Distribution Agreement

In presenting this thesis or dissertation as a partial fulfillment of the requirements for an advanced degree from Emory University, I hereby grant to Emory University and its agents the non-exclusive license to archive, make accessible, and display my thesis or dissertation in whole or in part in all forms of media, now or hereafter known, including display on the world wide web. I understand that I may select some access restrictions as part of the online submission of this thesis or dissertation. I retain all ownership rights to the copyright of the thesis or dissertation. I also retain the right to use in future works (such as articles or books) all or part of this thesis or dissertation.

Signature:

_____ _____

Carolyn Acker Date

Trauma-Informed Care in a Substance Abuse Treatment Setting:
A Mixed Methods Process Evaluation

By

Carolyn Acker
MPH

Behavioral Sciences and Health Education

_____
Iris Smith, MPH, PhD
Committee Chair

_____
Hannah Cooper, ScD
Committee Member

_____
Richard Levinson, PhD
Department Chair

Trauma-Informed Care in a Substance Abuse Treatment Setting:
A Mixed Methods Process Evaluation

By

Carolyn Acker

BA
Emory University
2014

Thesis Committee Chair: Iris Smith MPH, PhD

An abstract of
A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health
in Behavioral Sciences and Health Education
2014

Abstract

Trauma-Informed Care in a Substance Abuse Treatment Setting:
A Mixed Methods Process Evaluation

By Carolyn Acker

Trauma affects between 75% and 95% of clients in substance abuse treatment settings (Rosenberg, 2011; Wu, Schairer, Dellor, & Grella, 2010). Trauma-informed care (TIC) seeks to treat clients in a way that acknowledges and addresses clients' trauma and empowers them to recover. Evaluations have typically addressed outcomes related to substance abuse and trauma symptoms, but this study sought to evaluate the fidelity to TIC in a process evaluation and learn about client and staff experiences of TIC. Mixed-method interviews with 23 clients and in-depth interviews with 4 staff members were conducted in order to show what aspects of TIC are being implemented well and which aspects could be improved. The program had positive results, with a vast majority of the clients reporting that the program helped them feel empowered, hopeful, and safe. Although most clients felt the program was trustworthy, one client reported a possible breath of confidentiality. While clients felt that their goals were treated as the most important aspect of their treatment plan, some clients also felt that they did not have much choice and control over services offered. While women were familiar with trauma and its effects, 5 men reported not knowing the symptoms related to trauma. Staff were educated or trained in TIC, but not all of the staff reported feeling comfortable and competent with TIC. Recommendations were created with staff members based on the literature review, results of the study, and staff perceptions of feasibility and importance. These include conducting a follow-up TIC training, conducting a confidentiality training, optional client-run classes for the clients, continuing to improve clients' self-determination, improving male clients' knowledge of trauma and its effects, including a PTSD symptom scale during assessments, adding a comprehensive and sensitive trauma scale to the intake assessment

Keywords: trauma, substance abuse treatment, trauma-informed care

Trauma-Informed Care in a Substance Abuse Treatment Setting:
A Mixed Methods Process Evaluation

By

Carolyn Acker

BA
Emory University
2014

Thesis Committee Chair: Iris Smith MPH, PhD

A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health
in Behavioral Sciences and Health Education
2014

Acknowledgements

Like many evaluations, this master's thesis would not have been possible without the support of and collaboration with many people. First, I would like to thank my chair, Dr. Iris Smith, for all the revisions she read and made sense of as well as her encouragement throughout a difficult project. I'd also like to thank my Thesis committee member Dr. Hannah Cooper for making helpful revisions and cheering remarks

To Ko Hassan, I am so grateful to have been your intern. You give your time, trust, and wisdom in wonderful measure. I truly could not have done this without you.

I'd like to thank all the RCA staff, especially Cassandra Collins, Michael Banner (formerly of RCA), Lori Philips, and Melvenia Marable for giving me their time, attention, and feedback, as well as trusting me to interview their clients and interrupting their Tuesday and Thursday evening classes. I'd also like to thank the clients for their participation, support, and help.

I will never be able to thank my peer editors, Rachel Rigdon, Margeaux Akazawa, Erin Johnson, Arielle Ross, and the BSHE Thesis Support Group enough. Y'all read over my thesis, second coded my interviews, and helped me slog through the worst of organizing and editing. All while providing emotional support and, at times, tasty snacks.

Finally, I'd like to thank my family and friends for encouraging me and letting me know that I'm not in this alone.

"Anything that's human is mentionable, and anything that is mentionable can be more manageable. When we can talk about our feelings, they become less overwhelming, less upsetting, and less scary. The people we trust with that important talk can help us know that we are not alone."
Mr. Fred Rogers

Table of Contents

Table of Figures

Table of Tables

Chapter 1: Introduction

Defining the Problem: Substance Abuse and Trauma

Substance use disorders encompass problematic use of mind-altering substances. Stressful life events, or traumatic events, are common in people seeking substance abuse treatment, with about 75% to 95% of men and women reporting trauma in substance abuse treatment programs (Rosenberg, 2011; Wu, Schairer, Dellor, & Grella, 2010). Because trauma is so prevalent in individuals struggling with substance use disorders, treatment center staff members need to be aware of the possibility of histories of trauma in addition to symptoms related to trauma in order to better serve clients and prevent retraumatization (Harris & Fallot, 2001). Histories of trauma can include traumatic events that precede SUD as well as traumatic events that occur during substance use, including exposure to dangers during homelessness and domestic violence (McHugo, Kammerer, et al., 2005). In spite of pervasive trauma, some substance abuse treatment programs and interventions might not ever assess and treat clients' trauma (Morrissey, Jackson, et al., 2005). Because forgetting and denial is so common in survivors of trauma (Herman, 1997), substance abuse treatment needs to directly ask about traumatic events and support healthy trauma recovery in an environment that focuses on strengths and skills, a strategy termed "trauma-informed care" or TIC (Elliot et al., 2005). This evaluation seeks to find out how well integrated trauma-informed care is in a substance abuse treatment program in Atlanta, GA.

Explanation of Program

Recovery Consultants of Atlanta, Inc. (RCA) is an Atlanta-area nonprofit specializing in substance abuse prevention and treatment, as well as HIV prevention, linkage to HIV care, supportive housing. Historically, RCA has provided faith-based substance abuse treatment serving a predominately African American client population who deal not only with substance use disorders but also homelessness, poverty, and HIV. In the calendar year 2013, RCA treated more than 193 clients for substance use disorders.

Two thirds of the treatment clients are male. Their housing facilities do not currently support children and other family members, so many women with children are referred to Atlanta organizations that better meet their needs. RCA also focuses outreach to high-risk African Americans: 80% of their clients are non-Hispanic African American, 18% are non-Hispanic White/Caucasian, and 2% are Hispanic (Table 1). Currently, RCA is in the process of changing their programs to increase their diversity of participants and programs.

Demographics (N=193)	Median (IQR) n (%)
Race/Ethnicity (n=169)	
Non-Hispanic African American	136 (80%)
Non-Hispanic White	31 (18%)
Hispanic	2 (1%)
Gender	
Male	127 (66%)
Female	65 (34%)
Transgender	1 (1%)
Age (in years)	45 (14)

Table 1: Demographics of RCA Treatment Clients in 2013 (N=193)

An important aspect of RCA is its engagement with community organizations to address social problems. Programs are based on an overarching commitment to improving communities, families, and individuals (Figure 1).

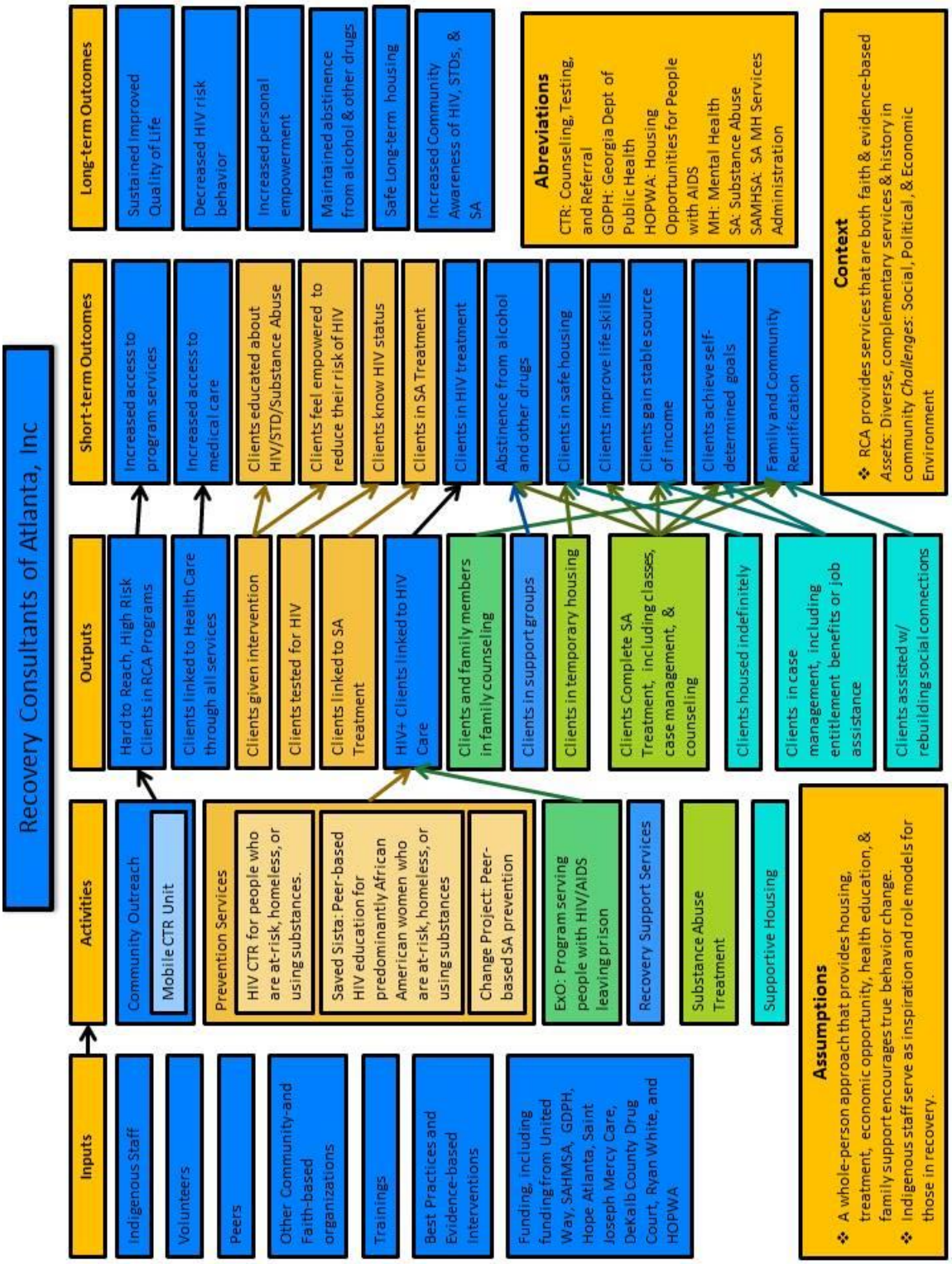

Figure 1: RCA Logic Model

There are several ways to begin substance use disorder treatment at RCA, including outreach, referrals, calling, and walking into the center. Their substance use disorder treatment includes both in- and out-patient options, with most of the clients living RCA's housing. Treatment is split into two levels. Level one lasts about a month and is a full-day treatment program with a variety group classes and individual counseling and case management. Which classes that a client takes depends on treatment goals that are created with a substance abuse counselor. Level two focuses on clients using the day to work, search for work, or doing some type of vocational training. As of Summer 2013, clients must finish treatment within 90 days. Twice a year, RCA holds a graduation ceremony for those who complete the program.

Throughout their time in treatment, clients may be referred to job training or outside mental health facilities as needed. While RCA does not currently have the capacity to provide in-house mental health medication, RCA is in the process of getting approval for Medicaid to add qualified staff and funding for mental health treatment. This could increase their ability to do wrap-around services for those with co-occurring disorders.

Justification

In Utilization-Focused Evaluation, it is important that the evaluation be relevant and useful (Patton, 2008). To accomplish this goal, the organization was the major decision-maker in the topic of this evaluation and subsequent thesis. Michael Banner, the Clinical Director, came up with a few possible ideas, including an evaluation of HIV-related services and Trauma-informed care, and discussed them with the executive

director, Cassandra Collins. Ultimately, the program identified that trauma affects a greater proportion of their clients than HIV, and they wanted to know if RCA's services meet the trauma needs of their clients. This evaluation assesses the extent to which the principles of TIC are incorporated into the program services, organizational structure, and treatment facilities by interviewing clients and staff about their experiences and perceptions of TIC. Ultimately, this evaluation explains strengths of the program and opportunities for improvement in order to inform future program planning. This evaluation aligns with RCA's commitment to evaluating and improving its fidelity to evidence-based practices, including Motivational Interviewing.

Research Questions

The overarching question to this evaluation is: To what extent is trauma-informed care integrated into RCA's treatment program? Several other questions were asked surrounding this question by the stakeholders, and these questions were developed into a series of sub-questions based on expert opinions, a literature review, and quality standards of feasibility and validity. Final evaluation questions are as follows:

To what extent is trauma-informed care integrated into RCA's treatment program?

1. To what extent does RCA integrate knowledge about trauma and recovery into program practices and activities?
2. To what extent is trauma being address during treatment?
3. To what extent is RCA systematically and sensitively assessing trauma and trauma symptoms?
4. To what extent are program activities and settings consistent with five core values of trauma-informed cultures of care: safety, trustworthiness, choice, collaboration, and empowerment?

Chapter 2: Literature Review

Substance Use Disorders

Substance use disorder is a common but stigmatized medical condition. Substance use, substance abuse, and substance dependence are all concepts along a spectrum of use that do not have clear boundaries. Typically, a person's use is considered abuse when use is out of the person's control. The DSM IV defines abuse as "a maladaptive pattern of substance use leading to clinically significant impairment or distress" (American Psychiatric Association, 2000). Substance dependence occurs with a worsening of a substance abuse problem. New DSM-5 standards combine substance dependence and abuse into one single "substance use disorder" or SUD. The DSM-5 defines a substance use disorder as "a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems" (American Psychiatric Association, 2013). Diagnostic criteria include:

- taking the substance "in larger amounts or over a longer period than was originally intended"
- being "unable to cut down or regulate substance use"
- spending "a great deal of time obtaining the substance, using the substance, or recovering from its effects"
- cravings
- failing "to fulfill major role obligations at work, school, or home"
- continuing "substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance"
- giving up or reducing "important social, occupational, or recreational activities", using the substance multiple times "in situations in which it is physically hazardous," and
- continuing "substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance" (American Psychiatric Association, 2013).

Substance use disorder can be a chronic, difficult to treat, and relapsing condition (Koob, 2006).

According to SAMHA's large and nationally representative National Survey on Drug Use and Health (NSDUH), 8.4% (95% CI: 8.1-8.6) of Americans above the age of 12 experienced issues with abuse or dependence of drugs or alcohol during the past year, with between 6.6% to 7.0% dealing with alcohol dependence or abuse and between 2.6% and 2.8% dealing with drug dependence or abuse (SAMHSA, 2012). Estimates for Georgia were lower, but not significantly so, with between 5.7% and 8.3% of Georgians experiencing issues with abuse or dependence of drugs or alcohol during the past year. Between 4.5% and 7.0% dealt with alcohol dependence or abuse and between 1.9% and 3.0% dealt with drug dependence or abuse (SAMHSA, 2012).

The consequences of problematic substance use include medical, social, and economic effects, which can change throughout an individual's lifetime. Medical consequences include acute conditions like overdoses, adverse reactions, and suicides (SAMHSA Center for Behavioral Health Statistics and Quality, 2012) and chronic conditions, like Hepatitis C (Murphy et al., 2000) and HIV (Otto-Salaj & Stevenson, 2001). Substance abuse can also cause serious social problems, like family conflict (Center for Substance Abuse Treatment, 2008; Reilly, 1992), child abuse (Institute of Medicine & National Research Council, 2014), unemployment (Henkel, 2011), and homelessness (Didenko & Pankratz, 2007). Substance abuse also has criminal implications, as many drugs of abuse are illegal and people who use drugs might engage in criminal acts associated with drug and alcohol abuse (e.g., theft, violence, and driving under the influence), (Sinha & Easton, 1999). In addition, substances can affect the brain in different ways, and many of these mechanisms have been shown to cause or exacerbate serious mental illness and psychosis (Muesser, Drake, Turner, & McGovern,

2006). Long-term use can make this even more apparent. All of these serious problems have led to national agencies prioritizing substance use disorder as a focus for Healthy People 2020 (United States Department of Health and Human Services, 2013).

Trauma

Trauma can be defined as both a terrible and significant experience and the response to that event. Psychological trauma happens when people witness or experience a serious event that exceeds their ability to cope. "Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning (Herman, 1997, p. 33)." The DSM V provides a more specific definition of trauma as:

> Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
> - Directly experiencing the traumatic event(s).
> - Witnessing, in person, the event(s) as it occurred to others.
> - Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
> - Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse) (American Psychiatric Association, 2013).

