noise or to being touched, fear of being separated from family, difficulty trusting others, feeling very sad, angry, afraid, emotional swings, unexplained medical problems, combining what is safe and what is dangerous, trouble focusing or concentrating, difficulty imagining the future, difficulty imagining the future.

**TALKING POINTS**

- What about children who experience trauma a little later in childhood? Those who have developed positive attachments and healthy relationship skills, but then encounter trauma in one form or another? In contrast to the “difficult” or “problem” children we were just discussing, these children may not get much attention.
• None of these signs is *always* associated with trauma. However, each of these signs can be *adaptations* to the neurobiological changes associated with trauma. Even one of these signs should be enough to raise the possibility of trauma.

• Just being aware that what we sometimes call “symptoms” may be adaptations to underlying trauma can change the way we view children and families. These “symptoms” can continue into adulthood.

Slide 14

**Additional Signs of Trauma**

- Flashbacks or frequent nightmares
- Sensitivity to noise or to being touched
- Always expecting something bad to happen
- Not remembering periods of your life
- Feeling emotionally numb
- Lack of concentration; irritability
- Excessive watchfulness, anxiety, anger, shame, or sadness

**TALKING POINTS**

• None of these signs is *always* associated with trauma.

• Each of these signs can be *adaptations* to the neurobiological changes that we discussed earlier.

• Each of these behaviors can in fact play an important role in the person’s life—they may protect the person or help them to survive.

Slide 15

**How Trauma Affects the Brain**

- [Experiences Build Brain Architecture](#)
- [Serve & Return Interaction Shapes Brain Circuitry](#)
- [Toxic Stress Derails Healthy Development](#)
TALKING POINTS

Trauma affects the brain, especially the developing brain. This three-part video series from the Harvard University Center on the Developing Child and the National Scientific Council on the Developing Child depicts how advances in neuroscience, molecular biology, and genomics now give us a much better understanding of how early experiences are built into our bodies and brains.

*Note to trainer:* The playlist containing all three videos is available at [http://www.youtube.com/playlist?list=PL0DB506DEF92B6347](http://www.youtube.com/playlist?list=PL0DB506DEF92B6347) and is listed on the Resources handout. Show the “Toxic Stress Derails Health Development” video to audience and refer them to resource list for the playlist URL.

Slide 16

**Brain Development**

TALKING POINTS

- The brain has a bottom-up organization.
- The bottom regions (i.e., brainstem and midbrain) control the most simple functions such as respiration, heart rate and blood pressure regulation.
- The top areas (i.e., limbic and cortex) control more complex functions such as thinking and regulating emotions.
- At birth, the human brain is undeveloped. Not all of the brain’s areas are organized and fully functional.
- During childhood brain matures and the whole set of brain-related capabilities develop in sequence. For example, we crawl before we walk, we babble before we talk.
- The development of the brain during infancy and childhood follows the bottom-up structure.
- The most regulatory, bottom regions of the brain develop first; followed, in sequence, by adjacent but higher, more complex regions.
• The process of sequential development of the brain and is guided by experience.

• The brain develops and modifies itself in response to experience.

Note: This information is from the work of Bruce D. Perry, M.D., Ph.D., an internationally recognized authority on brain development and children in crisis. (www.ChildTrauma.org).

### Slide 17

#### TALKING POINTS

This slide illustrates how the different parts of the brain develop as a result of interaction with different people in our environment, drawing from the work of Dr. Perry (mentioned on the previous slide).

• The brain stem controls blood pressure, body temperature, heart rate, and arousal states. It’s affected by interactions with a child’s mother.

• The diencephalon is responsible for motor regulation, affect regulation, hunger/satiety, and sleep. It’s affected by interactions with a child’s caregiver(s).

• The limbic system drives affiliation, attachment, sexual behavior, and emotional reactivity. It’s affected by interactions with family and friends.

• The neocortex is responsible for abstract and concrete thinking, and it’s affected by interactions with peers, teachers, and the community.
TALKING POINTS

• The “fire alarm” of the brain is located in the amygdala. It sounds the alarm about a threat and activates the fear response.

• The frontal lobes of the cortex – at the top or the thinking part of the brain – shut down to make sure the person is focusing completely on survival. That’s why it is so hard to think when you are in a crisis!

• At the same time, the ability to perceive new stimuli decreases and the focus is on information and processes to ensure survival.

• The area of the brain responsible for speech, called “Broca’s area” shuts down.

• In our work, we often approach people in distress, asking them to tell us what is wrong, to stop and think, or tell us how we can help. Access to the thinking resources of the brain may not be possible in these moments.

• This is an example that can and often does occur.

• So when people talk about “speechless terror” or “being scared speechless” they are not being metaphorical, they are describing a real response of the brain.

• This has important implications for how each of us responds to crisis situations or to people who are responding to the present through the lenses of their past.

• If we ask people in this state to “tell us what’s going on,” they may really not be able to do it! In that moment, they may actually not have the words.

• Remembering trauma can re-activate the original trauma response.

• When a person remembers a traumatic event, often the fear response is activated, just like it was when the event occurred.

• From the brain’s perspective, it’s like the threat is actually happening again.
Slide 19

Problems OR Adaptations?

FIGHT
- “Non-compliant, combative” OR
- Struggling to regain or hold onto personal power

FLIGHT
- “Treatment resistant, uncooperative” OR
- Disengaging, withdrawing

FREEZE
- “Passive, unmotivated” OR
- Giving in to those in power

TALKING POINTS

- The fight, flight or freeze responses are activated by danger. Some common behaviors of trauma survivors—behaviors that are often labeled as “problems” by the mental health system—can be directly linked to these responses and to the effects that trauma has on the brain.

- This slide lists three sets of “problems” that are often attributed to people in the mental health system and shows how the behavior may be a survival mechanism tied to a flight, flight or freeze response.

- First is the fight response. In the mental health system, anyone who struggles too hard to hold onto personal power may be labeled as non-compliant or combative.

- Second is the flight response. In the mental health system, anyone who emotionally withdraws or disengages too much may be labeled as treatment resistant or uncooperative.

- Third is the freeze response. In the mental health system, anyone who gives in too easily to authority may be labeled as passive or unmotivated.

- Many of the people we serve have survived circumstances we can hardly imagine. What we often label as pathological may be the very things that helped them to survive.

- When we take a trauma-informed approach, we recognize “symptoms” and “problem behaviors” as adaptations to trauma.