Covington expands that definition to include "stigmatization because of gender, race, poverty, incarceration, or sexual orientation" (Covington, 2008, p. 379). At the basest level, "psychological trauma is an affliction of the powerless (Herman, 1997, p. 33).""." The afflicted might feel they were powerless to stop the traumatic event from happening or they are powerless to stop future traumatic events from happening, leading to impairment in psychological and social functioning. Recent scholarship on trauma has expanded from the interpersonal aspects of trauma into political and social aspects, as

events like 9/11, the following war on terror, and school shootings affect the collective wellbeing (Ringel & Brandell, 2012). For many people, trauma is not so much a one-time occurrence as a series traumatic events throughout their lives (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995).

While the older DSM III-R described trauma as "an event outside the range of usual human experiences" and assumed its rarity (American Psychiatric Association, 1987), prevalence studies have shown trauma to be a common if not "normal" experience for Americans. The National Comorbidity Survey, a nationally representative study from the 1990s, found that about 60.7% of men and 51.2% of women had experienced at least one of 12 traumatic experiences (Kessler, et al., 1995). In an urban-based sample of 1,698 young adults in Detroit, 82.5% experienced least one of the DSM–IV qualifying traumatic events. On average, the participants had 4.8 traumatic events, with an average of 6.1 events per male respondent and 3.7 events per female respondent (Breslau & Anthony, 2007).

Not only is trauma pervasive in American society, its effects can be seen in many different physical and mental health problems. In particular, some people develop psychological disturbances in response to them, a condition called "Post-traumatic Stress Disorder" or PTSD. According to the DSM-5, symptoms of PTSD include recurrent memories or dreams about the traumatic event, flashbacks, psychological distress, physiological reactions, and avoidance of stimuli related to the trauma (Table 2). According to the National Comorbidity Survey Replication, about 6.8% of Americans over the age of 18 had have DSM-IV defined PTSD at some point in their life (Kessler et al., 2005). A longitudinal study of young adults found that while men experienced more

traumatic events, they experienced less PTSD. While the rates of PTSD between men and women experiencing non-assaultive trauma (e.g. witnessing violence or learning of a relative's trauma) as their worst event were not statistically different between the sexes, women were much more likely to develop PTSD from assaultive violence. Of the 23.2% of men who experienced assaultive violence as their worst event, 7.1% met DSM-IV criteria for PTSD, and of the 21.4% women who experienced assaultive violence as their worst event, 23.5% met DSM-IV criteria for PTSD. Some explanations for this include social and physiological factors, like men growing up with more normative violence and women's increased physical reactions to emotional stimuli (Breslau & Anthony, 2007).

Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
• Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
• Recurrent distressing dreams in which the content and/or effect of the dream are related to the traumatic event(s).
• Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)
• Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
• Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
• Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following: o Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s). o Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
• Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
• Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
• Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
• Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
• Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
• Markedly diminished interest or participation in significant activities.
• Feelings of detachment or estrangement from others.
• Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).
• Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
• Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
• Reckless or self-destructive behavior.
• Hypervigilance.
• Exaggerated startle response.
• Problems with concentration.
• Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep). o Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month. o The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. o The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Table 2: DSM-5 Trauma Definition

Judith Herman argues that central to the history of trauma in individuals' lives and in society is forgetting and denial (Herman, 1997). The effects of trauma can be seen throughout history and different communities, but these effects have often been misunderstood as personal problems or failings rather than reactions to traumatic events in the Western world. Freud's early studies of hysteria can be seen as some of the first uses of trauma theory, as he reports that many of the women he was treating suffered from the effects of sexual and physical abuse (Herman, 1997). However, he shrinks back from this hypothesis, denying that trauma causes hysteria and focusing instead on individuals' problems through psychoanalysis (Herman, 1997). Trauma theory was forgotten and re-introduced in response to the traumatic war experiences of soldiers in World War I and the Vietnam War, eventually leading to the American Psychological Association's recognition of PTSD in 1980 (Herman, 1997). As the feminist moment began raising consciousness about the sexual and physical violence experienced by women, PTSD was expanded to include the experiences of women survivors as well as combat veterans (Herman, 1997).

Substance use disorder can be seen as a part of this forgetting and denial, as people may use alcohol and other drugs to cope with their trauma and trauma symptoms. Failure to recognize these connections between the trauma and symptoms related to trauma could lead to relapse or continued use (Dass-Brailsford & Myrick, 2010; Snow & Anderson, 2000). Treatment of PTSD is possible, and many people recover through processing and integrating their traumatic experiences into their lives (Herman, 1997).

Trauma and Substance Use Disorder

Historically, the US has attributed problematic substance use to individuals' personal and moral failings (Cooper, 2004; Courtwright, 2010). Even though treatment has focused on substance use disorder as a medical condition, most interventions still focus on individual risk factors that, at times, blame the victim for the disease. In public health, many of the theoretical models commonly used for substance abuse focus on changing individuals' behaviors, like the Transtheoretical Model (TTM) and Motivational Interviewing (MI), without addressing individual's trauma history, which has been shown to be correlated with substance abuse and may be a significant cause of relapse (Dass-Brailsford & Myrick, 2010; Snow & Anderson, 2000). Use of trauma theory could allow for a more comprehensive and whole-person approach to dealing with substance use disorder.

Earlier studies in the 1990s found strong correlations among trauma exposure, PTSD, and SUDs. Among women with substance use disorder, between 30% and 59% had PTSD, and among women with PTSD, between 27% and 48% had SUDs (Najavits, Weiss, & Shaw, 1997). The Vietnam Experience study found that of the veterans living with PTSD, 39% had current alcohol abuse or dependence. Another study of Vietnam veterans found that 73% had SUDs (Najavits, et al., 1997). There could be many interrelated explanations for this connection.

There are four predominant theories concerning the complex link between SUDs and PTSD: self-medication of PTSD symptoms, increased risk of trauma due to high-risk behaviors, susceptibility, and the presence of a third variable, like a shared conduct disorder or genetic predisposition (Chilcoat & Breslau, 1998). A growing body of

evidence supports the self-medication hypothesis, suggesting substance use could be a coping mechanism to deal with the trauma. A number of factors have been studied, including temporality, dose response of trauma to substance use, and neurological mechanisms behind such a connection. Studies about whether trauma or PTSD precedes SUD remain equivocal. However, many people experience their first traumas in their childhood. The Adverse Children Experiences Study found that about 2/3rd of Adults in their sample of HMO patients had adverse childhood experiences. Patients experiencing at 4 or more ACEs had four times the rates of self-reported alcohol problems. Each of the 10 types of ACE increased the risk of illegal drug use by two to four times (Dube, Felitti, Dong, Giles, & Anda, 2003). These rates of childhood trauma and substance use disorders are even more pronounced in higher-risk populations. A longitudinal study of urban children estimated that 80% of their sample had at least one ACE (Mersky, Topitzes, & Reynolds, 2013), and a study of people in publicly funded residential substance abuse treatment centers found 95% of their population had at least one ACE (Wu, et al., 2010). All four of these studies found a gradient in risk for substance use disorders, with risk rising for each additional ACE reported. This gradient suggests a dose response.

SUD and PTSD risk are affected by similar brain neurochemical processes (Brady et al., 2000). Childhood trauma can deregulate parts of the brain that respond to stress; particularly the amygdala, which processes emotions, the hippocampus, which manages memory and learning, and the prefrontal cortex, which is responsible for higher cognitive functioning, through high levels of cortisol (Institute of Medicine & National Research Council, 2014). This dysregulation can negatively affect a number of psychosocial and

behavioral functions, including attachment, emotion regulation, and mental health, causing PTSD and depression (Institute of Medicine & National Research Council, 2014). People with childhood trauma may use substances to reduce the symptoms of PTSD and depression associated with trauma reducing the dysregulation of the neurological systems which handle stress (De Bellis, 2002). The transition from casual, voluntary substance use to automatic, compulsive substance use—addiction—may be explained by changes in cognitive function caused by complex, interrelated factors including genetic, environmental, and developmental processes (Volkow & Baler, 2014).

This evidence supports the need for integrated trauma and substance abuse treatment in order to help men and women recover from both trauma and their substance abuse disorder. People with trauma histories and PTSD are common in substance abuse treatment settings, including childhood trauma and trauma related to substance abuse. In fact, trauma could be an underlying cause of substance abuse (De Bellis, 2002). Treatment interventions that integrate knowledge about trauma could be effective at better treating those with SUD.

Trauma-Informed Care

A comprehensive definition of trauma-informed care (TIC) does not yet exist. Rather, many researchers have defined it depending on their own experiences. An overarching principle illustrated by SAMHSA's National Center for Trauma-Informed Care (NCTIC) is that TIC programs address the survivors' "need to be respected, informed, connected, and hopeful regarding their own recovery." Creating Cultures of Trauma Informed Care (CCTIC) includes five attributes of trauma-informed care in their

definition of TIC: Safety, Trustworthiness, Choice, Collaboration, and Empowerment (Fallot & Harris, 2011). Another possible model for trauma-informed care is the 10 Principles of TIC (Table 3) based on experiences and experts from the multi-site study of trauma-informed care with women "Women, Co-occurring Disorders, and Violence Study" or WCDVS study (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005).

Trauma-informed services…
• recognize the impact of violence and victimization on development and coping strategies
• identify recovery from Trauma as a primary goal
• employ an empowerment model
• strive to maximize a woman's choices and control over her recovery
• are based in a relational collaboration
• create an atmosphere that is respectful of survivors' need for safety, respect, and acceptance
• emphasize women's strengths, highlighting adaptations over symptoms and resilience over pathology
• minimize the possibilities of retraumatization
• strive to be culturally competent and to understand each women in the context of her life experiences and cultural background
• solicit consumer input and involve consumers in designing and evaluating services

Table 3: Definition of Trauma-informed services (Elliott, et al., 2005)

The WCDVS defined possible trauma-informed intervention elements and included "outreach and engagement", "screening and assessment", "resource coordination and advocacy", "crisis intervention", "trauma specific services", "parenting services", "mental health and substance abuse services", and "healthcare" (Elliott, et al., 2005), Outreach and Engagement encourages organizations to actively seek people who might be in need of services instead of waiting for them to come to them. TIC should include systematic and sensitive trauma screening and assessment for all clients so that no one's trauma is overlooked (Fallot & Harris, 2001). Resource coordination and advocacy is meant to replace "Case Management" and encourage a collaborative exchange of information and put consumers on the same level as staff. Trauma-specific services would include evidence-based trauma integrated interventions, like RCA's

TREM (Elliott, et al., 2005), and often are gender segregated (Fallot & Harris, 2011). Childcare and parenting services can provide women with resources to care for and, in some cases, reunite with their children. Because women often have physical and mental health needs in addition to their trauma and substance abuse needs, TIC includes wrap-around services meant to treat the whole person rather than parts of the person. Integration of a whole person with individual strengths and challenges is an essential part of trauma-recovery (Herman, 1997).

Changing systems to integrated, trauma-informed systems of care is "not a static endpoint but represents a dynamic relationship among evolving service systems" (Markoff et al. 2005). It involves the changing of multiple systems, including the organization, administration, clinicians, staff, and consumers. It also happens intermittently or perhaps in conjunction with other evidence-based programs (R. Fallot, personal communication, July 8, 2013).

Evaluations of Trauma-Integrated Substance Abuse Interventions

Trauma-integrated substance abuse treatment, or integrated treatment (IT) actively addresses the role of trauma in consumers' lives and seeks to address it and the substance abuse at the same time rather than "save" recovery for after the presenting problem is treated. SAMHSA's National Center for Trauma-Informed Care highlights several evidence-based IT programs, including Seeking Safety and Trauma Recovery and Empowerment Model (TREM and M-TREM) (SAMHSA National Center for Trauma-Informed Care, 2013). Herman defines 3 stages of trauma treatment: Safety,

Remembrance and Mourning, and Reconnection (Herman, 1997). These models primarily deal with the first step of bringing survivors into safety.

While the need for IT is strongly supported by evidence, the effectiveness of these programs still lacks strong evidence. Evaluation of these trauma-specific programs has primarily looked at outcomes, such as substance usage and PTSD symptoms for clients. A meta-analysis of 17 trauma-integrated treatment (IT) trials found that most of the studies found that their treatment program reduced PTSD and SUD symptoms. However, the studies that compared IT to other interventions found only small or non-significant improvements (Torchalla, Nosen, Rostam, & Allen, 2012). Rather than reflexively interpreting these results as proof that IT programs are no better than non-IT programs, it may be that IT interventions need to improve evaluations of their programs using stronger methods, including randomized control trials, larger populations, better dosage of intervention, and less contamination between IT and non-IT programs (i.e. discussing trauma in group sessions). Challenges to this kind of rigor include the retention and motivation of a population with many challenges (Torchalla, et al., 2012). There is also the ethical dilemma of not talking about trauma in a population that is documented to have trauma histories, which could continue the cycle of silence and denial. While whether ITs are better than Non-ITs needs better research, outcomes data does show that IT's can have positive outcomes for their clients.

RCA uses the Trauma Recovery and Empowerment Model (TREM) for women and the M-TREM for men. These versions are evidence-based, gender-segregated, trauma-specific interventions. There are 29 75 minute sessions for the version for women and 24 75 minute sessions for men. The intervention focuses on trauma education,

empowerment, and building skills. A study with women comparing treatment as usual and TREM in a substance abuse treatment setting found that the TREM reduced dissociative feelings and increased feelings of safety compared to the comparison group but did not find statistically different substance use, mental health, and physical health outcomes (Toussaint, VanDeMark, Bornemann, & Graeber, 2007). This fits in with the larger body of research on ITs with quasi-experimental designs, which tend to show an improvement over treatment as usual in PTSD symptoms but not SUDs. This could be because SUD is more difficult to treat, as it is a recurrent and relapsing condition. A research study by Back et al. suggests that treating PTSD symptoms has a greater impact on SUD recovery than SUD recovery on PTSD and can both increase completion of treatment and reduce relapse (Back, Brady, Sonne, & Verduin, 2006).

The effectiveness of trauma-integrated treatment and other substance abuse interventions rely on the context of the organizations that provide them (Covington, 2008; Fallot, 2011). Standards of trauma-informed care have been developed out of a need to define and implement this context.

Evaluations of Trauma-Informed Care Systems

While quite a few studies exist that evaluate TI interventions, the researcher only found one study of TIC systems. The "Women, Co-occurring Disorders, and Violence Study" (WCDVS) was undertaken by SAMHSA in two phases. The first phase (1998-2000) focused trauma-informed service integration at 14 sites. A distinction was made between client-level integration, where the focus is on making sure services for the client are integrated, and systems-level integration, where the focus is on building relationships

between organizations providing services, and sites were encouraged to concentrate on client-level integration of services.

The evaluation of the program took place during phase two. Nine phase one sites chose comparison organizations which do not implement trauma-informed care were chosen by the participating sites in order to increase the similarity of programs in size, location, and other services (McHugo, Kammerer, et al., 2005). The overarching question for the 2nd phase was whether "women in the intervention condition show greater improvement at follow-up than women in the comparison condition on the key outcomes of alcohol and drug use, mental health symptoms, and posttraumatic stress symptoms" (McHugo, Kammerer, et al., 2005).

During phase two, women were recruited into the study, with 2,729 women filling out baseline interviews. At the 6 month mark, 2,006 women were interviewed, and drug use and PTSD symptoms were significantly ($p<0.05$) improved compared to treatment as usual. While not statistically different ($p=0.06$), mental health status was also improved. The results were also highly variable among the sites, as the intervention was not uniformly implemented across sites, nor were the comparison organizations uniform (Cocozza et al., 2005). Person-level differences were not found to be as strong a factor as program-level factors, especially in integrated counseling (Morrissey, Ellis, et al., 2005). The 12-month outcomes leveled out in drug use severity, perhaps indicating that the intervention speeds up the effects of drug abuse treatment. (Morrissey, Jackson, et al., 2005).

Future studies might do well to make more uniform intervention and comparison conditions or assess individual components of TIC. Finding comparison organizations

that do not have aspects of TIC might also be difficult, as some organizations might already being implementing programs that focus on different aspects of TIC, like empowerment and collaboration with clients.

While the WCDVS is indispensable to the TIC community, uneven implementation of TIC made it difficult to properly assess its impact. This evaluation seeks add to the literature on how to assess fidelity to TIC principles to assist future studies in better assessing outcomes related to TIC, specifically in its use of qualitative interviews with clients. Since RCA uses the TREM and has had training from Community Connection in Washington, DC, its "Creating Cultures of Trauma-Informed Care" (CCTIC) program fidelity scale was found suitable to use (Fallot & Harris, 2011). While a complete use of the fidelity scale was not feasible due to the time constraints of RCA and the researcher, a conversation with the developer, Dr. Roger Fallot, revealed that the five principles of TIC are the most important feature of the scale (personal communication, July 8, 2013). Future evaluation opportunities of other parts of the scale will be explored in the summer of 2014.

Conclusion

SUD, PTSD, and other mental health disorders are strongly associated with each other (Rosenberg, 2011; Wu, et al., 2010). Trauma and trauma symptoms are important to address in treatment (Elliott, et al., 2005). Trauma-specific interventions and interventions involving women have been better studied that system-level TIC or interventions with men. While women experience more PTSD than men, men still

experience trauma and substance abuse related to trauma. More research needs to be done with men, especially research that covers TIC in mixed-gendered treatment settings.

Evaluation Questions

To what extent is trauma-informed care integrated into RCA's treatment program?

1. To what extent does RCA integrate knowledge about trauma and recovery into program practices and activities?
2. To what extent is trauma being address during treatment?
3. To what extent is RCA systematically and sensitively assessing trauma and trauma symptoms?
4. To what extent are program activities and settings consistent with five core values of trauma-informed cultures of care: safety, trustworthiness, choice, collaboration, and empowerment?

Chapter 3: Methods

Evaluation Methods

This evaluation was guided by the Creating Cultures of Trauma-Informed Care Program Fidelity Scale provided by Dr. Roger Fallot from Community Connections (Fallot & Harris, 2012). The scale explores different attributes of trauma-informed care and gives options about different sources of information about sources of trauma-informed care within programs (Appendix A). The scoring section of the trauma-informed care scale was not used, as it has not been validated and did not seem necessary to make recommendations at this stage. Instead, the scale was used as a way to systematically go through the organization to look for possible instances of trauma-informed care and options for future program planning. As correspondence with Dr. Roger Fallot suggested, the sections about the 5 principles (safety, trustworthiness, choice, collaboration, and empowerment) were the primary focus of this evaluation, while the other sections were less rigorously examined (personal communication, July 8, 2013).

The evaluation theory guiding the overall project stems from community-based participatory research (CBPR) (Israel, Schulz, Parker, & Becker, 1998). In order to accomplish this, the goal of the evaluation was to create a useful product in a collaborative way. RCA was an active partner in many stages of the evaluation. RCA staff and consumers were key to developing the evaluation focus and interview tools. They also assisted in recruiting clients. Employees of RCA made recommendations based on the results of the client and staff interview results, building evaluation capacity at RCA.

Formative Key Informant Interview Methods

Informal key informant interviews were undertaken with three of the staff leadership to find out more about the program and how to effectively and feasibly evaluate different parts of the organization for trauma-informed care. These results then guided the building of the logic model and data collection methods. Notes were taken to refer back to when necessary.

Data Collection Methods

Primary Data Collection included in-depth interviews with all the treatment program clinicians and mixed-methods interviews with both quantitative and qualitative questions with clients. Primary data collection was determined to be the best way to understand the culture of the program and TIC's place within that culture.

In-depth Interviews with Staff

Purpose: Staff interviews were carried out to learn more about how agency administrators support the integration of knowledge about trauma and recovery into all program practices; how trauma is being address during treatment; how RCA assesses trauma and trauma symptoms; and how safety, collaboration, and empowerment are integrated into program activities and settings.

Sampling: All treatment program staff members who were formally working on the treatment program were interviewed. While six counselors total could be considered treatment program staff, only four were deemed eligible for the study, as one counselor

started working after data collection began and the other was being temporarily borrowed from the case management program and was not formally a part of the treatment staff.

Measures: The theoretical basis for the interview guide was SAMHSA's definition of Trauma-informed Care (SAMHSA National Center for Trauma-Informed Care, 2013), including domains of safety, respect, informed consent, collaboration, and empowerment (Appendix C). Questions about competence and comfort were derived from a study by Stephanie Covington, as these two issues came up in her evaluation study (Covington, Burke, Keaton, & Norcott, 2008). Finally, questions about staff members' perceived institutional support of self-care were influenced by literature on compassion fatigue (Rasmussen, 2012).

Data collection: Qualitative interviews were about half an hour in length (Range: about 15 minutes to an hour). These interviews took place at RCA during the staffs' working hours. Interviews were recorded using a handheld voice recorder, and interview notes were taken during the interview to enhance accuracy. The staff members were encouraged but not required to participate by the organization, and no incentives were given to program staff for taking part in the interviews.

Data analysis: The researcher used recordings and notes of the interviews to create transcripts. Identifying information was removed where possible. After all of the four staff interviews were finished, the researcher created a codebook for the staff interviews using inductive codes based on the research questions and deductive codes based on important or reoccurring themes. After the codebook was finished, the researcher and another MPH student at Rollins coded the interviews using MAXQDA 10 (Verbi Software, Berlin, Germany). The coded interviews were examined for differences

in codes and reconciled. The interviews were then compared using the codes, and results were reported with explanations of codes and the variety of client responses, using direct quotes and paraphrasing. Codes were purposefully broad in order to notice and report the variety of responses.

Mixed methods interview with clients

Purpose: Client interviews were carried out to learn more about clients' perceptions of TIC, including how they experience the five core values of TIC: (safety, trustworthiness, choice, collaboration, and empowerment) and how they feel RCA is doing at assessing their trauma. Getting client feedback during evaluations in integral in TIC (Elliott, et al., 2005; Fallot & Harris, 2011).

Sampling: The target population was a census of all clients currently at RCA with over 30 days in the program. Because the questions address services that might not be implemented immediately at RCA (i.e. talking about trauma with a counselor might take time), sampling criteria were created to take consumers with at least 30 days of treatment. Maximum treatment length was changing from 120 days to 90 days, so people with 30 days should be well into their treatment. The sampling frame used was an official list of current clients in the program. People were recruited from group treatment sessions, including morning classes for people in phase one and evening classes for those in phase two. These groups are required for continuation in RCA's treatment program, and all of the clients currently in the program should be able to be interviewed this way. In order to encourage participation and thank participants for their time, snacks and drinks were provided with healthy options.

Measures: The theoretical basis for the interview was the five principles of Trauma-Informed care as defined by Community Connections: Safety, Trustworthiness, Empowerment, Collaboration, and Choice (Fallot & Harris, 2011).

Quantitative: Community Connections gave the researcher sample statements with Likert scale answer choices (Appendix B) which were expanded to include more statements involving the five principles (Fallot & Harris, 2011). A statement regarding hope about recovery was also added, as this was included in SAMHSA's definition of Trauma-Informed Care. Answers of less than agree were followed up with open-ended probes when possible.

Qualitative: Open-ended questions focusing on experiences of the program, including empowerment, peer leadership, and trauma-related referrals and open-ended questions about suggestions for improvement were also a part of the interview guide (Appendix D).

Data collection protocol: The mixed-methods interviews were between 20 and 40 minutes in length. They were recorded using a handheld voice recorder. Minimal notes were also taken, as there was not a note taker in attendance. A transcript of the qualitative sections and follow-up questions to any "disagree" or "strongly disagree" answers were created using the recording and interview notes soon to maintain accuracy. Any "disagree" or "strongly disagree" answers were qualitatively probed for more information and suggestions for improvement. This feature highlights a benefit of a mixed-methods approach, as details can better emerge from the data.

Data analysis: After the client interviews were transcribed and de-identified, a codebook was developed for the qualitative sections of the client interviews using both

inductive and deductive codes. For example, when clients tell stories about how staff members help them feel hopeful about recovery, these responses were coded for reoccurring themes (deductive) and answers to questions (inductive). Broad codes were purposefully used to increase the ability to get a variety of opinions (e.g. "Empowerment"). After the codebook was finished, the researcher and another MPH student at Rollins coded the interviews using MAXQDA 10 (Verbi Software, Berlin, Germany). The coded interviews were then examined for differences in codes and reconciled. The interviews were then compared using codes, and results were reported with explanations of codes and the variety of client responses, using direct quotes and paraphrasing.

Microsoft Excel was used on all quantitative analyses. Demographics were assessed using medians and interquartile ranges for age and length of stay in the program, and percentages for race/ethnicity and gender. Statements using the Likert scale were valued at 1 (strongly disagree) to 5 (strongly agree). Both the averages of each items and the number of answer responses less than agree (4) were reported, as answers less than agree suggest an area that has room for improvement (Fallot & Harris, 2012). Some questions related to trauma have answer choices that include "never asked" or "not applicable". These answers did not receive values and were not included in the averages of those questions, but the number of people under these categories was reported under "n/a".

Triangulation

After analysis is done on the staff and client interviews, triangulation was done to determine overall findings based on the clients' quantitative, clients' qualitative, and staff's qualitative results. Themes were drawn based on the different sources and added to a matrix for each question, and the way the client and staff responses do or do not match each other was highlighted. An overall triangulation of all the questions was also explored, giving room for a complex, rich description of to what extent TIC is integrated into the program.

To what extent does RCA integrate knowledge about trauma and recovery into program practices and activities?

Programmatic elements and intuitional support that integrate knowledge about TIC and make up the structure for TIC were collected using formal and informal staff interviews and client interviews. The CCTIC scale aided in providing a systematic checklist of possible activities, including trauma-specific interventions, peer leadership, and staff training and education (Fallot & Harris, 2011). Informal interviews and formal qualitative interviews were first used to paint a picture of what TIC activities look like, including the interventions and trauma referral process. Trauma training, experience, and self-reported comfort and competence with providing TIC were reported using the qualitative staff interviews. Qualitative staff interview answers about the ways and which they cope with their work and how RCA supports it or could better support were also reported. Qualitative data about peer leadership from both client and staff interviews were reported. The data about the structure of TIC at RCA were examined in a matrix

with recommendations from the CCTIC to better see what parts of RCA services integrate TIC and which could be improved.

To what extent is trauma being address during treatment?

The averages of quantitative questions about perceptions of trauma being addressed were reported, along with answers of less than "agree" or 4 with the reasons for not agreeing when possible. Qualitative data about clients' perception of trauma-integrated treatment and ways to improve it were also reported. Staff qualitative answers to how they address clients' trauma were reported. A matrix was used to compare the results.

To what extent is RCA systematically and sensitively assessing trauma and trauma symptoms?

Clients' perceptions of trauma assessment were reported using quantitative data and qualitative data. The staff members' explanation of how trauma and trauma symptoms are assessed was also reported. These were compared with other methods of assessing trauma and trauma symptoms.

To what extent are program activities and settings consistent with five core values of trauma-informed cultures of care: safety, trustworthiness, choice, collaboration, and empowerment?

Client's quantitative data was analyzed by reporting the averages and number of instances that clients did not agree for each question, along with the reasons for not agreeing. Qualitative data about clients' perception or experience of each principle ways to improve care related to that principle were also reported. Staff's qualitative answers to

how they support each aspect of TIC were recorded. A matrix was used to compare the results between the different data sources.

Ethical Considerations and Confidentiality

This study was deemed exempt from Emory's IRB (Appendix F). As the evaluation study is not generalizable, it is not considered "research" by IRB. IRB informed consent forms were used as guides to creating informed consent forms for the evaluation. Both clients and staff consented to be both in the evaluation and in this Master thesis (Appendix G & Appendix H). Informed consent forms were read out loud and, if the participant agreed to the study, signed. Neither the staff members nor the clients were required to participate by the organization.

Because trauma is such a sensitive issue not only for participants but also researchers, questions that elicited personal stories about trauma were avoided. Open ended questions about trauma-specific services were tweaked to focus on what RCA could to do to better address trauma rather than get more general data that included trauma histories. It's important that the organization know about these trauma histories, but an evaluation was not deemed an appropriate setting to gather them. No interviews were conducted without a trained staff person at RCA in the event of any adverse reactions to the questions.

Coercion was also carefully considered in the incentive and consent process. In order to thank the participants for their time while not making the incentive coercive, snacks and drinks were provided during the client interviews as an incentive to participate. Clients and staff members were not required to be in the evaluation.

Due to the nature of the evaluation, steps were taken to assure the confidentiality of evaluation records. Evaluation records included the recorded and written versions of the interviews and consent forms. A randomly generated number was assigned to each participant as well as a pseudonym. These identifiers were used on evaluation records wherever possible instead of participants' names. Electronic and paper versions of evaluation documents were kept on password-protected computers and in locked file storage. Records will be destroyed before May 2015, a year after the evaluation and thesis was completed in April 2014. The participants were told that they had the right to leave the evaluation at any time without penalty and that they could refuse to answer any questions they did not wish to answer. They were also told that they could request for the interview and evaluation records to be destroyed and the information not used. The participants were also given a copy of the consent form with information to contact the evaluators, including Dr. Iris Smith or Khurram Hassan, in the event that they changed their minds about being in the evaluation or experienced adverse effects.

Chapter 4: Results

Client Participants

A total of 23 clients were interviewed between June and August 2013. There were 28 clients in treatment at the beginning of data collection. Since clients needed to have at least 30 days of treatment, two clients were ineligible because they did not have enough days of treatment. Another three clients were AWOL or discharged before being interviewed (Figure 2). Three quarters of the participants were African American and another quarter was White. No one identified as Hispanic. A majority (70%) of the participants were male. Consistent with the literature, 20 people (87%) reported histories of trauma. The median age was 45, with half the clients between 41 and 53 years old. The median length of time in the program was 66 days (Table 4).

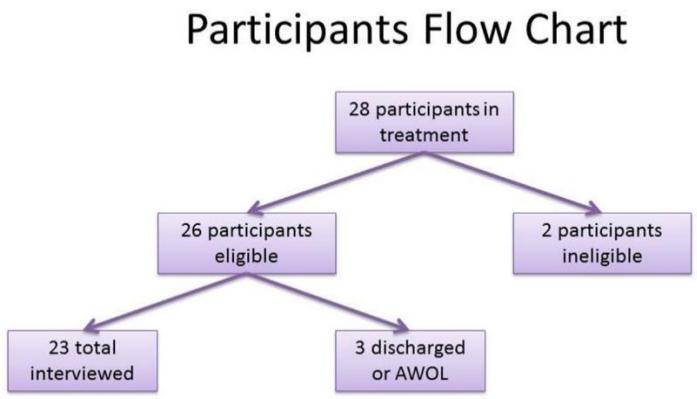

Figure 2: Client Participants Flow Chart

Demographics (N=23)	Median (IQR) n (%)
Race	
Non-Hispanic Black/African American	17 (74%)
Non-Hispanic White/Caucasian	6 (26%)
Gender	
Male	16 (70%)
Female	7 (30%)
Reported Trauma	20 (87%)
Age (in years)	45 (12)
Length of Time in Program (in days)	66 (35)

Table 4: Demographics of Client Participants (N=23)

To what extent does RCA integrate knowledge about trauma and recovery into program practices and activities?

Through integrating the TIC scale and conducting formal and informal interviews with staff and clients, several RCA institutional activities and practices were assessed in order to determine their fidelity to TIC. These included gender-segregated trauma processing groups, trauma-related referrals, peer leadership, and the level of administrative support for staff training, education, and self-care. Through examination of these program activities, it became clear that the administration supports the integration of TIC through its provision of TREM and TREM-M, trauma-related referrals, staff training. RCA's dedication to peer-based services spans their program, including the alumni group and treatment staff members who are also in recovery. While the interviewed staff members were trained or educated in TIC, not all of them felt comfortable and competent in giving TIC, and one staff member requested more training.

In group treatment, the TREM and TREM-M interventions are given as a weekly class to men and women in gender-segregated groups. According to the counselors, clients with severe trauma are typically referred to outside organizations if they feel safe

getting help outside of RCA. All clients who reported being referred to outside services for help with trauma reported acceptable to decidedly positive experiences. The staff interviews indicate that referrals happen when the trauma is serious and counselors feel that they need extra help. Some places clients reported being referred to include Winn Way (DeKalb Addiction Clinic), a community-based organization that has a trauma support group, and the Department of Veterans Affairs (VA) (n=3). Since only three clients reported having trauma-related referrals, further examination of referrals might be required, including looking into referral documentation.

RCA has a number of different "peer leaders". In asking about Peer Leaders, many identified their counselors as peer leaders. This was an unexpected finding, as peer leaders was meant to refer to other people who were in or graduated from the program who were leaders. However, the clients overwhelmingly interpreted their counselors as peer leaders because they were also in recovery. One said that they help "just by coming to work." A staff member similarly asserted that seeing people in recovery in multiple settings can inspire hope in clients. These findings also confirm one of the logic model's assumptions that indigenous staff serve as an inspiration to clients.

Others talk about the support of other clients and how seeing other people succeeding or getting advice about difficult experiences is helpful to their recovery. Two clients specifically mentioned how other clients helped them process their trauma by listening and giving positive feedback. One client said he had a lot of mixed feelings about a traumatic event from many years ago.

> And I was harboring a lot of resentment and had a lot of misdirected anger. And when I was really able to open up to share about it, you know, I received some positive feedback and also some suggestions in how to

> cope with it. And periodically I have been pulled to the side and asked how am I doin' and concern about that situation.

Another client mentioned how the alumni events were a great experience for them. Informal interviews with staff also indicated that the alumni group works with RCA to paint and decorate the facility and raises funds for RCA in addition to providing events and support for current clients. The alumni group meets once a month, and some continue to be involved in aftercare at RCA.

Staff that RCA not only supported them in education related to TIC but through personnel, like their psychiatrist Dr. Farzana Bharmal and the weekly round tables where staff can discuss their clients and get support when needed. One staff member suggested adding a person the staff who had particular training in the treatment of trauma. Many reported learning about TIC during their education or through continuing education. Some reported learning more through reading and studying on their own. While staff reported studying and learning about trauma, not all staff reported being comfortable and competent at providing TIC. One staff member did not receive the TIC training done a few years ago because they were not yet a part of RCA, and at least one staff member reported wanting more education, recommending that RCA provide more training.

In addition to training, staff reported receiving institutional support for self-care in the form of personal days and staff wind-downs, which happen one Friday a month and include relaxation and hanging out as a group. The staff see a good portion of clients who come through the program and have the burden of listening and responding to clients' trauma histories, which can take a toll and result in vicarious traumatization and compassion fatigue (Rasmussen, 2012). Many counselors also have trauma histories and coping strategies themselves. Healthy counselors are key to providing quality services,

and Rasmussen highlights self-care and organizational support as protective factors against vicarious traumatization and compassion fatigue (Rasmussen, 2012).