INSTRUCTOR GUIDANCE

This reframe from “problem behaviors” to survival strategies is essential in a Trauma-Informed approach. Take some time to discuss this shift in perspective. Ask people if they can think of examples of people in their system who have received any of these labels. Discuss how their behavior might be tied to trauma experiences.
TALKING POINTS

- The younger the age when trauma occurs, the more likely the consequences. We will discuss why this is true—even when the individual has no memory of the trauma—when we briefly discuss how trauma affects the brain, or the neurobiology of trauma.

- Shame and humiliation are core features of the trauma experience for many people. These emotions can be devastating and impede healing. One of the most important messages you can give a trauma survivor is that no matter what happened, it wasn’t their fault in any way.

- Sometimes trauma survivors are intimidated by their perpetrators into not telling what happened. Other times, when they do try to talk about what happened to them, they are ignored or disbelieved. One of the most important things you can do for trauma survivors is to give them the chance to tell their stories. Healing starts when a person’s personal experience is heard and validated.

- The impact of trauma is magnified when the perpetrator is a trusted figure—a relative, religious leader, coach, teacher, or therapist. This kind of trauma is often called “betrayal trauma” because the sense of betrayal can be so profound.
TALKING POINTS

- Adopting health risk behaviors can be a coping response to trauma—such as drinking alcohol to manage flashbacks.
- This can put the person at greater risk and perpetuate the cycle of trauma and adversely affect their physical health and mortality.
- Research has shown a connection between adverse childhood experiences (ACEs), or potentially traumatic experiences a person had before age 18, and health risk later in life.

TALKING POINTS

- Perhaps one of the largest, if not the largest, ongoing health risk studies that established this relationship between trauma exposure and physical health is the ACE Study, organized by the CDC and Kaiser Permanente in San Diego, CA.
• Researchers surveyed more than 17,000 insured individuals from 1995-1997 about their history of ACEs.

• The ACE Study uses the ACE Score, which is a count of the total number of ACEs respondents reported, to assess the total amount of stress during childhood.

**Findings:**

- Childhood abuse, neglect, and exposure to other traumatic stressors (ACEs) are common.

- Almost two-thirds of study participants reported at least 1 ACE, and more than 1 in 5 reported 3 or more ACE.

- The short- and long-term outcomes of these childhood exposures include a multitude of health and social problems.

- As the number of ACEs increases, the risk for the types of health problems on the previous slide increases in a strong and graded fashion and with that a direct, negative impact on mortality and longevity.

- “Is drug abuse self-destructive or is it a desperate attempt at self-healing, albeit while accepting a significant future risk?” (Felitti et al, 1998)

I’m going to read you the questions asked in the ACE study to determine childhood exposure to traumatic stressors. You may wish to make a note of any questions that stand out to you as you think about these events in your own life and in the lives of the people you serve.

**INSTRUCTOR GUIDANCE**

Read the questions below and give participants a moment to reflect on each question before moving to the next. After reading and reflecting on all of the questions, offer participations the opportunity to share any observations.

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? Or Act in a way that made you afraid that you might be physically hurt?

2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? Or Ever hit you so hard that you had marks or were injured?

3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? Or Attempt or actually have oral, anal, or vaginal intercourse with you?
4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? Or Your family didn’t look out for each other, feel close to each other, or support each other?

5. Did you often or very often feel that … You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you? Or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

6. Were your parents ever separated or divorced?

7. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? Or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or Ever repeatedly hit at least a few minutes or threatened with a gun or knife?

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

10. Did a household member go to prison?

Slide 23

Trauma Prevalence in Children

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>71%</td>
<td>Number of children who are exposed to violence each year (Finkelhor, et al., 1990)</td>
</tr>
<tr>
<td>3 million</td>
<td>Number of children maltreated or neglected each year (ChildWelfareInfo, 2012)</td>
</tr>
<tr>
<td>3.5-10 million</td>
<td>Children witnessed violence against their mother each year (ChildWelfareInfo, 2014)</td>
</tr>
<tr>
<td>1 in 4 girls &amp; 1 in 6 boys</td>
<td>Number who are sexually abused before adulthood (NCTIC Fact Sheet, 2006)</td>
</tr>
<tr>
<td>94%</td>
<td>Percentage of children in a study of juvenile justice settings who have experienced trauma (Pettit, 2014)</td>
</tr>
</tbody>
</table>

TALKING POINTS

A high percentage of children are exposed to potentially traumatizing events on a regular basis.

Exposure to traumatic events greatly increases the likelihood that children will eventually receive behavioral health and social services.

These statistics are so high that many social service settings assume that every child they see may have had some form of trauma in their background, whether anyone knows about it or not.
Statistics:

- 60% of children 17 or younger are exposed to violence every year (Finkelhor, et al., 2009)
- 3 million children are maltreated or neglected every year (Child Welfare Information Gateway, 2013)
- 3.5-10 million children witness violence against their mother every year (Child Witness to Violence Project, 2013)
- 1 in 4 girls and 1 in 6 boys are sexually abused before adulthood (NCTSN Fact Sheet, 2009)
- 94% of children in a study of juvenile justice settings have experienced trauma (Rosenberg, et al., 2014)

REFERENCES


Slide 24

**Prevalence (Children) (con.)**

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
<th>Source(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>40-80%</td>
<td>40-80% of school-age children experience bullying</td>
<td>(Graham, 2013)</td>
</tr>
<tr>
<td>75-93%</td>
<td>75-93% of youth entering the juvenile justice system have experienced trauma</td>
<td>(Justice Policy Institute, 2010)</td>
</tr>
<tr>
<td>92%</td>
<td>92% of youth in residential and 77% in non-residential mental health treatment</td>
<td>(NCTSN, 2011)</td>
</tr>
<tr>
<td></td>
<td>reported multiple traumatic events</td>
<td></td>
</tr>
</tbody>
</table>

**TALKING POINTS**

- 40-80% of school-age children experience bullying at some point during their school careers (Graham, 2013)
- 75-93% of youth entering the juvenile justice system have experienced trauma (Justice Policy Institute, 2010)
- 92% of youth in residential and 77% in non-residential mental health treatment reported multiple traumatic events (NCTSN, 2011)

**REFERENCES**


TALKING POINTS

• A very high percentage of people served in mental health settings have been exposed to potentially traumatizing events as children and/or as adults.

• The evidence is now strong that trauma plays a causal role in virtually all mental health conditions.