Source	Trauma-Informed Care Structure
Client Qualitative	• Peer leaders include staff members in recovery, alumni, and other clients.
Staff Qualitative	• While many staff members are trained and/or education in trauma treatment, not all feel comfortable and competent giving TIC. • Staff reported wanting more training. • Ability to give TIC growing with Medicaid expansion. • Psychiatrist Dr. Bharmal seen as asset. • Staff members refer clients with severe trauma to other community organizations that will support them if the client feels safe doing so.

Table 5: How Trauma-Informed Care is Structured

To what extent is trauma being addressed during treatment?

An element of trauma-informed care includes addressing clients' trauma and helping them understand the connections between their trauma and substance abuse. All but one client who reported having trauma and answered the questions agreed that RCA staff helped them understand the connections between their trauma and symptoms related to trauma and trauma symptoms and substance abuse, and everyone who reported having trauma said that RCA helped them make connections between their trauma and substance abuse (Table 6). The one client did not want to say how making connections could be improved (Appendix I). All but two reported understanding what trauma was, with one saying they did not have trauma and the other not being sure they knew what it was. Five clients reported not knowing what the symptoms related to trauma are, and all of those clients were male. All of the clients reporting less than agree in this "addressing trauma"

category were males, indicating that women are getting their trauma addressed quantitatively better than the men are.

Address Trauma	Average	Less than Agree
RCA staff have helped me understand the connections between my trauma symptoms and substance abuse. (n=18)	4.5	1
RCA staff have helped me understand the connections between my trauma and substance abuse. (n=18)	4.4	0
I understand what trauma is. (n=23)	4.4	2
RCA staff have helped me understand the connections between my trauma and symptoms related to trauma. (n=18)	4.3	1
I know what symptoms related to trauma are. (n=23)	4.0	5
Domain Average & Total Less than Agree	**4.3**	**9**

Table 6: Client Perceptions of How Trauma is Addressed (N=23)

Staff and clients reported that trauma care or referrals to trauma care happened through both the individual and group treatment sessions. A few clients talked about the process of trusting and opening up to share trauma histories as a difficult but rewarding process. Once they were able to talk about it, it became easier to talk about and find real solutions to problems. One client explains that this process is helpful because "if you try to subdue it with the drugs and alcohol, once that wear off, the problem is still at the surface." A female client talked about the release in processing trauma.

> I used to get irritated when I started to talk about trauma, but when I talk about it now, it's just that was then and this is now. And I can't keep holdin' that burden on me. I gotta free myself. So RCA brought that out of me. It took some crying and some one-on-one counseling, and some processing groups, but I did it. And I practice it every day.

Another female client said specifically that the trauma-processing group helped them make connections between their trauma and substance abuse. More than just helping

process the trauma, a few clients specifically mentioned that RCA helped them realize there are productive ways of coping and handling their problems.

Referrals that clients reported included a support group and psychiatrists with specialties in trauma. Even if clients are not referred to treatment, they might know that it is a possible treatment opportunity. One client reported that they were thinking about getting a referral for outside help and trusted that RCA would help with the referral. One client mentioned that staff follow-up with them specifically about their trauma, and that helps them.

Many of the clients thought that RCA was doing a great job now of making connections between trauma and substance abuse or that they could not do anything better. There is still room for improvement in this area, though. One client said that they had not talked to RCA about trauma, and quite a few clients wanted to talk more about their trauma and wanted their counselors to ask more questions. Another wished there was more aftercare related to trauma.

Staff talked about the importance of treating clients' trauma. There was a perception that if clients' trauma was not addressed, they were just putting a Band-Aid on a larger wound. They reported trauma-specific counseling being done in group classes and one-on-one counseling through exercises, handouts, and homework. One staff member talked about teaching clients coping skills because while RCA cannot change clients' mood as quickly as drugs, there are ways that can "get them to the same place". Staff also reported referring clients who need trauma-specific counseling to other organizations when they felt RCA could not meet their needs and the clients felt safe

doing so. One staff member pointed out that RCA's possible expansion through Medicaid would allow for more intense trauma work to be done with a psychiatrist at RCA.

If an initial assessment finds out there are trauma needs, they determine which groups or curriculums those clients need, including the gender segregated TREM classes or substituting certain classes with outside trauma-specific support groups. Trauma-specific care also happens in counseling sessions. Staff mentioned activities like educating clients about trauma, empowering clients, asking questions, asking permission to talk about trauma, checking in, person-centered care in talking about how they help clients with trauma. Client-centered care was mentioned across all the interviews and the clients were most important to the timing and the way that counselors help them.

Source	How Trauma is Addressed
Client Quantitative	• Clients generally agree that RCA helps them make connections between trauma, trauma symptoms, and substance abuse. • Five men reported not knowing that symptoms related to trauma were.
Client Qualitative	• Some clients talked about the benefits of trauma care. • Suggestions for improvement mostly involved asking more questions and talking more about trauma, but more people said that they were satisfied with what was happening.
Staff Qualitative	• Processing group. If something notable happens in group with trauma, primary counselor gets a note about it. • Counselors report doing some trauma care in individual counseling when clients want it. • If client needs more trauma care than counselor can give – referred to other organization.

Table 7: How Trauma is Addressed

To what extent is RCA systematically and sensitively assessing trauma and trauma symptoms?

Clients agreed that staff members are as sensitive as possible when they ask about possibly trauma events. Only one person didn't agree that they feel safe talking to the staff, and they had previously mentioned a confidentiality breach. Another client could not remember whether or not the staff explained why they asked about possibility traumatic experiences. The averages of above "agree" or 4 indicate that clients generally felt that the staff members were sensitive when asking about trauma (Table 8).

Assess Trauma	Average	Less than Agree
The staff are as sensitive as possible when they ask me about difficult or frightening experiences I may have had.	4.5	0
I feel safe talking with staff here about my experiences with violence or abuse.	4.4	1
The staff explained to me why they asked about difficult experiences in my life (like violence or abuse).	4.4	1
Domain Average & Total Less than Agree	**4.4**	**2**

Table 8: Client Perceptions of Trauma Assessment (N=23)

Interviews with staff indicated that trauma history is assessed during the initial assessments through the Bio-Psycho-Social history and through a question on the GPRA survey but also kept in mind throughout the treatment process. Specifically, staff reported looking for signs of discomfort or emotional distress during group and individual sessions, listening for signs of trauma, and asking questions about difficult life experiences and triggers. The bio-psycho-social assessment does provide a way to collect and record a client's abuse history through general areas like "family history" and "medical history", but it is less systematic and complete than other scales used specifically for trauma histories. Trauma symptoms are not currently being recorded in a

systematic way, and one staff member recommended using tool to assess trauma symptoms. Staff members are sensitive when asking about trauma, and there are ways in which staff members are taking trauma histories. The process of taking trauma histories and trauma symptoms could be more systematic (Table 9).

Source	How Trauma is Assessed
Client Quantitative	• Average score for trauma assessment questions was 4.4. • Clients generally agreed that RCA staff were sensitive when asking about trauma, that they feel safe talking to staff, and that staff members explain why they take trauma histories. • Only 2 less than agree answers.
Client Qualitative	• Reasons for less than agree: one did not say (but previously mentioned confidentiality breach?) and the other could not remember whether why was explained to them.
Staff Qualitative	• Take trauma histories through bio-psycho-social and GPRA at beginning and continue to notice signs of abuse of discomfort. No systematic symptom assessment.

Table 9: How Trauma is Assessed

To what extent are program activities and settings consistent with five core values of trauma-informed cultures of care: safety, trustworthiness, choice, collaboration, and empowerment?

All the separate principles of TIC have averages above 4, indicating agreement. The scale recommends that any individual answers with less than 4 or "agree" indicate room for improvement (Figure 3). The results of the separate principles was reported in order from best average to the areas that have the most room for improvement, including qualitative data from both clients and staff interviews.

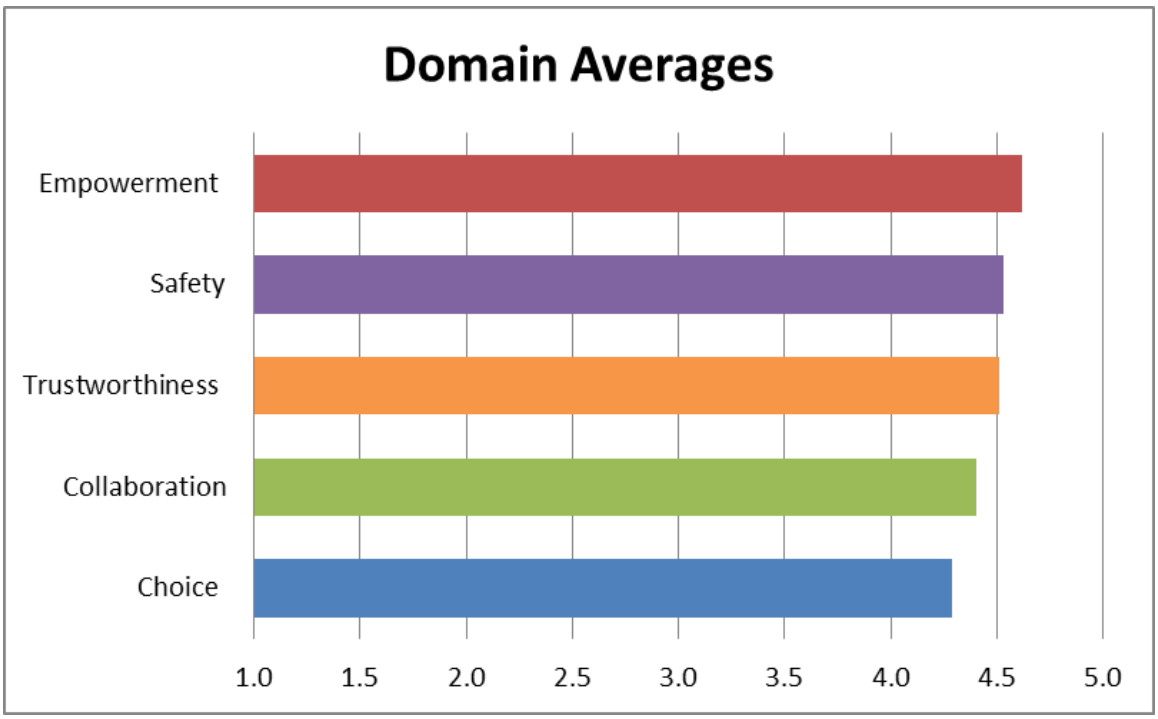

Figure 3: Five Principles of Trauma Informed Care

Empowerment

The average for Empowerment was 4.6, the highest average of the 5 principles. The CCTIC scale suggested questions related to empowerment included valuing the client and helping the clients feel stronger and build skills that are helpful to them. Not only did everyone agree that they felt hopeful about their recovery, it was also the highest average of all the questions. Clients also all agreed that RCA recognizes that they have strengths and skills, let them know that they value them, and that they feel stronger as a person since coming to RCA. All but one client agreed that RCA helped them learn new skills that are helpful to their goals (Table 10). A common narrative throughout the interviews showed that many clients felt disempowered before coming to RCA and gained skills and strength to change their lives for the better. One client said, "They gave

me support. They gave me courage. They gave me a willingness to want to live again instead of dying out here in this society in my madness."

Empowerment (n=23)	Average	Less than Agree
I feel hopeful about my recovery	4.8	0
RCA recognizes that I have strengths and skills as well as challenges and difficulties.	4.7	0
The staff here at RCA are very good at letting me know that they value me as a person.	4.6	0
I feel stronger as a person because I have been coming to RCA.	4.5	0
The staff here at RCA help me learn new skills that are helpful in reaching my goals.	4.5	1
Domain Average & Total Less than Agree	**4.6**	**1**

Table 10: Client Perceptions of Empowerment (N=23)

All the interviewed clients indicated that they felt that RCA lets them know that they valued them as a person. In response to a question about what makes them feel valued, clients reported that staff have “spiritually uplifting things to say” and “encouraging words”. Not only do staff tell clients they are wanted and worth this opportunity, they also recognize and use clients skills when they can by asking them to help with stuff around the office. Some clients felt valued because they felt that RCA helped clients when they said they would and that the counselors listen to what the clients want and pay attention to clients’ feelings. Another indicated that their counselor is involved with clients’ recovery and makes creates treatment plans that are what they want and need, helping them feel valued. Staff support was a common way that clients feel appreciated. One client felt because RCA had staff available for crises or help, even if it was not their counselor. Another client appreciated that staff support was balanced with the freedom to make mistakes, saying staff give “enough freedom to make mistakes but

not so much that [clients are] alone when they fall." One client said that they felt appreciated and understood because the staff members were once in their shoes (i.e. starting to recover from substance addiction). Another had a similar comment that they felt valued because the staff "put up with me" and accepted clients for who they are.

Many clients also reported feeling stronger as a person because of RCA. RCA has several events that made clients feel stronger, including Family and Friends Day, where friends and family members speak about the person in recovery, and Phasing Up, where clients go from Phase 1 to Phase 2 and get positive feedback from RCA staff members. Having family notice their recovery was a moment that one client felt stronger. Clients also reported feeling stronger when receiving emotional support from staff and other clients, including one client who reported getting support after a setback in their treatment goals and other who felt stronger when their counselor encouraged them to go for their goals. Other clients talked about RCA helping them build a foundation, build self-esteem, and learn more about themselves and coping skills that work for them.

All but one client agreed that RCA helped them learn skills that are helpful to their goals. The skills they learned included intrapersonal skills: learning more about their thoughts, emotions, and behavioral patterns and interpersonal skills, like conflict resolution. One client mentioned that confronting feelings was difficult at first but got easier. Some reported learning coping skills that work for them and learning ways to change thoughts to be more positive. A few mentioned learning patience, including learning to do things one at a time and slowing down. Others reported learning interpersonal skills, including how to talk in crowds and deescalate conflicts. Another mentioned other skills like managing money and being a better parent as helpful to their

recovery. Clients recounted learning these skills in classes, through journaling, and talking with their counselors. One client says that it helps that the staff are also people in recovery because “they been there and I see that it works for them, so it gives me encouragement." Many say that these skills are the ones they need to “stay clean and sober”. Client said, “They gave me skills to handle things that was causing me to relapse."

Of the 23 clients, two experienced events that made them feel disempowered. One felt not valued when they experienced a breach of confidentiality breach. Another felt not valued when they were chastised for being late with what they felt was a good reason. A suggestion for improvement was to teach more skills, like how to get grants to go back to school.

One finding is that empowerment and hope was connected for people, as this quote illustrates.

> I make a 30 day goal and one of the things that [my counselor] does that really makes me hopeful in my recovery is that [they mark] them off as I do them. But then [they show] it to me. Every time I go in [their] office [they’re], “Look man you about done this.” … That’s very hopeful because I’ve accomplished more in these last 90 days than I have in [many] years of getting high. That is something that I can actually see. It’s not something that someone tells me. [The counselor] can show it to me. That is the most hopeful thing in the world to me.

Clients commonly said that staff support, positive affirmations, and encouraging words during difficult times helped them feel hopeful. One client said that the staff helped them realize what their disease was, and that helped instill a sense of hope for recovery.

One client said that RCA helped them feel hopeful “by givin' me the tools to work with. Just helping me to see that I am somebody. That I do matter. Set my goals higher for myself.” This change in the way clients see themselves inspired many clients to feel

hope. Not only did clients talk about staff helping them build skills and accomplishing goals inspiring hope, some replied that staff treating them in a way that let them know they are worthy helped them feel hope. One client said that staff members "talk to me every day" and another reported that staff let them know "that I am wanted. I am somebody." Another client said that staff "care….They listen whenever I have something to say." One client mentioned that seeing others succeed also helped them feel hope, which is an important reason to have peer leaders in treatment settings. Not only does hope help people feel empowered, it can help clients feel emotionally safe, as one person suggested.

Staff talked about several strategies for helping clients feel respected, empowered and hopeful, focusing on creating goals, encouraging clients, and asking clients how they want to be treated. In fact, one staff member pointed out that feeling empowered is to also feel respected. Counselors use Motivational Interviewing as an evidence-based practice that empowers clients. It focuses on encouraging clients to articulate their own goals and plans of actions while reinforcing progress towards goals. One staff member focused on the importance of helping clients see alternatives or other options to their problems, so clients can better choose which path they want to take. Staff also reported getting client input for goals that are not progressing well, keeping clients involved in their treatment plans. Because clients make their own plans, they are more likely to stick with them.

Positive reinforcement was commonly cited by staff members. This included telling clients that they are victorious simply by being at RCA to telling them at it's their time. This fits into to what the clients say about positive feedback from staff being helpful to their recovery. Staff also report asking clients about the way they want to be

treated and asking permission as a way to show clients that they respect them. One staff member reported letting clients make their own rules in group sessions, allowing the clients to take a leadership role. Another staff member said that RCA encourages clients to "do support groups so they can see people in varying places of healing, and hopefully they'll see people that have gone through what they've gone through and have done a lot of work and are reaping the rewards. And they can see that the work is worth it, and that's the hope I believe." This matches a few comments from the clients that seeing other people in recovery is empowering and hopeful.

Safety

Safety had the second highest average response with an average of 4.5, well over 4 or "agree" (Table 11). Everyone agreed that they feel safe at RCA. All but one client agreed that they felt emotionally safe at RCA, that staff notice signs of distress and that their first contact was welcoming and respectful. The reason for less than agreement about staff noticing signs of distress and reacting in a gentle, compassionate way was that they perhaps notice too much: the client found the staff to be "nosy" and treat clients like children. Another client suggested that RCA could do a better job providing guidelines to clients unfamiliar with the program before they commit to it, so that they could better determine if RCA would be a good fit for them, increasing their sense of safety and control (Appendix H).