• Exposure to traumatic events increases the likelihood that people will use more mental health services and more intensive interventions

• These statistics are so high that many mental health settings assume that every person they see may have had some form of trauma in their background, whether anyone knows about it or not.

Expanded and additional statistics:

• 84%+ of adult mental health clients have histories of trauma (Mueser et al, 2004)

• 50% of female and 25% of male clients have experienced sexual assault in adulthood (Read et al, 2008)

• Content of hallucinations and delusions is often based on memories of childhood trauma (Read et al, 2008)

• Children who grow up in poverty are seven times more likely to develop schizophrenia (Read et al, 2008)

REFERENCES


**TALKING POINTS**

Clients with histories of childhood abuse:

- Have earlier first admissions
- Have more frequent and longer hospital stays
- Spend more time in seclusion or restraint
- Are more likely to self-injure or attempt suicide
- Use more medication
- Have more severe symptoms

**INSTRUCTOR GUIDANCE**

These statistics are taken from review articles that look across multiple studies conducted with a high standard of scientific rigor. While people may have seen higher statistics, they are usually taken from single studies and/or are estimated by combining different forms of abuse.
REFERENCES

Sliden27

Trauma in Adults: Substance Abuse

TALKING POINTS
- A very high percentage of people who abuse substances have been exposed to potentially traumatizing events as children and/or as adults.
- Understanding the role of trauma is key to effective treatment.
- These statistics are so high that many substance abuse treatment settings assume that every person they see may have had some form of trauma in their background, whether anyone knows about it or not.

REFERENCES
Retrieved 9/16/13

INSTRUCTOR GUIDANCE

Substance abuse treatment programs, especially those for women, have long recognized that most of the people they serve have experienced significant trauma in their lives, and that people often use substances to cope. However, there is still considerable discussion about how to balance this understanding with the goal of abstinence.

REFERENCES

National Center for PTSD.


Slide 29

Discussion Question

What makes something traumatic?
TALKING POINTS

- Discussion question: What makes something traumatic?
- Summary answer: The EVENT, the EXPERIENCE and the long lasting EFFECT.

Section 2: Trauma-Informed Approaches

Slide 30

Slide 31

Learning Objectives

TALKING POINTS

After completing this section, you will be able to:
• Explain why trauma-informed programs operate with the universal expectation that trauma has occurred

• Explain each of SAMHSA’s principles and why it is important

• Give positive examples of the implementation of each principle

• Name at least three changes that would make your work setting more trauma-informed

INSTRUCTOR GUIDANCE
The appendix contains the following handout for this slide:

• Applying Principles of Trauma-Informed Approaches

This session is designed to be an interactive discussion applying principles of trauma-informed approaches to the trainee’s own work environments and practices. If possible, discuss this process ahead of time with the agency director or another person in a leadership position in the organization. Focus on the importance of leadership in creating a trauma-informed organization, and the fact that this is an opportunity for participants to get input and ideas directly from staff and demonstrate a commitment to involvement of staff in decision-making.

When you introduce the exercise, either have the agency leader introduce it, or tell people about your conversation and convey whatever commitment was made for reviewing and incorporating their feedback. Possibilities include recording people’s suggestions during the discussion, collecting worksheets for further analysis, and having a real or online “suggestion box” where people can make additional suggestions or comments.

Pass out the handout and explain that during the discussion, they should jot down ideas that might make a difference in their work settings. Point out that they should pay attention to how the principles apply to staff as well as to the people they serve. They should not put their names on the handout so the input remains confidential (unless they choose to, of course.)

The format for the exercise and discussion includes a brief introduction of the principles – where they came from, how they can be used, and why they matter. Each individual principle is introduced and defined, and a few minutes can be spent discussing why the principle is so important. A second slide for each principle provides an opportunity to elaborate on implementation and to give examples. While a few examples are provided here, this is a perfect place for trainers to bring in their own experience. A third slide for each principle provides discussion questions. Ask people to take 1-2 minutes to consider the discussion questions and to make notes about the application of that principle in their own work setting – good examples (what they are doing right), examples of practices that are inconsistent with the principle, and suggestions for changes. Discussion is then opened up for people to share their observations.

[The document SAMHSA’s Working Concept of Trauma and Framework for a Trauma-Informed Approach will be added to the appendix and references and cited here when it is formally released.]
TALKING POINTS

What may seem like inappropriate or unexpected behaviors in children are usually rooted in their experiences. (These are two examples often shared by another NCTIC trainer):

*Read this example and follow with discussion:* “Quiet? Isn’t that the goal and dream of every school? For some of our students, it may signal danger or make them highly anxious. I had a habitually disruptive student explain to me that when it is quiet, it makes him feel like something bad is going to happen or that something is wrong because that is what happens at home when his Dad has been drinking. Another student, who is constantly in trouble for tapping and singing, shared that he cannot recall a time when the radio and TV have not been on in his house. Many of our students are conditioned to expect noise; when this is removed it doesn’t feel right.”

*Read this example and follow with discussion:* “In my experience, a very common reminder is the “Your Mama” joke. It starts off innocently, but it usually doesn’t end well. We tell students it doesn’t matter, ignore it, they don’t even know your Mom. But what we sometimes forget is that jokes and comments about family members strike a nerve in all of us…and it can be devastating for students who have complicated family relationships. One student explained, “I feel like I have to defend my Mom. When my stepdad hit her I didn’t do anything and now I am grown I’m not going to let anyone disrespect her.”

Trauma-informed approaches take into account how an individual’s past experiences can affect his reactions and perceptions now.
INSTRUCTOR GUIDANCE

Show video, available at https://www.youtube.com/watch?v=p_dZAqP_tfY, and discuss with participants.

TALKING POINTS

• Trauma-informed approaches reflect a fundamental shift in the culture of an entire organization.

• The four Rs highlight basic aspects of culture change that an organization will demonstrate as it becomes trauma-informed.

• The Four Rs reflect that it is not enough to simply know about trauma.

• To be trauma-informed, people must be able to identify trauma when they see it, and they must know how to respond in a way that doesn’t unintentionally re-traumatize people.
• Trauma-Informed approaches can be implemented anywhere, by anyone. Everyone in the organization has a role to play in becoming trauma-informed.