Safety (n=23)	Average	Less than Agree
The staff (including the reception staff) notice signs of distress among fellow clients and respond in a gentle, compassionate way.	4.7	1
My first contact (by phone or in person) with the program was welcoming and respectful.	4.6	1
I was given clear guidelines in advance about what to expect of the program	4.6	1
When I come to RCA, I feel emotionally safe.	4.5	1
When I come to RCA, I feel physically safe.	4.4	0
Domain Average & Total Less than Agree	**4.5**	**4**

Table 11: Client Perceptions of Safety (N=23)

All clients agreed that they felt emotional safe. “They provide it like it's a home, and I feel safe in my home and family.” Emotional safety for many clients came from getting help and having support when they needed it. Just RCA providing treatment helped them feel safe. Talking with counselors and hearing what they had to say during difficult times came up a few times. The open door policy helped clients feel emotionally safe because even if their counselor is not available, there is someone else to talk to. There was a common feeling that if a client really needed help, RCA would provide it. Some clients specifically mentioned that counselors listen and pay close attention to their emotional state and can tell if something is wrong. “Any time I am having mood swings or some emotions that I don’t understand you can process it with a counselor and they’re equipped to help you identify the things that are causing these emotions.” Others mentioned the words of encouragement and positive support their counselor give. Knowing that what is said in counseling is confidential was helpful to some clients.

Many clients felt safe with RCA because the counselors have “been there” and understand what it is like to be in recovery and “it makes me feel like I fit in.” “They

broke everything down to what I needed to know and they put up with my stuff. ‘Cause I came here with a little attitude and I came here willing too thought but they said it’s okay though ‘cause it was part of the process.”

Another felt emotionally safe because of group classes and activities, like picnics. "Well, this is a safe haven. Most of the people here, you can get along with, so it's basically safe." The skills taught in classes made clients feel emotionally safe, like the anger management class. “The very clients in this room - not even the staff - just put their arms around and told me things that would comfort me and make me feel better. And then, when I finally reached my counselor and talked to him about it, he gave me some really sound advice that I should follow.”

By far, a safe, gender-segregated housing environment was the most common service cited by clients that provided them with physical safety. “[RCA provides] me with shelter, a place to be where I'm not in the streets, where I'm not out there in the open where people can do any harm to me.” Not only does RCA provide “a drug-free atmosphere”, “[The staff here] are very attentive to us clients.” Many clients appreciated having people around the facility and sticking in groups outside of RCA. A few stated that RCA provides services like a home, and that the people at RCA have their best interests in mind.

RCA policy and procedures helped clients feel safer, including locking the doors between the waiting area and the treatment rooms and offices and having the “buddy system,” where clients have to leave with at least two other clients during much of the treatment time. One client specifically said that RCA could keep the “buddy system” around longer because “it keeps people out of trouble.” Support of the Buddy System was

not universally appreciated: some clients wanted RCA to give them more freedom and trust. Another aspect of rules was that one client appreciated that rules were explained to them in a way that let them know why they benefit them rather than just yelling the rules at them. Some things people mentioned possible improvements in security, including having security in the parking area, going over *all* the rules and regulations, and letting clients move if there are housing conflicts.

Counselors recognize the importance of safety, including that it is needed to get to clients' issues. Providing physical safety is a starting point for a greater talk about their thoughts about what they need to feel safe because the problem might be more in-depth. For staff, there was not such a clear difference between providing physical versus emotional safety. They reported doing physical things like moving on the same side of the desk, turning on a noise machine, or locking a door to help clients feel emotionally safe and comfortable. And they reported encouraging clients to talk about what is making them feel unsafe to find out alternatives or ways of dealing with fears or safety issues.

To provide emotional safety, staff reported asking clients about how they feel and how to help them feel more comfortable and safe. They also talked about using techniques like grounding clients in the present moment. Explaining confidentiality and the limits of confidentiality was important. Staff also reported asking permission before touching clients, sharing information between care providers, and moving forward with treatment plans. One staff member talked about the importance of being authentic and having cultural sensitivity to help clients feel safe. There was also this idea that safety is not a "pre-packaged" service – it requires a client-centered approach.

With physical safety, policies and procedures like locking the door in an emergency and the color code system, with different color codes for different emergencies came up. Respect personal boundaries. One staff member reported that being careful to have clients within RCA's ability to handle was important after an incident with an outpatient with mental health issues.

Trustworthiness

All the clients agreed that RCA provides good information about what to expect of its staff and services, that they trust the people who work at RCA, and that staff are professional and respectful. All but one client trust that RCA will protect their confidential information, and all but two clients trust that RCA staff will do what they say when they say they will do it. These answers can be explained by one client suspecting a breach of confidentiality, leading them to feel that staff is less trustworthy. Another client wanted better follow-up on referrals.

Trustworthiness (n=23)	**Average**	**Less than Agree**
RCA provides me good information about what to expect from its staff and services.	4.7	0
I trust the people who work here at RCA.	4.6	0
The people who work here at RCA act in a respectful and professional way toward me.	4.5	0
I trust that people here at RCA will protect my private information and records as much as possible.	4.5	1
I trust that people here at RCA will do what they say they are going to do, when they say they are going to do it.	4.3	2
Domain Average & Total Less than Agree	**4.5**	**3**

Table 12: Client Perceptions of Trustworthiness (N=23)

Clients have to trust counselors in order to talk about trauma and recovery, and one client reported that their counselor made them feel comfortable enough to trust them and share their challenges related to trauma. Make sure that people who have been referred from other places know what exactly the program is before intake because not everyone who gets referred is a perfect fit or will agree with the policies.

Some clients felt that their counselors could not always trust that people at RCA will do what they say they are going to do when they say they are going to do it. One said that a counselor missed a meeting without warning, and another reported that RCA tries to do things when they say but are not always successful.

Confidentiality also came up during the client interviews. Many feel like RCA keeps confidentiality. One reported their counselor asking permission to connect with other support systems before doing so, which they liked. However, one client suspected a breach in confidentiality occurred because some other clients knew information about them that they had not disclosed. Breaches in confidentiality can seriously undermine TIC.

Staff saw the importance of confidentiality as well. One staff said it was the number one thing we talk about, and another reported that it was the first thing they talk about, including the limits of confidentiality in the case of immediate harm. It was also important to encourage the client to have the opportunity to ask questions about confidentiality. To ensure confidentiality, some staff reported closing the door, putting up a “do not disturb” sign, and using a white noise machine so that clients feel like it is confidential and no one will just walk into the room. Only administrator and supervisors

have access to client records. According to one counselor, rules for the classes that the clients create for themselves generally include confidentiality.

Collaboration

All of the clients reported that staff members are willing to work with them instead of doing things for them or to them. All but one client indicated that group sessions are responsive to clients, and all but two felt like that were a partner with staff and that they listened. The lowest scored question with three clients, about 13%, not agreeing was that consumers play a big role in deciding how things were done. Of those who did not agree, one said that they were assigned their classes without much input and another wanted the staff to listen more.

Collaboration (n=23)	Average	Less than Agree
At RCA, the staff is willing to work with me (rather than doing things for me or to me).	4.6	0
My group sessions are responsive to what I and other consumers want.	4.4	1
When decisions about my services or recovery plan are made, I feel like I am a partner with the staff, that they really listen to what I want to accomplish.	4.3	2
Consumers play a big role in deciding how things are done here at RCA.	4.2	3
Domain Average & Total Less than Agree	**4.4**	**6**

Table 13: Client Perceptions of Collaboration (N=23)

A good summation of positive experiences people had with staff can be seen in this quote: "I like my treatment plan. It's what I need and what I want." For the most part, clients reported that counselors worked with them to accomplish clients' goals. "They actually listen and want input from the client about the goals, what you would like to

accomplish." One said that they were comfortable with counselor and could be honest and truthful, which was what they needed to be to get help. Another client reported that they enjoyed the way their counselor coordinated with their sponsor with their permission. Clients also reported that RCA staff members were patient and understanding with their bad attitudes at the beginning of treatment. One client in particular was grateful that the counselors told them about controlling their temper not by telling them to stop but by explaining why anger isn't a good way to communicate.

Clients differed on their perceptions about staff follow-up on recommendations and referrals. One client reported that RCA staff "explain that if you need any other services, they are able to provide," while one person said that the staff didn't follow-up on recommendations and referrals, another said that "they're more on you scheduling about the things you should be doing and the things you should be doing… They're very helpful. They don't let you slide between no cracks." Two people mentioned that the staff could be more reliable about coordinating events and including the clients in those plans.

Staff talked about giving client-centered care and motivational interviewing to create collaborative treatment plans. They reported having their clients make their goals, establish their options, chose actions that they felt they could do, do updates with the clients, and follow-up on action items and goals. Sometimes the clients are surprised that they can create a treatment plan for themselves, as the counselors only try to present options without telling them how to do things. Counselors talked about how important listening is to this process, from getting client input on how counselors should best respond to them to hearing clients make goals and say they can follow through with the actions. Specifically with trauma, counselors let clients determine when they talk about

trauma by asking permission to talk about it or by waiting until they are ready. More than just listening, one staff member talked about how they have to respect the choices of the client even if they do not agree with them. Staff also talked about encouraging clients with progress updates at each stage, including just beginning to talk about feelings and present situations or determining alternative actions. One staff member elaborates that this client-center planning and collaboration is a technique to empower clients and prevent co-dependency.

Choice

With an average of 4.3, this section was above 4 or "agree" and showed the greatest room for improvement according to quantitative data. Clients all agree that their goals are treated as the most important factor in their recovery plans. From the responses, RCA generally provides services that work for clients' times and locations, as only one person finds RCA's location difficult and no one finds that RCA's services are given at times that don't work for them. The questions with the lowest scores had to do with the variety of services, knowing about all the services, and clients not being able to control much about the services provided (Table 14).

Choice (n=23)	Average	Less than Agree
My goals are treated as the most important factor in my recovery plan by the people at RCA.	4.6	0
RCA is easy to get to for me (by MARTA/car).	4.5	1
People here at RCA really listen to what I have to say about things.	4.5	1
The services I receive are given at times that work for me.	4.5	0
RCA offers me a lot of choices about the services I receive.	4.2	3
I knew about all the service options at RCA, like the types of services offered, housing possibilities, and clinicians, before I started my treatment planning.	4.0	3
I have a great deal of control over the kinds of services I receive, including when, where, and by whom the services are offered.	3.8	7
Domain Average & Total Less than Agree	**4.3**	**15**

Table 14: Client Perceptions of Choice (N=23)

The clients expressed a wide range of opinions about their service options and how much they know about them and can control them. Some expressed that they had little control over the services offered. One client said that

> It's kind of structured. They have your classes, they have your meetings, they tell you, you have to go to meetings and stuff, so we really can't just go and do what we want we have to stay within the rules and their limits.

But the client also argued that clients have a choice of engaging with the program:

> They don't make you do nothing, you can walk out these doors any time you want to.

A few clients admitted that there is less control but they like the format or do not feel like they want to be in control because it is not helpful. One client actually wanted for the classes to be required for a longer amount of time because the classes were so helpful.

While some clients do not mind not having much control, one client stated that it feels empowering to know that they have choices. Suggestions for improving client

choices included having better and more functions (like softball team or bowling) in addition to more reliable planning for these events. One client told a story about missing out a program due to poor planning. Another client wanted more choices for downtime and longer time before curfew. Other clients were interested in more help with case management, including current and future housing, medical services, including hospitalization, and job help. A few people expressed concern over finding a job and a desire for RCA to assist them, including helping them search for jobs or possibly starting a program that would place them in a temporary or permanent position with a partner from the business community. Not only did they want help, one client reported wanting staff to follow up more on their referrals and recommendations. Finally, one client wanted more aftercare related to trauma for when they left the program.

In addition to more choices, a few clients wanted more in-depth explanations of the treatment options at the beginning of treatment. Another client received the information but was having a hard time paying attention at the beginning of recovery. There are also changes in rules when clients phase up, and one participant knew what was going on before starting treatment but was unsure of what happens in the second phase.

In addition to suggestions for improvement, many clients expressed that they were satisfied with their services at RCA even though the choices may be limited. Many clients had no complaints or suggestions. While there are improvements that could be made, many clients are still happy with RCA's choices.

Counselors reported that around the time of the study, the intake procedures were changed to allow for more a more client-centered approach. It used to be that clients created treatment plans at intake with the intake specialist, but now the clients create their

treatment plans based on their goals with their counselor a little later. This will hopefully increase clients' sense of control over time.

While the administration and structure of the program provide a good deal of choices, staff members also give clients treatment choices in a variety of ways. Counselors reported focusing on exploring choices or alternative actions for clients during counseling and case management, so they feel like they have the opportunity to choose a path that works for them. They also provide check-ins about treatment plans to see if there need to be any changes because the treatment plans can be modified at any time and should be flexible to meet clients' needs. If clients' needs cannot be met within the program, staff members also can give referrals, which could improve choice. Staff members were concerned with providing choices to clients. One staff member reported wanting to expand classes to give clients more choices.

Five Principles of TIC

Generally, the five principles were integrated into program elements for the clients, as evidenced by the averages above agree and the qualitative reports about activities that support TIC principles. While these comments were generally positive, there is room for improvement. One client reported a possible confidentiality breach, some male clients are not learning about trauma symptoms, and clients reported less control and choice in treatment services. Finally, RCA empowers clients in many ways. From providing staff members who serve as role models for recovery to creating a supportive and strength-based environment, RCA's dedication to empowering clients is apparent and producing positive experiences for clients (Table 15).

Five Principles of TIC			
	Client Quantitative	**Client Qualitative**	**Staff Qualitative**
Empowerment	Highest average: 4.6; only 1 less than agree answers.	Many clients report RCA helping them feel more hopeful and stronger while building skills that help them meet their goals through their classes and counseling sessions.	Staff reported empowering clients through respect, focusing on goals and alternative options, and encouraging clients.
Safety	Average of 4.5; 4 less than agree.	Emotional Safety: Counselors who understand and have "been there". Emotional support from counselors and other clients. Physical Safety: Housing, drug-free, attentive clients, and rules.	Less clear boundaries between physical and emotional safety than clients. Ensure confidentiality, ask clients permission and what will make them feel safe. Color codes and locked door between back offices and public front waiting area
Trustworthy	Average of 4,5; 3 less than agree answers.	Clients generally trust RCA staff with few exceptions, including a possible confidentiality breach.	Providing confidentiality important to staff. Use noise machines, close doors, limit access to records, and talk about confidentiality at beginning of treatment.
Collaboration	Average of 4.4; 6 less than agree answers. Clients feel that the staff members are willing to work with them. Clients indicated that could have a larger role	"I like my treatment plan. It's what I need and what I want." Clients like how staff work with them, ask permission, and are understanding. Could be more reliable and do more updates.	Collaboration involves clients making their goals, establishing their options, choosing actions that they felt they could do, doing updates with the clients, and following up on action items and goals.
Choice	Lowest average: 4.3; 15 less than agree answers. Clients have lower sense of control and choice.	Clients indicated that there could be more functions, classes, and job search help. Some clients explained that while they felt they did not have a lot of control over their services, they were still happy with those services. Could have more control over classes	Intake procedures recently changed to increase clients' choice and control. Focus on providing alternative solutions during counseling.

Table 15: How Five Principles of TIC are Integrated

Chapter 5: Discussion

Conclusions

There are many aspects of RCA's services that are trauma-informed, including their dedication to addressing trauma, peer leadership, training and education of staff members, and providing client-level integrated services. Of the five TIC principles, all of the domains for the clients had averages over agree (4), which shows that they are working, with empowerment as the highest-rated principle. The domain of choice showed the greatest opportunity for improvement, with specific possibilities for enhancements in control over services and choice. While RCA provided training for TIC a few years ago, not all of the counselors feel comfortable and confident in giving TIC and one requested more training. Clients generally agree that RCA helps them make connections between trauma, trauma symptoms, and substance abuse. Many male clients were not sure what the symptoms related to trauma are, possibly indicating that male clients could use more trauma education. Trauma history is being assessed during intake and throughout the program in a sensitive way. However, it could be a more comprehensive and specific process with a validated scale. RCA could also start monitoring clients' trauma symptoms in a systematic way (Table 16).

Question	Findings
Structure	• Peer leaders include staff members in recovery, alumni, and other clients • While many staff members are trained and/or education in trauma treatment, not all feel comfortable and competent giving TIC. Staff reported wanting more training • Ability to give TIC growing with Medicaid expansion • Psychiatrist Dr. Bharmal seen as asset • Staff members refer clients with severe trauma to other community organizations that will support them if the client feels safe doing so
Addressed	• Clients generally agree that RCA helps them make connections between trauma, trauma symptoms, and substance abuse • Five men reported not knowing that symptoms related to trauma were • Gender-specific processing group • Counselors report doing some trauma care in individual counseling when clients want it • If client needs more trauma care than counselor can give – referred to other organization
Assessed	• Clients generally agreed that RCA staff were sensitive when asking about trauma • Systematic trauma history but could be improved Could start taking trauma symptoms systematically
5 Principles	• All domains have averages above agree • Strong in empowerment • Could improve on choice and control for clients

Table 16: Overall Evaluation Findings

Recommendations

Recommendations were produced through a meeting with RCA Executive Director, Cassandra Collins, and other program staff. All recommendations from staff were classified as both highly important and highly feasible during the meeting, which involved participatory methods of coming up with ideas for recommendations and discussing their importance and feasibility as a group. The recommendations generated

from that meeting are followed by additional recommendations from the evaluator based on the literature review and evaluation results. These recommendations are listed below.