Slide 35

**SAMHSA’s Principles**

• Six principles that guide a trauma-informed change process
• Developed by national experts, including trauma survivors
• Goal: Establish common language/framework
• Values-based
• A way of being

**TALKING POINTS**

• SAMHSA’s principles for trauma-informed approaches emerged from a year-long process involving trauma survivors, family members, practitioners, researchers and policymakers.

• During a public comment period, thousands of individuals wrote in with feedback on the definitions and overall approach.

• The goal was to develop a common language and framework. As more agencies and organizations work to become trauma-informed—and as more and more claim to BE trauma-informed—there needs to be some standard way to define and assess consistency with the approach.

• The principles are value-based. Unlike “manualized” models for specific treatment interventions, these principles can be applied in a wide variety of settings, in many different ways, using whatever resources are available.

• Implementing a trauma-informed approach requires constant attention and caring; it’s not about learning a particular technique or checking things off a checklist. Think about something as basic as respect or compassion. Can you do it once, implement a policy, and then check it off as “done”? Trauma-informed approaches are about a *way of being*, not a specific set of actions or implementation steps.

• Becoming trauma informed requires a culture shift.

*Expanded text for bullets:*

• Six principles to guide a trauma-informed change process.
Developed by a group of national experts including trauma survivors, with extensive public input.

Goal is to establish a common language and framework.

A values-based approach.

A way of being, not a checklist or technique.

Slide 36

**SAMHSA’s Six Key Principles of a Trauma-Informed Approach**

- Safety
- Trustworthiness and Transparency
- Peer Support
- Collaboration and Mutuality
- Empowerment, Voice, and Choice
- Cultural, Historical, and Gender Issues

TALKING POINTS

- We will now discuss each principle in detail.

Slide 37

**Principle 1: Safety**

Throughout the organization, staff and the people they serve, whether children or adults, feel physically and psychologically safe.
INSTRUCTOR GUIDANCE

Show video on Safety featuring Leah Harris (https://vimeo.com/107476472) and discuss.

- Safety throughout the organization, staff and people served
- Physical and psychological safety
- Physical setting is safe
- Interpersonal interactions promote a sense of safety

Discussion question: From what we have discussed so far today, why do you think safety is so important to trauma survivors?

Slide 38

Who Defines Safety?

For people who use services:
- “Safety” generally means maximizing control over their own lives

For providers:
- “Safety” generally means maximizing control over the service environment and minimizing risk

TALKING POINTS

- Many of these principles—like safety—sound so simple and obvious that you might wonder why it needs to be highlighted. Of course we want everyone to be safe!

Safety means that throughout the organization staff and the people they serve:

- Feel physically safe
- Feel psychologically safe
- Have interpersonal interactions that promote a sense of safety

But if we go below the surface, a more complicated reality emerges.

- About 10 years ago, Laura Prescott, a trauma survivor and advocate, went on the wards of a psychiatric hospital and asked both patients and staff what it was that made them feel safe.
• What she found was very interesting. Point for point, staff and patients defined safety in almost completely opposite terms.

• In fact, it turned out that the very things that staff were doing to make the ward safer were making the patients feel less safe.

• So what can you do in a situation like this? First, just recognizing that safety may look different depending on your role and situation—or your personal history—is an important first step. The best thing you can do is to ask each individual what makes them feel safe and unsafe.

• This may mean rethinking policies and practices to attend to what both survivors and staff mean by safety. For example, re-thinking use of seclusion and restraint, use of locked and unlocked spaces, tone of interactions.

Slide 39

**Discussion**

**TALKING POINTS**

• Safety is a surprisingly volatile issue for staff as well as people served.

• Often, physical safety is a concern, especially for people who work at night and have to walk into dark parking lots or who work in rough neighborhoods.

• Incidents of workplace violence can have a ripple effect far beyond the specific circumstances.

• Staff may fear that their jobs are in jeopardy due to budget cutbacks, or they may be terrorized by workplace bullying.

• While these issues cannot be resolved in this workshop, getting people to identify their safety concerns is an important first step.
INSTRUCTOR GUIDANCE

In the discussion about client safety, ask people if they can think of examples when an organizational effort to enhance safety—for example, after an incident—turned out to be counterproductive. For example, does a facility-wide lock-down after an incident make people safer? Does putting someone in seclusion or restraint make them more or less likely to be violent? Why or why not? Encourage people to think about how often they make assumptions about safety without checking them out with the people most directly involved.

Encourage people to consider a wide range of examples of good safety improvement measures: Better lighting in parking lots, effective grievance procedures or mediation programs to resolve internal conflicts, individualized safety plans for both clients and staff, team support, more transparent staff evaluation procedures, reduced use of coercive measures, etc.

Slide 40

Principle 2: Trustworthiness and Transparency

Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among clients, family members, staff, and others involved with the organization.

INSTRUCTOR GUIDANCE

Show video on trustworthiness and transparency featuring Pat Risser (https://vimeo.com/107478500) and discuss.

- Maximizing trustworthiness, making tasks clear, and maintaining appropriate boundaries
- Organizational operations and decisions are conducted with transparency
- Constantly building trust

Discussion questions: How is trust affected by trauma? How does lack of trust affect relationships? Can you see why this would be a big issue for trauma survivors?
### Examples of Trustworthiness

- Making sure people really understand their options
- Being authentic
- Directly addressing limits to confidentiality

### TALKING POINTS

- One of the most powerful ways of building trust is to give people full and accurate information. Just telling people what’s going on and what’s likely to happen next can be very important.

- Being clear is essential. Telling people they have more control than they really do will eventually destroy trust. For example, calling a program “peer-run” when in fact key decisions are made by the host organization is not trustworthy. Much better to explain what decisions are made by peers and what decisions are not.

- Similarly, if you are required by your organization to break confidentiality when someone talks about wanting to hurt themselves, better to tell the individual up front than to assure them of confidentiality and then break that trust.

- Sharing your own reactions and responses in a truthful manner—being authentic—is also essential. Trauma survivors often have finely tuned “radar” to detect other people’s emotional states—they have had to develop this capacity, a form of vigilance, to protect themselves. If you are untruthful about your feelings—even if you are trying to protect the other person—they are likely to detect it, and trust goes out the window.
**INSTRUCTOR GUIDANCE**

Go through these questions and let participants answer.

### Slide 42

**Discussion**

- How can we promote trust throughout the organization?
- Do the people served trust staff? How do you know?
- What changes could be made to address trust concerns?

### Slide 43

**Principle 3: Peer Support**

*Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, serving as models of recovery and healing, and maximizing a sense of empowerment.*

**Talking Points**

- In this context, the term “peer” refers to individuals with lived experiences of trauma.
- In the case of children this may also refer to family members of children who have experienced traumatic events and are key caregivers in their recovery.

**Instructor Guidance**

TALKING POINTS

• Peer support is not a “service model”—it is about developing authentic mutual relationships, not applying a cookie-cutter approach to everyone.

• Peer supporters don’t use clinical language or focus on what’s “wrong” with people.

• Peer support doesn’t offer top-down “helping” that disempowers people by taking away choice and voice.

• Peer support is not “Peer Counseling”, which implies that one person knows more than the other—peer support is about power-sharing.

• The heart of peer support involves building trust. That isn’t possible if people feel that peer support staff are acting as proxies for clinicians, case managers, or administrators, or are reporting on people’s behavior.

• Trauma-informed peer support is not just important for people who receive services. It is important that staff who are trauma survivors have access to peer support, too.

INSTRUCTOR GUIDANCE

The definition of peer support used in these materials comes from Shery Mead’s Intentional Peer Support, and also from the work of pioneers in the early consumer/survivor/ex-patient movement in the 1970s. These activists developed what was then referred to as self-help or mutual support. It grew from the recognition that people who had been disempowered by the mental health system could come together as equals and develop supportive relationships to help reclaim their power.

Peer support has been established as an effective mode of support and healing in a wide variety of forms and contexts. There are many ways to organize peer support, and these may differ among service systems.

For example:
1) Mutual support groups such as AA, NA, Al Anon, Double Trouble, etc. are familiar to most of us. There is a wide variety of formal and informal mutual support options, some—but not all—organized by “problem area.” This is the most common form of peer support in the substance abuse community.

2) Many service systems support independent peer-run programs, such as peer support and advocacy centers, crisis respite programs, housing programs, etc.

3) Many service systems have peer advocacy or peer support components. One of the most well-known is in the rape crisis response system, where women who have been through the experience provide the vast majority of advocacy services for rape survivors.

**Slide 45**

**Discussion**

- Does your organization offer access to peer support for the people who use your services? If so, how?
- What barriers are there to implementing peer support in your organization?
- Does your organization offer peer support for staff?

**Things to consider:**

- Does your organization offer access to peer support for the people who use your services? If so, how?
- Does your organization offer peer support for staff?
- What barriers are there to implementing peer support in your organization?

**INSTRUCTOR NOTE**

Remind people that there is a whole day of training on Trauma-Informed Peer Support that is offered as part of this curriculum package, and suggest that any agency that is introducing peer support consider offering this training.
**Slide 46**

**Principle 4: Collaboration and Mutuality**

*Partnering and leveling of power differences between staff and clients and among organizational staff from direct care to administrators; demonstrates that healing happens in relationships, and in the meaningful sharing of power and decision-making.  
Everyone has a role to play; one does not have to be a therapist to be therapeutic.*

**Talking Points**

- Maximizing collaboration and sharing of power with consumers and families
- Leveling of power differences between staff and clients and among organizational staff from direct care staff to administrators
- Recognition that healing happens in relationships and meaningful sharing of power and decision-making
- Everyone has a role to play in trauma-informed approaches; “one does not have to be a therapist to be therapeutic.”

**Instructor Guidance**

- Show video on collaboration and mutuality featuring William Killebrew (https://vimeo.com/107476474) and discuss.

Developing true partnerships between staff and the people they serve may be more difficult than it sounds. Most professionals have been trained to think that their job is to have answers, to maintain clinical distance, and to know the right techniques to fix a given problem. Many professions have ethics standards that explicitly prohibit friendships with clients. In contrast, a trauma-informed model recognizes that healing happens in authentic relationships; how to establish a true partnership while also maintaining healthy personal boundaries is one of the challenges of a trauma-informed approach. There has been some excellent work done in this area, much of it by trauma survivors who are developing trauma-informed peer support models.

It may also be hard for people to break down the barriers between different levels of staff. Most if not all organizations are essentially hierarchical, with power flowing down from the top. It requires a shift of thinking to see that everyone has an important role to play in a trauma-informed environment – including kitchen staff, security guards, data clerks, etc. Use the
discussion on this principle to identify some of the barriers to sharing power in a hierarchically structured organization.

Slide 47

**Examples of Collaboration**

- “There are no static roles of ‘helper’ and ‘helpee’—reciprocity is the key to building natural community connections.” —Sherry Mead
- Hospital abolished special parking privileges and opened the “Doctor’s Only” lounge to others
- Models of self-directed recovery where professionals facilitate but do not direct
- Direct care staff and residents in a forensic facility are involved in every task force and committee and are recognized for their valuable input

**TALKING POINTS**

- Collaboration and mutuality refers both to collaboration between staff and people served and among different levels of staff. Use examples from your experiences.

Slide 48

**Discussion**

- Can you think of examples from your agency of true partnership between staff and people served?
- What about partnership between top-level administrators and line staff?
- Can you think of changes that would significantly decrease the power differentials in your agency?
Principle 5: Empowerment, Voice, and Choice

- Individuals’ strengths and experiences are recognized and built upon; the experience of having a voice and choice is validated and new skills developed.
- The organization fosters a belief in resilience.
- Clients are supported in developing self-advocacy skill and self-empowerment

TALKING POINTS

- Strengthens clients and family member’s experience of choice
- Recognizes that every person’s experience is unique
- Individualized approach

INSTRUCTOR GUIDANCE

Show video on empowerment, voice, and choice featuring Mike Skinner (https://vimeo.com/107476470) and discuss.

Gains Center video available at http://www.youtube.com/watch?v=avyzumgwxqm

This principle is one of the most powerful tools for organizational change. While it has become almost a cliché to talk about recognizing people’s strengths, it requires us to turn our thinking and actions around – to identify what people are doing right and build on their capacities rather than focusing on what’s wrong with them. This may seem counterintuitive to some participants, particularly clinicians who may (rightfully) state that people come to them with problems that they are supposed to help them solve. You can remind them that sometimes the best way to solve a problem is not by focusing on it, but by strengthening an alternative response so that the problem eventually goes away by itself.

Participants may also nod and agree with the concepts of voice and choice, but privately be skeptical about how broadly these concepts can be implemented. They may be worried about risk management – a common concern – or other issues. Use the discussion to elicit people’s concerns and get them to think deeply about the long-term consequences of controlling people’s behavior rather than helping them to develop their own skills and decision-making abilities.
TALKING POINTS

- There are as many ways of building on people’s strengths and resilience as there are people on the planet. What are some ways you can use your clients’ strengths?