Follow-Up TIC Training:

Institute a follow-up TIC training during a "staff wind-down." This would be an all-day training covering the basics of TIC for all staff in the program, including talking about the symptoms of trauma and finding a new possible tool for monitoring trauma symptoms.

Confidentiality Training:

Implement a staff training on confidentiality and how to prevent sensitive information from being shared. Confidentiality is key to keeping an organization safe and trustworthy for clients, and many of the staff members in interviews and at the meeting expressed a desire to provide confidential services.

Optional Classes for Clients:

The executive director suggested starting groups that would be based on clients' interests and led by clients. These optional, client-led and –run classes addressing topics that matter to them could potentially increase clients' role and choice in treatment. Not only would this increase the diversity of classes and increase the roles available to clients, it would ease pressure on RCA staff to provide more classes.

Continuing to Improve Clients' Self-determination:

Another suggestion was to increase the clients' input into the services provided. There was some discussion that this was already something the providers were working on through changing the assignment of classes from the intake interview to waiting until making goals with counselors to choose which classes to participate in.

Improving Male Clients' Knowledge of Trauma and its Effects:

Educate male clients about trauma and its effects through classes. Not all clients are required to do the trauma-processing group, so having education at some point in treatment might help them learn more about the symptoms related to trauma. Some staff also felt that screening for trauma symptoms might help clients learn about the symptoms related to trauma.

PTSD Symptom Scale during Assessment:

Add the PTSD Symptom Scale to assess trauma symptoms systematically to intake and discharge assessments in order to better monitor the changes in symptoms during treatment and improve the evaluability of TIC outcomes. This already has some buy-in from staff members, as a few requested a way to systematically take clients' PTSD Symptoms, and a validated scale would aid in this. The PTSD Symptom Scale (PSS) is a commonly used assessment tool that allows practitioners to assess the existence and severity of the DSM-IV symptoms of PSTD (Dass-Brailsford & Myrick, 2010).

Comprehensive and Sensitive Trauma Scale to Intake Assessment:

Include the Life Stressor Checklist- Revised for trauma history at intake. The Life Stressor Checklist- Revised is a validated and sensitive way to take a trauma history that has been used in both men and women (Norris & Hamblen, 2004). It can be made into composite variables: lifetime exposure to stressful events, lifetime frequency of interpersonal abuse, frequency of childhood abuse, current exposure to interpersonal abuse, and current exposure to other stressors. It's also broken down into dichotomous variables: childhood physical abuse, childhood sexual abuse, adulthood physical abuse, and adult sexual abuse (McHugo, Caspi, et al., 2005). The WCDVS built in a retest, tolerance, and face validity testing component to their study, and this measure was found to be a way to accurately and sensitively measure trauma histories. Since asking about traumatic events can be stressful, the researchers monitored how the respondents and data collectors tolerated and will help guide the measure. Overall, interviewers reported that the women had little to positive responses to the measure. Out of about 6000 interviews, only a few cases required special attention and only one severe case (McHugo, Caspi, et al., 2005), indiciating a low chance for adverse effects.

Limitations

Even though looking at complete programs and all staff and clients in a parallel way is recommended (Fallot & Harris, 2011), this will have to be left for a future evaluation scheduled for summer 2014. For the purpose of this analysis, the decision was made to focus on the treatment staff, as they ask questions about trauma and lead the groups that process trauma. While the sample size of 23 clients was good for qualitative

data, the validity of the quantitative data is limited to due to small sample size. The clients who were not interviewed were disproportionately female, leading to possible bias. Three questions about making connections between trauma, trauma symptoms, and substance abuse were changed from qualitative to quantitative questions after the first two interviews because of the risk of clients' disclosing their trauma. While an open-ended follow-up about what improvements could be made was asked of all clients, two fewer clients answered the quantitative version of the question as a result of the change in protocol. Finally, since this is an evaluation of a specific program and has a small sample size, its specific findings related to fidelity are not generalizable to other programs. However, its findings about the impact of TIC on staff and clients could be relevant to other similar programs.

Strengths

The main strengths of this evaluation are its inclusion of clients in the evaluation process, its mixed methods approach, its strengths-based approach, and the inclusion of staff in recommendations. Giving clients a voice is an important aspect of creating evaluations meant to empower groups of people. Clients were both interviewed and involved in the development of the interview instrument, as a former client helped in the editing of the questions through piloting the questionnaire and giving feedback on the questions. The mixed methods approach allowed the evaluation to not only find out what aspects of TIC were working well and which could be improved, but it also found details about what specific program and staff activities were working well for the clients and which could be improved. This evaluation also focused on finding out what was working

well, which empowers organizations to continue to implement programmatic elements that positively impact the program and articulate those elements to current, past, and prospective clients, staff members, community members, program leadership, and funders. Finally, including the staff in the development of recommendations not only increases the buy-in to those specific recommendations, it also can improve the organization's capability to think evaluatively and improve their programs.

Dissemination Plans

Some of the findings of this report have been shared with RCA. The results will further be shared through meetings with RCA's Quality Improvement Committee and through meetings with RCA leadership and the substance treatment counselors. Results will also be shared with SAMSHA through RCA's quarterly grant report. A meeting with CCTIC Scale developer Roger Fallot over the evaluation results and lessons learned is also planned.

Further Evaluation Plans

An evaluation of TIC in all of the different programs run by RCA is planned for summer 2014. This evaluation will cover more of the program and program staff and will be less in-depth and client-focused than this evaluation due to the feasibility of interviewing clients with less contact time with the program.

References

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders: DSM-III-R* (3rd ed.). Washington, DC: American Psychiatric Association.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders: DSM-IV* (4th ed.). Washington, DC: American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5* (5th ed.). Arlington, VA: American Psychiatric Association.

Back, S. E., Brady, K. T., Sonne, S. C., & Verduin, M. L. (2006). Symptom improvement in co-occurring PTSD and alcohol dependence. *Journal of Nervous and Mental Disease, 194*(9), 690-696.

Breslau, N., & Anthony, J. C. (2007). Gender differences in the sensitivity to posttraumatic stress disorder: An epidemiological study of urban young adults. *Journal of Abnormal Psychology, 116*(3), 607-611.

Center for Substance Abuse Treatment. (2008). *Substance abuse treatment and family therapy*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Chilcoat, H. D., & Breslau, N. (1998). Posttraumatic stress disorder and drug disorders: testing causal pathways. *Archives of General Psychiatry, 55*(10), 913-917.

Cocozza, J. J., Jackson, E. W., Hennigan, K., Morrissey, J. P., Reed, B. G., Fallot, R., & Banks, S. (2005). Outcomes for women with co-occurring disorders and trauma: program-level effects. *Journal of Substance Abuse Treatment, 28*(2), 109-119.

Cooper, H. (2004). Medical Theories of Opiate Addiction's Etiology and Their Relationship to Addicts' Perceived Social Position in the United States: An Historical Analysis. *International Journal of Drug Policy, 15*(5-6), 435-445.

Courtwright, D. T. (2010). The NIDA brain disease paradigm: History, resistance and spinoffs. *Biosocieties, 5*(1), 137-147.

Covington, S. (2008). Women and addiction: a trauma-informed approach. *Journal of Psychoactive Drugs, Suppl 5*, 377-385.

Covington, S., Burke, C., Keaton, S., & Norcott, C. (2008). Evaluation of a trauma-informed and gender-responsive intervention for women in drug treatment. *Journal of Psychoactive Drugs, Sarc Suppl 5*, 387-398

Dass-Brailsford, P., & Myrick, A. C. (2010). Psychological trauma and substance abuse: the need for an integrated approach. *Trauma Violence Abuse, 11*(4), 202-213.

De Bellis, M. D. (2002). Developmental traumatology: a contributory mechanism for alcohol and substance use disorders. *Psychoneuroendocrinology, 27*(1-2), 155-170.

Didenko, E., & Pankratz, N. (2007). Substance Use: Pathways to homelessness? Or a way of adapting to street life? *Visions, 4*(1), 9-10.

Dube, S. R., Felitti, V. J., Dong, M., Giles, W. H., & Anda, R. F. (2003). The impact of adverse childhood experiences on health problems: evidence from four birth cohorts dating back to 1900. *Preventative Medicine, 37*(3), 268-277.

Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-Informed or Trauma-Denied: Principles and Implementation of Trauma-Informed Services for Women. *Journal of Community Psychology, 33*(4), 461-477.

Fallot, R. (2011). Trauma-informed care: A values-based context for psychosocial empowerment. In Preventing Violence Against Women and Children. Forum on Global Violence Prevention. Workshop Summary, pp. 97-102. Institute of Medicine of the National Academies. Washington, DC: The National Academies Press.

Fallot, R., & Harris, M. (2001). A trauma-informed approach to screening and assessment. *New Directions for Mental Health Services* (89), 23-31.

Fallot, R., & Harris, M. (2011). *Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol*.

Fallot, R., & Harris, M. (2012). *Creating Cultures of Trauma-Informed Care (CCTIC): Program Fidelity Scale*.

Fallot, R., McHugo, G.J., Harris, M., & Xie, H. (2011). The Trauma Recovery and Empowerment Model (TREM): A quasi-experimental effectiveness study. Journal of Dual Diagnosis, 7(1), 74-89.

Harris, M., & Fallot, R. (2001). A trauma-informed approach to screening and assessment. *New Directions for Mental Health Services* (89), 23-31.

Henkel, D. (2011). Unemployment and Substance Use: A Review of the Literature (1990-2010). *Current Drug Abuse Reviews, 4*, 4-27.

Herman, J. L. (1997). *Trauma and recovery* (Rev. ed.). New York: BasicBooks.

Institute of Medicine, & National Research Council. (2014). *New Directions in Child Abuse and Neglect Research*. Washington, DC: The National Academies Press.

Israel, B. A., Schulz, A. J., Parker, E. A., & Becker, A. B. (1998). Review of community-based research: assessing partnership approaches to improve public health. *Annual Review of Public Health, 19*, 173-202.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 593-602.

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry, 52*(12), 1048-1060.

Koob, G. F. (2006). The Neurobiology of Addiction: A Hedonic Calvinist View. In W. R. Miller & K. Carroll (Eds.), Rethinking substance abuse : what the science shows, and what we should do about it (pp. 182-200). New York: Guilford Press.

McHugo, G. J., Caspi, Y., Kammerer, N., Mazelis, R., Jackson, E. W., Russell, L., . . . Kimerling, R. (2005). The assessment of trauma history in women with co-occurring substance abuse and mental disorders and a history of interpersonal violence. *Journal of Behavioral Health Services & Research, 32*(2), 113-127.

McHugo, G. J., Kammerer, N., Jackson, E. W., Markoff, L. S., Gatz, M., Larson, M. J., . . . Hennigan, K. (2005). Women, Co-occurring Disorders, and Violence Study: Evaluation design and study population. *Journal of Substance Abuse Treatment, 28*(2), 91-107.

Mersky, J. P., Topitzes, J., & Reynolds, A. J. (2013). Impacts of adverse childhood experiences on health, mental health, and substance use in early adulthood: a cohort study of an urban, minority sample in the U.S. *Child Abuse & Neglect, 37*(11), 917-925.

Morrissey, J. P., Ellis, A. R., Gatz, M., Amaro, H., Reed, B. G., Savage, A., . . . Banks, S. (2005). Outcomes for women with co-occurring disorders and trauma: program and person-level effects. *Journal of Substance Abuse Treatment, 28*(2), 121-133.

Morrissey, J. P., Jackson, E. W., Ellis, A. R., Amaro, H., Brown, V. B., & Najavits, L. M. (2005). Twelve-month outcomes of trauma-informed interventions for women with co-occurring disorders. *Psychiatric Services, 56*(10), 1213-1222.

Muesser, K. T., Drake, R. E., Turner, W., & McGovern, M. (2006). Comorbid Substance Use Disorders and Psychiatric Disorders. In W. R. Miller & K. Carroll (Eds.), *Rethinking substance abuse : what the science shows, and what we should do about it* (pp. 115-133). New York: Guilford Press.

Murphy, E. L., Bryzman, S. M., Glynn, S. A., Ameti, D. I., Thomson, R. A., Williams, A. E., . . . Nemo, G. J. (2000). Risk factors for hepatitis C virus infection in United States blood donors. NHLBI Retrovirus Epidemiology Donor Study (REDS). *Hepatology, 31*(3), 756-762.

Najavits, L. M., Weiss, R. D., & Shaw, S. R. (1997). The link between substance abuse and posttraumatic stress disorder in women: A research review. *The American Journal on Addictions, 6*(4), 273-283.

Norris, F., & Hamblen, J. (2004). Standardized Self-Report Measures of Civilian Trauma and PTSD. In J. P. Wilson, T. M. Keane & T. Martin (Eds.), *Assessing psychological trauma and PTSD* (pp. 63-102). New York: Guilford Press.

Otto-Salaj, L. L., & Stevenson, L. Y. (2001). Influence of psychiatric diagnoses and symptoms on HIV risk behavior in adults with serious mental illness. *AIDS Read, 11*(4), 197-204, 206-198.

Patton, M. Q. (2008). *Utilization-focused evaluation* (4th ed.). Thousand Oaks: Sage Publications.

Rasmussen, B. (2012). The Effects of Trauma on the Therapist. In S. Ringel & J. R. Bandell (Eds.), *Trauma: Contemporary Directions in Theory, Practice, and Research*. Thousand Oaks: SAGE Publications.

Reilly, D. M. (1992). Drug-abusing families: Intrafamilial dynamics and brief triphasic treatment. In D. M. Reilly (Ed.), *Drug-abusing families: Intrafamilial dynamics and brief triphasic treatment.* (2nd ed., pp. 105-119). Boston: Allyn and Bacon.

Ringel, S., & Brandell, J. R. (2012). *Trauma : contemporary directions in theory, practice, and research*. Thousand Oaks: SAGE Publications.

Rosenberg, L. (2011). Addressing trauma in mental health and substance use treatment. *Journal of Behavioral Health Services & Research, 38*(4), 428-431.

SAMHSA. (2012). 2010-2011 National Survey on Drug Use and Health Model-Based Estimates (50 States and the District of Columbia). from SAMHSA http://www.samhsa.gov/data/NSDUH/2k11State/NSDUHsaeTables2011.pdf

SAMHSA Center for Behavioral Health Statistics and Quality. (2012). Highlights of the 2010 Drug Abuse Warning Network (DAWN) Findings on Drug-Related Emergency Department Visits. Rockville: Substance Abuse and Mental Health Services Administration.

SAMHSA National Center for Trauma-Informed Care. (2013) Retrieved April 9, 2013, from http://www.samhsa.gov/nctic/

Sinha, R., & Easton, C. (1999). Substance abuse and criminality. *Journal of the American Academy of Psychiatry and the Law, 27*(4), 513-526.

Snow, D., & Anderson, C. (2000). Exploring the factors influencing relapse and recovery among drug and alcohol addicted women. *Journal of Psychosocial Nursing and Mental Health Services, 38*(7), 8-19.

Torchalla, I., Nosen, L., Rostam, H., & Allen, P. (2012). Integrated treatment programs for individuals with concurrent substance use disorders and trauma experiences: a systematic review and meta-analysis. *Journal of Substance Abuse Treatment, 42*(1), 65-77.

Toussaint, D. W., VanDeMark, N. R., Bornemann, A., & Graeber, C. J. (2007). Modifications to the trauma recovery and empowerment model (TREM) for substance-abusing women with histories of violence: Outcomes and lessons learned at a Colorado substance abuse treatment center. *Journal of Community Psychology, 35*(7), 879-894.

United States Department of Health and Human Services, H. P. (2013). Substance Abuse. Retrieved January 3, 2014, from http://www.healthypeople.gov/2020/TopicsObjectives2020/overview.aspx?topicid=40).

Wu, N. S., Schairer, L. C., Dellor, E., & Grella, C. (2010). Childhood trauma and health outcomes in adults with comorbid substance abuse and mental health disorders. *Addict Behav, 35*(1), 68-71.

Creating Cultures of Trauma-Informed Care: Program Fidelity Scale Version 1.1 (12-12)
Community Connections, Washington, DC

Introduction to the Draft Fidelity Scale

Several questions have come up in relation to this first draft of the CCTIC Fidelity Scale. Eventually these will be addressed in an introductory instructional guide for the scale. In the meantime, here are some overview considerations:

1) The intent of this instrument is to gauge the extent to which a program or agency has developed a culture of trauma-informed care. By trauma-informed, we mean a culture that incorporates knowledge about trauma—its prevalence, impact, and the complex paths to recovery and healing—into every aspect of the program's contacts, activities, relationships, and physical settings. Safety, trustworthiness, choice, collaboration, and empowerment are the core values of that culture.

2) When scoring a program, we recommend being conservative in deciding whether or not a specific indicator is met. For instance, in #1.d., if some of the signage is missing or unclear or unwelcoming, then the score should indicate that the standard has not been met (even if some of the signs are welcoming and hospitable). This may mean that, especially the first time the fidelity scale is used, the scores may be quite low. That is fine. It simply means there is more room for growth in the program's culture.