- Sometimes people want a list of things they should be doing, but this principle reflects a positive, creative attitude rather than a specific technique.

- Empowerment, voice and choice apply to staff as well as the people served. We often see patient art on the walls of psychiatric facilities. In one hospital, staff with artistic talents joined residents in painting murals on the walls—a great example of collaboration as well as building on strengths.

- Some examples of turning “problems” into strengths:

  - In one hospital, a young woman who was often self-injurious when she was under stress, was made the hospital safety officer. Whenever she started to want to hurt herself, she made rounds and identified all the possible ways she could do it and let staff know. She often found dangerous items in the environment that no one else had noticed.

  - In another hospital, a person who was extremely meticulous, always keeping detailed notes about everything that happened. After a TIC training, staff stopped trying to get him to give up his stacks of paper and made him a peer advocate. His detailed note-taking became a valued asset when advocating for others.
TALKING POINTS

This is just one example:

- In one adolescent residential program, a young man was required to make amends to the community after he was involved in an incident. While this process is important in establishing a sense of responsibility, it has the potential to be humiliating, especially for trauma survivors who often have a deeply embedded sense of shame and self-blame. In this case, staff knew that the boy was musically talented, and they encouraged him to write a rap song and sing his apology. His fellow residents loved it, he was able to feel good about himself at the same time he was taking responsibility for his actions, and the number of incidents he was involved with dropped dramatically.

INSTRUCTOR GUIDANCE

Encourage participants to think of real and hypothetical examples.
TALKING POINTS
Show video on Cultural, Historical, and Gender issues featuring William Kellibrew (https://vimeo.com/107488464) and discuss.

INSTRUCTOR GUIDANCE
Trauma is context specific. That’s why the first “E” in SAMHSA’s definition is “event.” Women and men often experience different kinds of traumatic events, so gender-responsiveness is important in trauma work. The “experience” of trauma – the second “E” – depends on how the person understands what happened to them, the meaning ascribed to the event – which is heavily influenced by culture. Use the discussion of this principle to help people understand why culture, gender and history are not just “value-added” but are in fact essential in a trauma-informed approach.

You may want to recommend the following resource (which are also included in the reference list at the end of this manual) if appropriate to the audience: Engaging Women in Trauma-Informed Peer Support: A Guidebook. by Andrea Blanch, Beth Filson, and Darby Penney with contributions from Cathy Cave.
TALKING POINTS

A women’s prison in Hawaii reinvented itself as a place of healing for the women it serves.

*Video available at [http://www.youtube.com/watch?v=8ucc3dedyfu](http://www.youtube.com/watch?v=8ucc3dedyfu)*

**Section 3: SAMHSA’s Guidance for Implementation**

**Slide 55**

TALKING POINTS

- The change process for becoming a trauma-informed organization is conscious, intentional, and ongoing.
- The organization becomes a learning community, constantly responding to new knowledge and developments.

**Slide 56**

*Learning Objectives*

- Describe why change is required at multiple levels of an organization
- Identify the organizational domains involved in creating a trauma-informed organization
TALKING POINTS

After completing this section, you will be able to:

- Describe why change is required at multiple levels of an organization
- Identify the organizational domains involved in creating a trauma-informed organization

INSTRUCTOR GUIDANCE


TALKING POINTS

- Developing a trauma-informed approach requires change at multiple levels of an organization and systematic alignment with the six key principles we just discussed.
• The guidance provided here builds upon the work of Harris and Fallot and in conjunction with the key principles, provides a starting point for developing an organizational trauma-informed approach. 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.

• The guidance for implementing a trauma-informed approach is presented in the ten domains described below. This is not provided as a “checklist” or a prescriptive step-by-step process.

• These are the domains of organizational change that have appeared both in the organizational change management literature and among models for establishing trauma-informed care. What makes it unique to establishing a trauma-informed organizational approach is the crosswalk with the key principles and trauma-specific content.

INSTRUCTOR GUIDANCE

VIDEO: SAMHSA Awardee Seclusion and Restraint DVD

Show the “SAMHSA Awardee Seclusion and Restraint DVD” and listen for application of the domains. After each chapter, have the participants identify domains practiced.

Developing a Trauma-informed approach requires a change at multiple levels of an organization. SAMHSA identified the 10 domains listed on these two slides as the key organizational areas that should be examined and addressed in developing a trauma-informed change process. Ask participants to think about their own work environment and how a Trauma-Informed change process might happen.
slide 59

**Governance and Leadership**

1. How does agency leadership communicate its support and guidance for implementing a trauma-informed approach?
2. How do the agency’s mission statement and/or written policies and procedures include a commitment to providing trauma-informed services and supports?
3. How do leadership and governance structures demonstrate support for the voice and participation of people using services who have trauma histories?

**Talking Points**

- The leadership and governance of the organization support and invest in implementing and sustaining a trauma-informed approach; there is an identified point of responsibility within the organization to lead and oversee this work; and there is inclusion of the peer voice.
- A champion of this approach is often needed to initiate a system change process.

slide 60

**Policy**

- Include a focus on trauma and issues of safety and confidentiality?
- 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?
- Culturally relevant?
- Trauma-informed?

**Talking Points**

- There are written policies and protocols establishing a trauma-informed approach as an essential part of the organizational mission. Organizational procedures and cross agency protocols, including working with community-based agencies, reflect trauma-informed principles.
- This approach must be “hard-wired” into practices and procedures of the organization, not solely relying on training workshops or a well-intentioned leader.
Slide 61

Policy (con.)

- How do human resources policies attend to the impact of working with people who have experienced trauma?
- What policies and procedures are in place for including trauma survivors/people receiving services and peer supports in meaningful and significant roles in agency planning, governance, policy-making, services, and evaluation?

Slide 62

Physical Environment of the Organization

- How does the physical environment promote a sense of safety and collaboration?
- In what ways do staff members and the agency support these efforts?
  - Recognition and addressing aspects of the physical environment that may be re-traumatizing?
  - Work with people on developing strategies to deal with this?
  - Developed mechanisms to address gender-related physical and emotional safety concerns (e.g., gender-specific spaces and activities)?

TALKING POINTS

- The organization ensures that the physical environment promotes a sense of safety and collaboration. Staff working in the organization and individuals being served must experience the setting as safe, inviting, and not a risk to their physical or psychological safety.

- The physical setting also supports the collaborative aspect of a trauma-informed approach through openness, transparency, and shared spaces.
Slide 63

**Physical Environment (con.)**

![Image of painted cell]

**TALKING POINTS**

In a juvenile facility in Florida, the director understood that bedtime was a scary time for many of the girls. Whether they had been abused or witnessed violence in the home, night time was frightening. Thinking creatively on what could make a difference, the director utilized the talent of an officer and had him paint each cell to make them comforting. Simple paint and blankets did much to reduce fear and decrease anxiety at bedtime.

Slide 64

![Image of another painted cell]
You don't need to be a therapist to be therapeutic! At Western Maryland Hospital, pets are welcomed visitors.
**Slide 68**

**Engagement & 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?

**Slide 70**

**Engagement & Involvement (con.)**

- How are transparency and trust among staff and clients promoted?
- What strategies are used to reduce the sense of power differentials among staff and clients?
- How do staff members help people to identify strategies that contribute to feeling comforted and empowered?
Cross-Sector Collaboration

- Is there a system of communication in place with other partner agencies working with the individual receiving services for making trauma-informed decisions?
- Are collaborative partners trauma-informed?
- How does the organization identify community providers and referral agencies that have experience delivering evidence-based trauma services?
- What mechanisms are in place to promote cross-sector training on trauma and trauma-informed approaches?

TALKING POINTS

- Collaboration across sectors is built on a shared understanding of trauma and principles of a trauma-informed approach.

- While a trauma focus may not be the stated mission of various service sectors, understanding how awareness of trauma can help or hinder achievement of an organization’s mission is a critical aspect of building collaborations.

- People with significant trauma histories often present with complex needs, crossing various service sectors. Even if a mental health clinician is trauma-informed, a referral to a trauma-insensitive program could then undermine the progress of the individual.

INSTRUCTOR GUIDANCE

Walla Walla is a small community in Washington that has taken on the project of creating a trauma-informed community. When they became aware of the research on Adverse Childhood Events (ACE) and the impact of toxic stress to a child’s developing brain, they felt their community would want to know about this amazing research because it clearly shows that they
can do things to reduce ACEs, and they can help people see the power in Resilience! So they created the Children's Resilience Initiative™ (CRI), a grassroots, community response to ACEs, and they've been working on this effort for nearly four years now.

They educated the many systems in their community: law enforcement, schools, parents, etc. Their community initiative is called "Resilience Trumps ACES" with the goal of reducing the ACE score in their community. They engaged all stakeholders, especially families.

They created a resiliency model for the community with the understanding that all parts of the community play a role in developing thriving and resilient children. *(Extensive write up available online)*

**TALKING POINTS**

- Practitioners use and are trained in interventions based on the best available empirical evidence and science, are culturally appropriate, and reflect principles of a trauma-informed approach.

- Trauma screening and assessment are an essential part of the work.

- Trauma-specific interventions are acceptable, effective, and available for individuals and families seeking services.

- When trauma-specific services are not available within the organization, there is a trusted, effective referral system in place that facilitates connecting individuals with appropriate trauma treatment.

**Slide 73**

**Screening, Assessment, and 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?
- Does the organization have the capacity to provide trauma-specific treatment or refer to appropriate trauma-specific services?
TALKING POINTS

• Trauma-informed approaches are different from “trauma-specific interventions”—specific treatment modalities designed to address the behavioral health consequences of trauma.

• Both are essential.

• There are many effective trauma-specific treatments available (for example, Prolonged Exposure Therapy, Trauma Resolution Therapy, Seeking Safety, Risking Connection, Trauma-Focused Cognitive Behavioral Therapy, etc.) and it is important that trauma survivors have access to these models.

• Both trauma-informed approaches and trauma-specific interventions are based on resilience and strengths:
  • Belief in resilience and the ability of individuals, organizations and communities to heal and recover
  • Promote recovery from trauma
  • Builds on what clients, staff and communities have to offer rather than responding to perceived deficits

INSTRUCTOR GUIDANCE

The distinction between “trauma-specific” treatments and “trauma-informed” care was first made by Roger Fallot and Maxine Harris. However, becoming trauma-informed requires a more fundamental culture change than simply adopting a new treatment model.

This is a critical distinction, and worth spending a few minutes on. In mental health settings, if people don’t understand the difference, they may assume that this training will teach them skills to deliver a specific clinical intervention. In non-mental health settings, people may assume that trauma-informed approaches are really for behavioral health clinicians and wonder why they should learn the material.
Slide 75

Screening, Assessment, and Treatment Services (con.)

- How are peer supports integrated into the service delivery approach?
- How does the agency address gender-based needs in the context of trauma screening, assessment, and treatment?
- For instance, are gender-specific trauma services and supports available for both men and women?
- Do staff members talk with people about the range of trauma reactions and work to minimize feelings of fear or shame and to increase self-understanding?
- How are these trauma-specific practices incorporated into the organization’s ongoing operations?

Slide 76

TALKING POINTS

- On-going training on trauma and peer-support are essential.
- The organization’s human resource system incorporates trauma-informed principles in hiring, supervision, staff evaluation; procedures are in place to support staff with trauma histories and/or those experiencing significant secondary traumatic stress or vicarious trauma, resulting from exposure to and working with individuals with complex trauma.

Slide 76

TALKING POINTS

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Slide 77

Training and Workforce Development (2)

- How does workforce development/staff training address the ways identity, culture, community, and oppression can affect a person’s experience of trauma, access to supports and resources, and opportunities for safety?

- How does ongoing workforce development/staff training provide staff supports in developing the knowledge and skills to work sensitively and effectively with trauma survivors?

Slide 78

Training and Workforce Development (3)

- What types of training and resources are provided to staff and supervisors on incorporating trauma-informed practice and supervision in their work?

- What workforce development strategies are in place to assist staff in working with peer supports and recognizing the value of peer support as integral to the organization’s workforce?

Slide 79

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?

- What strategies and processes does the agency use to evaluate whether staff members feel safe and valued at the agency?
TALKING POINTS

There is ongoing assessment, tracking, and monitoring of trauma-informed principles and effective use of evidence-based trauma specific screening, assessments, and treatment.

Slide 80

Progress Monitoring and Quality Assurance (con.)