3) The codes in the far right hand column are designed to indicate the use of specific sources of information in arriving at a decision about a score (see the meanings of the codes on page three). More than one source may frequently be used to score a particular item. For example, item #2.b. may call for input not only from the staff (STINT), but from the Executive Director or CEO (CEOINT), from consumers (CONSINT), via in-person observation (IPOBS), and possibly from consumer or staff surveys (SURR).

4) The next draft will include a section for a narrative summary of the program's strengths and weaknesses. In the interim, please simply append a list of the three most noticeable strengths and the three areas where most obvious growth is needed.

5) Scoring should be done on a program-specific basis, acknowledging that there are many items that may apply to the larger, multi-program agency or organization. Programs may then be combined to arrive at an organization-wide score.

6) Please send suggestions for clarification or editing to Roger Fallot at rfallot@ccdc1.org. Thank you for using this scale!

 For information: rfallot@ccdc1.org

Creating Cultures of Trauma-Informed Care: Program Fidelity Scale Version 1.1 (12-12)
Community Connections, Washington, DC

Domain 1. Program Procedures and Settings: "To what extent are program activities and settings consistent with five core values of trauma-informed cultures of care: safety, trustworthiness, choice, collaboration, and empowerment?"

Domain 1A. Safety for Consumers and Staff—Ensuring Physical and Emotional Safety: ***"To what extent do the program's activities and settings ensure the physical and emotional safety of consumers and staff members?"***

Criterion/Indicators	1	2	3	4	5	Evidence for Ratings (circle those that apply and indicate letter(s) of indicator(s) for each)
1. Physical Setting: a) The area around the program (sidewalks and parking lots, e.g.) is safe and the program is accessible for both clients and staff. b) The program's entrance area and waiting room is safe and hospitable, offering adequate personal space; exits are clearly marked and accessible; c) If there are security personnel present, they are trained in customer service as well as in maintaining safety; d) The program's signage is clear and welcoming; it directs people to the most frequently used areas (e.g., rest rooms, intake and reception areas); e) The program's décor includes gender-specific images and colors that fit well with the recovery goals of the clients; ideally, some of the art work, paint, and flooring should have been created or selected by a team of consumers; f) The program has designated "quiet spaces" for use by clients and staff who need or want a place of respite; g) Staff offices are safe and/or have appropriate safety back-ups like "panic buttons."	None of the possible indicators is present.	One or two indicators are present.	Three indicators are present.	Four or five indicators are present.	Six or seven indicators are present.	CEOINT CONSINT STINT CRR PDR IPOBS SURR

 For information: rfallot@ccdc1.org

Creating Cultures of Trauma-Informed Care: Program Fidelity Scale Version 1.1 (12-12)
Community Connections, Washington, DC

2. Interpersonal Contacts: a) The program's first contact (by phone or in person) with prospective clients is welcoming and respectful. b) The staff (including the reception staff) are attuned to signs of distress among clients and respond in a gentle, compassionate way. c) In making contact with clients, staff take into account whether clients may be currently exposed to potentially dangerous situations (e.g., domestic violence or living in a shelter); d) Clients are given clear guidelines in advance about what to expect of the program; e) All staff are given clear guidelines in advance about what to expect of the program; supervisors and managers set the tone by offering clear and reassuring messages about the program's tasks and expectations; f) All staff members (including senior administrators) feel supported when they have challenges in their work; "we are all in this together." g) Staff doing work that takes them into areas away from the office feel safe and supported by the program.	None of the possible indicators is present.	One or two indicators are present.	Three indicators are present.	Four or five indicators are present.	Six or seven indicators are present.	CEOINT CONSINT STINT CRR PDR IPOBS SURR

CEOINT=Chief Executive Officer or Clinical Director Interview (or equivalent)
CONSINT=Consumer or Client Interview
STINT=Staff Interview
CRR=Clinical Record Review (or equivalent)
PDR=Policy Document Review
IPOBS=In-Person Observation
SURR=Survey Review (Results of a Formal Consumer or Staff Survey)

 For information: rfallot@ccdc1.org

Creating Cultures of Trauma-Informed Care: Program Fidelity Scale Version 1.1 (12-12)
Community Connections, Washington, DC

Domain 1B. <u>Trustworthiness for Consumers and Staff</u>—Maximizing Trustworthiness through Task Clarity, Consistency, Transparency, and Interpersonal Boundaries: ***"To what extent do the program's activities and settings maximize trustworthiness by making the tasks involved in service delivery clear, by ensuring consistency and transparency in practice, and by maintaining boundaries that are appropriate to the program?"***

Criterion/Indicators	1	2	3	4	5	Evidence for Ratings
a) The program makes it clear who will do what, when and with what goals in mind actions will be taken and who is responsible for these actions—this is true in all aspects of the program's functioning, for both clients and staff. b) The program is transparent in the way it operates; administration and managers share information openly with staff and clients (without violating their own responsibilities regarding confidentiality) c) The program reviews its services with each prospective consumer, based on clear statements of the goals, risks, and benefits of program participation, and obtains informed consent from each consumer; new staff go through a parallel process in which expectations are clarified and responsibilities made clear. d) The program has a clear procedure for the review of any allegations of boundary violations, including sexual harassment and inappropriate social contacts. e) Administrators and supervisors consistently validate the importance of staff support.	None of the possible indicators is present.	One indicator is present.	Two or three indicators are present.	Four indicators are present.	Five indicators are present.	CEOINT CONSINT STINT CRR PDR IPOBS SURR

 For information: rfallot@ccdc1.org

Creating Cultures of Trauma-Informed Care: Program Fidelity Scale Version 1.1 (12-12)
Community Connections, Washington, DC

Domain 1C. Choice for Consumers and Staff —Maximizing Consumer and Staff Choice and Control. ***"To what extent do the program's activities and settings maximize consumer and staff experiences of choice and control?"***

Criterion/Indicators	1	2	3	4	5	Evidence for Ratings
1. Routine Practice: a) Staff review the program's service options (e.g., types of services offered, locations, housing possibilities, choices regarding clinicians—including gender) with each consumer prior to the development of an initial recovery or service plan b) The program routinely asks consumers about how and when they would like to be contacted. c) The program ensures that each service option is as independent of others as possible, so that a consumer's choice about one service does not necessarily affect another. d) The consumer's goals are given the greatest weight in recovery planning. e) Staff members are provided options, when possible, regarding factors that affect their daily work (hours and flex-time; timing of leave; décor of office; trainings offered). f) The program offers a balance between autonomy and clear guidelines for staff members' work responsibilities; it is alert for ways to maximize staff choice regarding how they meet their job requirements.	None of the possible indicators is present.	One indicator is present.	Two or three indicators are present.	Four indicators are present.	Five or six indicators are present.	CEOINT CONSINT STINT CRR PDR IPOBS SURR
2. Crisis Preferences: a) The consumer collaborates in developing a plan (e.g., Wellness Recovery Action Plan and/or a crisis/safety plan) that indicates the consumer's preferred options, including responses from staff, in crisis situations. b) The program consistently takes into account these preferences in responding to client crises.	Neither of the indicators is present.		One of the indicators is present.		Both of the indicators are present.	CEOINT CONSINT STINT CRR PDR IPOBS SURR

Creating Cultures of Trauma-Informed Care: Program Fidelity Scale Version 1.1 (12-12)
Community Connections, Washington, DC

Domain 1D. Collaboration for Consumers and Staff —Maximizing Collaboration and Sharing Power: ***"To what extent do the program's activities and settings maximize collaboration and sharing of power between staff and consumers? Between staff and supervisors and administrators?"***

Criterion/Indicators	1	2	3	4	5	Evidence for Ratings
a) The program has a routine and effective way of gathering consumer opinions about the program's direction and operations; weighs consumers' opinions in their decision-making; and communicates clearly with consumers the process of decision-making. Alternatives include a Consumer Advisory Board, regularly used focus groups, suggestion boxes, etc. b) The program has a routine and effective way of gathering staff opinions about the program's direction and operations; weighs staff opinions in their decision-making; and communicates clearly with staff the process of decision-making. All staff are included in any major change process, including support staff. c) The program cultivates a model of doing things "with" rather than "to" or "for" consumers. d) The program creates ways to engage consumers as partners in plans for the recovery support services they need and want.	None of the possible indicators is present.	One indicator is present.	Two indicators are present.	Three indicators are present.	Four indicators are present.	CEOINT CONSINT STINT CRR PDR IPOBS SURR

Creating Cultures of Trauma-Informed Care: Program Fidelity Scale Version 1.1 (12-12)
Community Connections, Washington, DC

Domain 1E. Empowerment for Consumers and Staff—Prioritizing Empowerment and Skill-Building: ***"To what extent do the program's activities and settings prioritize consumer and staff empowerment and growth?"***

Criterion/Indicators	1	2	3	4	5	Evidence for Ratings
a) The program routine recognizes consumer strengths and skills in the planning, implementation, and evaluation of its services. b) The program routine recognizes all staff members' strengths and skills in the planning, implementation, and evaluation of its services. c) In each formal activity, the program helps to develop or enhance consumer skills explicitly. d) In each contact, the consumer feels validated and affirmed. e) The program offers training designed to strengthen or develop specific skills needed by staff in order to perform their jobs well. f) The program emphasizes shared accountability and responsibility throughout its hierarchy (in contrast to blaming the person with the least power).	None of the possible indicators is present.	One indicator is present.	Two or three indicators are present.	Four indicators are present.	Five or six indicators are present.	CEOINT CONSINT STINT CRR PDR IPOBS SURR

 For information: rfallot@ccdc1.org

Creating Cultures of Trauma-Informed Care: Program Fidelity Scale Version 1.1 (12-12)
Community Connections, Washington, DC

Domain 2. Formal Service Policies: ***"To what extent do the formal policies and procedures of the program reflect an understanding of trauma and recovery?"***

Criterion/Indicators	1	2	3	4	5	Evidence for Ratings
a) The program has developed written policies that seek to eliminate involuntary or coercive practices (seclusion and restraint, involuntary hospitalization or medication, outpatient commitment). For those programs whose clients are "mandated" to treatment, efforts are made to maximize the realistic choices enrollees have. These efforts are part of the program's written policies. b) The program has a written de-escalation policy that minimizes possibility of retraumatization; the policy includes reference to a consumer's statement of preference for crisis response. c) The program's policies regarding confidentiality (including limits and mandated reporting) and access to information are clearly written, maximize legal protection of privacy, and are communicated to each consumer. e) The program has clearly written and easily accessible policies outlining consumer and staff rights and responsibilities as well as a grievance policy. f) The program's policies address issues related to staff safety, e.g., community visits, being alone in an area of the building, incident reviews reduce staff vulnerability g)) The program's policies address the need for debriefing after critical incidents, Both staff and clients involved in the incident are also engaged in the debriefing, which has as its goal an understanding and preventive approach (in contrast to a blaming one).. h) All services take contextual factors into account in understanding the individual (e.g., gender and culture).	None of the possible indicators is present.	One or two indicators are present.	Three or four indicators are present.	Five or six indicators are present.	Seven or eight indicators are present.	CEOINT CONSINT STINT CRR PDR IPOBS SURR

 For information: rfallot@ccdc1.org

Creating Cultures of Trauma-Informed Care: Program Fidelity Scale Version 1.1 (12-12)
Community Connections, Washington, DC

Domain 3. Trauma and Gender Screening, Assessment, Service Planning and Trauma-Specific Services: ***"To what extent does the program have a consistent way to identify individuals who have been exposed to trauma and to include trauma-related information in planning services with the consumer? To what extent are trauma-specific services readily available?"***

Criterion/Indicators	1	2	3	4	5	Evidence for Ratings
1. Screening, Assessment, and Service Planning: a) Universal Trauma Screening. Within the first month of service participation, every consumer has been asked about exposure to trauma. b) The trauma screening includes questions about lifetime exposure to sexual, physical, and emotional abuse. c) The trauma screening is implemented in ways that minimize consumer stress; it reflects considerations given to gender of interviewer, timing, setting, relationship to interviewer, consumer choice about answering, and unnecessary repetition. d) Unless specifically contraindicated due to consumer distress, the program conducts a more extensive assessment of trauma history and needs and preferences for trauma-specific services for those consumers who report trauma exposure. e) Recovery planning is conducted in an individualized, person-centered way.	None of the possible indicators is present.	One indicator is present.	Two or three indicators are present.	Four indicators are present.	Five indicators are present.	CEOINT CONSINT STINT CRR PDR IPOBS SURR

 For information: rfallot@ccdc1.org

Creating Cultures of Trauma-Informed Care: Program Fidelity Scale Version 1.1 (12-12)
Community Connections, Washington, DC

Criterion/Indicators	1	2	3	4	5	Evidence for Ratings
2. Trauma-Specific, Gender-Specific Services: a) The program ensures that those individuals who report the need and/or desire for trauma-specific (TS) services are either offered them on-site or referred for appropriately matched services. b) Trauma-specific group services provided by the program are offered entirely in gender-specific groups. c) TS services are effective; they have an evidence base for the population being served. d) TS services are accessible. People can get to them easily and they are offered at times that meet the members' needs. e) TS services are affordable for the members. f) TS services, in style and content, are responsive to the preferences of the program's consumers.	None of the possible indicators is present.	One indicator is present.	Two or three indicators are present.	Four indicators are present.	Five or six indicators are present.	CEOINT CONSINT STINT CRR PDR IPOBS SURR

Creating Cultures of Trauma-Informed Care: Program Fidelity Scale Version 1.1 (12-12)
Community Connections, Washington, DC

Domain 4. Administrative Support for Program-Wide Trauma-Informed Services: ***"To what extent do agency administrators support the integration of knowledge about trauma and recovery into all program practices?"***

Criterion/Indicators	1	2	3	4	5	Evidence for Ratings
1. Overall Administrative Support: a) The program has adopted a formal policy or mission statement that refers to the importance of trauma and the need to account for consumers' experiences of trauma in all aspects of program operation. b) The program has a clear philosophy, reflected in its day-to-day operations, that takes trauma into account. The philosophy is reflected in written materials as well as in informal practices. c) The program has named a trauma specialist ("champion") and workgroup(s) to lead agency activities in trauma-related areas and provides needed support for these initiatives. d) The group reflects the composition of the staff and people in recovery in terms of gender, race, and cultural background. All constituencies in the program are represented on the workgroup. e) Program administrators monitor and participate actively in responding to the recommendations and activities of the trauma leadership.	None of the possible indicators is present.	One indicator is present.	Two or three indicators are present.	Four indicators are present.	Five indicators are present.	CEOINT CONSINT STINT CRR PDR IPOBS SURR
Criterion/Indicators	**1**	**2**	**3**	**4**	**5**	**Evidence for Ratings**
2. Services Offered by the Program: a) The program offers simultaneous, integrated services for mental health, substance abuse, and trauma. b) The program uses peer role models and mentors, who are also people in recovery. c) The program makes available, on site or by referral, primary care, spiritual, employment, and parenting services. d) The program offers child care or helps make arrangements for such care for parents who need it.	None of the possible indicators is present.	One indicator is present.	Two indicators are present.	Three indicators are present.	Four indicators are present.	CEOINT CONSINT STINT CRR PDR IPOBS SURR

 For information: rfallot@ccdc1.org

Creating Cultures of Trauma-Informed Care: Program Fidelity Scale Version 1.1 (12-12)
Community Connections, Washington, DC

Criterion/Indicators	1	2	3	4	5	Evidence for Ratings
3. Trauma Survivor/Person in Recovery Involvement: a) Administrators actively solicit the opinions of people in recovery who have had experiences of trauma. By membership on a Consumer Advisory Board (CAB), by focus groups, by individual interviews, and/or by suggestion boxes, people in recovery can have their voices heard .b) People in recovery who have had lived experiences of trauma are actively involved in all aspects of program planning and oversight.	Neither of the indicators is present.		One of the indicators is present.		Both of the indicators are present.	CEOINT CONSINT STINT CRR PDR IPOBS SURR
Criterion/Indicators	**1**	**2**	**3**	**4**	**5**	**Evidence for Ratings**
4. Program Data-Gathering and Program Evaluation: a) Program gathers data addressing the needs and strengths of consumers who are trauma survivors and evaluates the effectiveness of the program and trauma-specific services. b) Administrators include at least five key values of trauma-informed cultures in consumer satisfaction surveys: safety, trustworthiness, choice, collaboration, and empowerment. c) Administrators include at least five key values of trauma-informed cultures in staff satisfaction surveys: safety, trustworthiness, choice, collaboration, and empowerment. d) Results of both the consumer and staff surveys are consistent with a trauma-informed culture. All ten of the key values ratings are at the "agree" or higher level on the rating scale.	None of the possible indicators is present.	One indicator is present.	Two indicators are present.	Three indicators are present.	Four indicators are present.	CEOINT CONSINT STINT CRR PDR IPOBS SURR

For information: rfallot@ccdc1.org

Creating Cultures of Trauma-Informed Care: Program Fidelity Scale Version 1.1 (12-12)
Community Connections, Washington, DC

Domain 5. Staff Trauma Training, Education, and Support: ***"To what extent have all staff members received appropriate training in trauma and its implications for their work? Have adequate support for coping with the stressors of their work?"***