- How does the agency incorporate attention to culture and trauma in agency operations and quality improvement processes?
- What mechanisms are in place for information collected to be incorporated into the agency’s quality assurance processes?
- How well do those mechanisms address creating accessible, culturally relevant, trauma-informed services and supports?

Slide 81

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?
- What funding exists for peer specialists?
- How does the budget support provision of a safe physical environment?

TALKING POINTS

Financing structures are designed to support a trauma-informed approach which includes resources for:

- Staff training on trauma, key principles of a trauma-informed approach;
- Development of appropriate and safe facilities;
- Establishment of peer-support;
- Provision of evidence-supported trauma screening, assessment, treatment, and recovery supports; and
• Development of trauma-informed cross-agency collaborations.

Slide 82

**Evaluation**

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

**TALKING POINTS**

- Measures and evaluation designs used to evaluate service or program implementation and effectiveness reflect an understanding of trauma and appropriate trauma-oriented research instruments.

Slide 83

**Evaluation (con.)**

- What processes are in place to solicit feedback from people who use services and ensure anonymity and confidentiality?
- What measures or indicators are used to assess the organization's progress in becoming trauma-informed?
INSTRUCTOR GUIDANCE

Watch video Developing Capabilities (https://www.youtube.com/watch?v=urU-a_FsS5Y) and discuss.

TALKING POINTS

- Self Care: At times the material presented is difficult to hear. It might bring back memories of painful times in our past. Please feel free to take a break at any time and speak to instructors or colleagues when you need support.

INSTRUCTOR GUIDANCE

This section of the training is typically dedicated to the survivor voice. If a survivor is not presenting, please use this section.
Learning Objectives

TALKING POINTS

After completing this section, you will be able to:

- Describe the effects of trauma on the lives of those served in the community and across systems.
- Think about what our system can do differently to enable healing to take place.
- Reflect on changes needed to implement trauma informed approaches to focus on healing.

INSTRUCTOR GUIDANCE

Learning about how widespread trauma is and how it can affect all aspects of a person’s life can sometimes feel overwhelming. The most important point to convey in this section is how resilient people really are. With support, people can survive and thrive, even after devastating trauma, and protective factors can really make a difference in how a child responds to trauma. Even people with extremely high ACE scores can live long and healthy lives, especially if they have support.
Start this section by showing “Behind Closed Doors” video to provide a case study of how trauma survivors can and do heal.

**INSTRUCTOR GUIDANCE**

Lead a discussion based on the video. Ask people: How did this video make you feel? Trauma survivors often talk about “being stronger at the broken places.” Were you surprised by Tonier’s success? What do you think made a difference?

Can you give examples from the video about how “symptoms” were actually adaptations to trauma? What is the take-home lesson from this video for you?

**Slide 88**

**SAMHSA’s Definition of Recovery**

*Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.*

**TALKING POINTS**

- This definition developed by a group of individuals who had been diagnosed with mental health and substance abuse problems. They were asked by SAMHSA to develop a common definition and set of principles for recovery.
Recovery was a break-through in mental health because so many people with mental health diagnoses thought they would never be able to overcome their problems. It was also a break-through because it emphasized that what people want is a meaningful life—not just help in reducing or controlling “symptoms” or “problem behaviors.”

Recovery has now been adopted as the basic framework by many behavioral health programs.

While we often use the term “healing” instead of “recovery” when we are talking about trauma, the basic message is the same: Everyone has the possibility of living a satisfying and meaningful life, regardless of what happened to them or what diagnosis they have been given.

Slide 89

INSTRUCTOR GUIDANCE
At the conclusion of the training, facilitate a discussion with participants about what they will do differently tomorrow as a result of the this training.

Encourage the trauma survivor who speaks to stay for a while after the session ends so she/he can talk individually with audience members. Having an opportunity to ask questions or share stories can be reassuring to participants and offer closure to them after hearing the survivor’s story.
SAMHSA’s mission is to reduce the impact of substance abuse and mental illness on America’s communities.

www.samhsa.gov

1-877-SAMHSA-7 (1-877-726-7277) • 1-800-487-4889 (TDD)

End of Basic Training Curriculum


SAMHSA (2014). Working concept of trauma and framework for a trauma-informed approach (DRAFT for internal purposes only).


**Proposed Handouts**

- SAMHSA Statement on Recovery
- SAMHSA Principles of Trauma-Informed Approaches
- Evaluation
National Center for Trauma-Informed Care (NCTIC) & Alternatives to Seclusion & Restraint

Applying Principles of Trauma-Informed Approaches

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

From SAMHSA’s perspective, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Consistent with SAMHSA’s definition of recovery, services and supports that are trauma-informed build on the best evidence available and consumer and family engagement, empowerment, and collaboration.

The six key principles fundamental to a trauma-informed approach include:

1. **Safety**: Throughout the organization, staff and the people they serve, whether children or adults, feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety. Understanding safety as defined by those served is a high priority.

2. **Trustworthiness and Transparency**: Organizational operations and decisions are conducted with transparency with the goal of building and maintaining trust with clients and family members, and among staff, and others involved in the organization.

3. **Peer Support**: Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing their stories and lived experience to promote recovery and healing. The term “Peers” refers to individuals with lived experiences of trauma, or in the case of children this may be family members of children who have experienced traumatic events and are key caregivers in their recovery. Peers have also been referred to as “trauma survivors.”

4. **Collaboration and mutuality**: Importance is placed on partnering and the leveling of power differences between staff and clients and among organizational staff from clerical and housekeeping personnel, to professional staff to administrators, demonstrating 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. As one expert stated, “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 and experiences are recognized and built upon. The organization fosters a belief in the primacy of the people served, in resilience, and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. The organization understands that the experience of trauma may be a unifying aspect in the lives of those who run the organization, who provide the services, and/or who come to the organization for assistance and support. As such, operations, workforce development and services are organized to foster empowerment for staff and clients alike. Organizations understand the importance of power differentials and ways in which clients, historically, have been diminished in voice and choice and are often recipients of coercive treatment. Clients are supported in shared decision-making, choice, and goal setting to determine the plan of action they need to heal and move forward. They are supported in cultivating self-advocacy skills. Staff are facilitators of recovery rather than controllers of recovery.

6. **Cultural, Historical, and Gender Issues**: The organization actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, religion, gender-identity, geography, etc.); offers, either directly or through referral, access to gender responsive services; leverages the healing value of traditional cultural connections; incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; and recognizes and addresses historical trauma.