Criterion/Indicators	1	2	3	4	5	Evidence for Ratings
a) All staff (including administrative and support personnel) have participated in at least 2.5 hours of "basic" trauma education that addresses at least the following: 1) trauma prevalence, impact, and recovery; 2) ensuring safety and avoiding retraumatization; 3) maximizing trustworthiness (clear tasks and boundaries); 4) enhancing consumer choice; 5) maximizing collaboration; 6) emphasizing empowerment. b) All staff have participated in at least 2.5 hours of education addressing the necessity of staff support and care in a trauma-informed context. c) All new staff receive at least one hour of trauma education as part of orientation. d) Direct service staff have received at least three hours of education involving trauma-specific techniques (e.g., grounding, teaching trauma recovery skills). e) All staff are provided adequate resources for self-care, including supervision, consultation, and/or peer support that addresses secondary traumatization.	None of the possible indicators is present.	One indicator is present.	Two or three indicators are present.	Four indicators are present.	Five indicators are present.	CEOINT CONSINT STINT CRR PDR IPOBS SURR

Creating Cultures of Trauma-Informed Care: Program Fidelity Scale Version 1.1 (12-12)
Community Connections, Washington, DC

Domain 6. Human Resources Practices: ***"To what extent are trauma-related considerations part of the hiring and performance review process?"***

Criterion/Indicators	1	2	3	4	5	Evidence for Ratings
a). Prospective staff interviews include trauma-related questions. (What do applicants know about trauma, including sexual, physical, and emotional abuse? About its impact? About recovery and healing? Is there a "blaming the victim" bias? Is there potential to be a trauma "champion?") b) Staff performance reviews include trauma-informed, skills and tasks, including the development of safe, trustworthy, collaborative, and empowering relationships with consumers that maximize consumer choice.. c) The program routinely assesses staff members' knowledge of trauma relevant for the program's goals (see content in Domain 5). This may be done following educational events or as part of performance reviews or in ongoing supervision. d) The program has a consistent way to recognize outstanding performance among staff.	None of the possible indicators is present.	One indicator is present.	Two indicators are present.	Three indicators are present.	Four indicators are present.	CEOINT CONSINT STINT CRR PDR IPOBS SURR

Creating Cultures of Trauma-Informed Care: Program Fidelity Scale Version 1.1 (12-12)
Community Connections, Washington, DC

Agency/Program _____ **Date** _____

Person(s) Completing Scale:_____

Domain 1. Program Procedures and Settings

1A.1.	**# of indicators**_____	**Rating.** _____
1.A.2.	**# of indicators**_____	**Rating.** _____
1B.	**# of indicators**_____	**Rating.** _____
1C.1.	**# of indicators**_____	**Rating.** _____
1C.2.	**# of indicators**_____	**Rating.** _____
1D.	**# of indicators**_____	**Rating.** _____
1E.	**# of indicators**_____	**Rating.** _____
Domain 1 Subtotal	**# of indicators**_____	**Rating.** _____

Domain 2. Formal Services Policies

Domain 2 Subtotal	**# of indicators**_____	**Rating.** _____

Domain 3: Trauma and Gender Screening, Assessment, and Service Planning

1.	**# of indicators**_____	**Rating.** _____
2.	**# of indicators**_____	**Rating.** _____
Domain 3 Subtotal	**# of indicators**_____	**Rating.** _____

Domain 4: Administrative Support for Program-Wide Trauma-Informed, Gender-Responsive Services

1.	**# of indicators**_____	**Rating.** _____
2.	**# of indicators**_____	**Rating.** _____
3.	**# of indicators**_____	**Rating.** _____
4.	**# of indicators**_____	**Rating.** _____
Domain 4 Subtotal	**# of indicators**_____	**Rating.** _____

Domain 5: Staff Trauma and Gender Training and Education

Domain 5 Subtotal	**# of indicators**_____	**Rating.** _____

Domain 6: Human Resources Practices

Domain 6 Subtotal	**# of indicators**_____	**Rating.** _____

Grand Total of Ratings_____**÷ 16 = Overall Mean of** _____

Interpretive ranges for overall mean*: 1.00-2.00 = *Beginning the trauma-informed, gender-responsive process;* 2.00-3.00 = *Not very trauma-informed or gender-responsive;* 3.00-4.00 = *Somewhat trauma-informed and gender-responsive;* 4.00-5.00 = *Very trauma-informed and gender-responsive;* 5.00 = *Fully trauma-informed and gender-responsive.

Grand Total of Indicators _____

 For information: rfallot@ccdc1.org

Appendix B: CCTIC Self-Assessment and Planning Protocol

Creating Cultures of Trauma-Informed Care (CCTIC):
A Self-Assessment and Planning Protocol

Roger D. Fallot, Ph.D. and Maxine Harris, Ph.D.

November, 2011

Over the past fifteen years, there has been growing acknowledgement of several interrelated facts concerning the prevalence and impact of trauma in the lives of people in contact with various human service systems. We advocate for trauma-informed service approaches for a number of reasons.

•**Trauma is pervasive.** National community-based surveys find that between 55 and 90% of us have experienced at least one traumatic event. And individuals report, on average, that they have experienced nearly five traumatic events in their lifetimes. The experience of trauma is not the rare exception we once considered it. It is part and parcel of our social reality.

•**The impact of trauma is very broad and touches many life domains.** Trauma exposure increases the risk of a tremendous range of vulnerabilities: mental health problems like posttraumatic stress disorder, depression, excessive hostility, and generalized anxiety; substance abuse; physical health problems; interpersonal struggles; eating disorders; and suicidality, among many others. Trauma thus touches many areas of life not obviously or readily connected with the experience of trauma itself. This broad impact makes it particularly important to understand the less evident links between trauma and its sequelae.

•**The impact of trauma is often deep and life-shaping.** Trauma can be fundamentally life-altering, especially for those individuals who have faced repeated and prolonged abuse and especially when the violence is perpetrated by those who were supposed to be caretakers. Physical, sexual, and emotional violence become central realities around which profound neurobiological and psychosocial adaptations occur. Survivors may come to see themselves as fundamentally flawed and to perceive the world as a pervasively dangerous place. Trauma may shape a person's way of being in the world; it can deflate the spirit and trample the soul.

•**Violent trauma is often self-perpetuating.** Individuals who are victims of violence are at increased risk of becoming perpetrators themselves. The intergenerational transmission of violence is well documented. Community violence is often built around cycles of retaliation.

Many of our institutions—criminal justice settings, certainly, but also schools and churches and hospitals—are too frequently places where violent trauma is perpetuated rather than eliminated.

•**Trauma is insidious and preys particularly on the more vulnerable among us.** People who are poor, who are homeless, who have been diagnosed with severe mental health problems, who are addicted to drugs, or who have developmental disabilities—all of these groups are at increased risk of violent victimization.

•**Trauma affects the way people approach potentially helpful relationships.** Not surprisingly, those individuals with histories of abuse are often reluctant to engage in, or quickly drop out of, many human services. Being vigilant and suspicious are often important and thoroughly understandable self-protective mechanisms in coping with trauma exposure. But these same ways of coping may make it more difficult for survivors to feel the safety and trust necessary to helpful relationships.

•**Trauma has often occurred in the service context itself.** Involuntary and physically coercive practices, as well as other activities that trigger trauma-related reactions, are still too common in our centers of help and care.

•**Trauma affects staff members as well as consumers in human services programs.** Stressors deeply affect administrators, clinicians, and support staff working in human services. Not only is "secondary" or "vicarious" traumatization common but direct threats to physical and emotional safety are also frequent concerns. Being asked to do "more and more with less and less" becomes a pervasive theme underlying work experiences that may threaten to overwhelm coping abilities.

Growing awareness of these facts regarding trauma has led to calls for the development of both trauma-informed and trauma-specific services. Human service systems become **trauma-informed** by thoroughly incorporating, in all aspects of service delivery, an understanding of the prevalence and impact of trauma and the complex paths to healing and recovery. Trauma-informed services are designed specifically to avoid retraumatizing those who come seeking assistance as well as staff working in service settings. These services seek "safety first" and commit themselves to "do no harm." The SAMHSA-funded Women, Co-Occurring Disorders, and Violence Study (1998-2003) has provided evidence that trauma-informed approaches can enhance the effectiveness of mental health and substance abuse services. By contrast, **trauma-specific services** have a more focused primary task: to directly address trauma and its impact and to facilitate trauma recovery. An increasing number of promising and evidence-based practices address PTSD and other consequences of trauma, especially for people who often bring other complicating vulnerabilities (e.g., substance use, severe mental health problems, homelessness, contact with the criminal justice system) to the service setting.

This Self-Assessment and Planning Protocol and its accompanying CCTIC Program Self-Assessment Scale attempt to provide clear, consistent guidelines for agencies or programs interested in facilitating trauma-informed modifications in their service systems. It is a tool for administrators, providers, and survivor-consumers to use in the development, implementation, evaluation, and ongoing monitoring of trauma-informed programs.

Overview of the Change Process, Protocol, and Scale

Culture Change in Human Service Programs

The Creating Cultures of Trauma-Informed Care approach to organizational change is built on five core values of **safety, trustworthiness, choice, collaboration, and empowerment**. If a program can say that its **culture** reflects each of these values in each *contact*, *physical setting*, *relationship*, and *activity* and that this culture is evident in the experiences of staff as well as consumers, then the program's culture is trauma-informed.

We emphasize organizational culture because it represents the most inclusive and general level of an agency or program's fundamental approach to its work. Organizational culture reflects what a program considers important and unimportant, what warrants attention, how it understands the people it serves and the people who serve them, and how it puts these understandings into daily practice. In short, culture expresses the basic values of a program. Culture thus extends well beyond the introduction of new services or the training of a particular subset of staff members; it is pervasive, including all aspects of an agency's functioning.

In order to accomplish this culture change, we strongly recommend several steps:

1) Initial Planning. In this phase, the program considers the importance of, and weighs its commitment to, a trauma-informed change process. The following elements are key to the successful planning of organizational trauma-informed change: a) administrative commitment to and support of the initiative (see Domain 4 below); b) the formation of a trauma initiative workgroup to lead and oversee the change process; c) the full representation of each significant stakeholder group on the workgroup—administrators, supervisors, direct service staff, support staff, and consumers; d) identification of trauma "champions" to keep the initiative alive and "on the front burner;" e) programmatic awareness of the scope (the entire agency and its culture) and timeline (usually up to two years) of the culture shift.

Discussions of trauma-informed program modifications constitute an opportunity to involve all key groups in the review and planning process. In our experience, the more inclusive and fully representative these discussions are, the more effective and substantial the resulting changes.

2) A Kickoff Training Event. Usually two days long, the kickoff training is attended by as many of the staff as practical and includes significant consumer representation; it certainly includes all members of the trauma initiative workgroup. During this event, there are at least three presentations. In the first, central ideas of trauma-informed cultures are presented, emphasizing shifts in both understanding and in practice. Second, the importance of staff support and care is emphasized, ensuring that staff members experience the same values in the organizational culture that consumers need to experience. Finally, a third presentation addresses the importance of trauma in the work of the specific agency (e.g., trauma and substance use, trauma and children or youth, trauma and mental health problems). There is also a great deal of time for the workgroup members and other attendees to discuss the planning process in more detail and to conduct preliminary conversations that will mirror those to be held in the larger

agency after the kickoff. The goal of the kickoff is to motivate and energize the change process while simultaneously providing a beginning sense of direction. The kickoff ends with discussion of next steps in the implementation of this change initiative.

3) Short-term Follow-up. Over the next several months, the agency takes the ideas from the training and applies them in more detail, using this Self-Assessment and Planning Protocol. First, the workgroup develops an Implementation Plan for review by the rest of the administration, staff, and consumers, as well as by outside consultants with experience in facilitating agency change. Community Connections consultants, for example, provide detailed feedback on Implementation Plans; discuss any barriers as they arise; and assist in developing strategies to overcome these obstacles. Community Connections staff offer this consultation on site or by written or telephone discussions.

Simultaneously, two educational events are scheduled for <u>all</u> staff. The first is on "Understanding Trauma" or "Trauma 101." This training is designed to discuss the prevalence and impact of trauma as well as some of the multiple paths to recovery, emphasizing the ways in which trauma may be seen in the lives of consumers and in the work experience of staff. The second training focuses more directly on "Staff Support and Care," emphasizing that a culture shift toward a trauma-informed system of care rests on staff members' experiences of safety, trustworthiness, choice, collaboration, and empowerment. Ideally, these training events are offered by experienced trainers who are also able and willing to encourage and teach staff members to become trainers themselves. In this way, as the program is able, its own trainers become equipped to pass along the important information about trauma to newer or untrained staff.

4) Longer-term Follow-up. After about six-nine months, Community Connections consultants revisit the program site to meet with the workgroup and selected others, in order to review and discuss progress to date. At that time, ongoing processes may be put in place to sustain the initiative to its conclusion. Depending on the program's needs and interests, consultants may return for additional site visits until the trauma-informed care initiative is firmly established in the agency culture. Sustainability is obviously a key factor in this transformation and programs have a range of choices about the best ways to maintain a trauma-informed culture. For example, many agencies build trauma-informed questions into their Consumer Satisfaction Survey (or use a specially developed survey to capture the five core values for consumers and staff). Many add the Implementation Plans to the quality assurance or improvement process. Still others, in larger systems, discuss ways to build in consultation to their own and other agencies through a "train the consultant" approach. The most important goal in this phase is to maintain the momentum established after the kickoff training until the culture change is thoroughgoing. In our experience, this process may take from two to five years.

The CCTIC Self-Assessment and Planning Protocol

The Self-Assessment and Planning Protocol is divided into six domains; they address both services-level and administrative or systems-level changes. In each domain, there are guiding questions for a collaborative discussion by a comprehensive workgroup of a program's activities and physical settings, followed by a list of more specific questions and/or possible indicators of a trauma-informed approach. Many of these questions and indicators are drawn from the experiences of human service agencies that have previously engaged in this self-assessment.

Part A: Services-level Changes

Domain 1. Program Procedures and Settings: "To what extent are program activities and settings consistent with five guiding principles of trauma-informed practice: safety, trustworthiness, choice, collaboration, and empowerment?"

This section of the protocol can be used to assess the extent to which formal and informal procedures and the physical environment in a human services program are trauma-informed and to plan corresponding modifications in service delivery practices. Consumer-survivors should be actively involved in the review process as should support staff, direct service staff, supervisors, and administrators.

Step One: Identify Key Formal and Informal Activities and Settings

The goal of Step One is to gain a comprehensive sense of the experiences of both consumers and staff members as they come to the setting and participate in its activities, relationships, and physical settings. The goal of this review is to capture for each of these groups—consumer and staff—their experiences *in detail* from their very first to their very last contact with the program or agency. Though some programs accomplish this effectively by forming a representative workgroup to review the full range of contacts, others have found it very helpful to engage in a "walk-through." A walk-through is a process in which staff members come to the setting "as if" they are new consumers and thus enter the setting with a consumer-oriented perspective. For more details about one way to conduct such a walk-through, see the NIATx website: www.niatx.net. Sites routinely begin by focusing on the experiences of consumers and then repeat the process for staff members.

A. List the sequence of service ***activities*** in which new consumers are usually involved (e.g., outreach, intake, assessment, service planning). Think broadly to include informal as well as formal contacts. For example, consumers may be greeted and given directions by a number of people prior to formal service delivery.

B. Identify the ***staff members*** (positions and individuals) who have contact with consumers at each point in this process.

C. Identify the ***settings*** in which the various activities are likely to take place (e.g., home, waiting room, telephone, office, institution).

Step Two: Ask Key Questions about Each of the Activities and Settings

(See list of questions for Domains 1A-1J following Step Four)

Step Three: Prioritize Goals for Change

After the workgroup has reviewed services and has developed a list of possible trauma-informed changes in service delivery procedures, these goals for change should be prioritized. Among the factors to consider in this prioritizing are the following: (1) feasibility (which goals are most likely to be accomplished because of their scale and the kind of change involved?); (2) resources (which goals are most consistent with the financial, personal, and other resources available?); (3) system support (which goals have the most influential and widespread support?); (4) breadth of impact (which goals are most likely to have a broad impact on services?); (5) quality of impact (which goals will make the most difference in the lives of consumers?); (6) risks and costs of not changing (which practices, if not changed, will have the most negative impact?).

Step Four: Identify Specific Objectives and Responsible Persons

After goals have been prioritized, specific objectives (measurable outcomes with timelines for achievement) can be stated and persons responsible for implementing and monitoring the corresponding tasks can be named. These objectives are incorporated into the program's Implementation Plan.

Domain 1A. Safety—Ensuring Physical and Emotional Safety

♦ ***Key Questions: "To what extent do the program's activities and settings ensure the physical and emotional safety of consumers? How can services be modified to ensure this safety more effectively and consistently?"***

Sample Specific Questions:

- How safe is the area around the program's building? Are sidewalks and parking areas well-lit? How far do consumers need to walk to get to the building or program entrance? Is this walk a safe one?
- Are directions to the program's location readily available? Are they clear?
- Once a consumer arrives, are directions to the receptionist or other offices clear?
- Where are services delivered? In the office, institution, home, or community? What safety considerations are important in the location of various services?
- When are they delivered? Are there services available in addition to usual office hours? If so, what safety considerations are important in the timing of various services?
- Who is present (other consumers, etc.)? Are security personnel present? What impact do these others have?
- What signs and other visual materials are there? Are they welcoming? Clear? Legible?
- Are doors locked or open? Are there easily accessible exits?

•How would you describe the reception and waiting areas, interview rooms, etc.? Are they comfortable and inviting?
•Are restrooms easily accessible? Are there signs indicating their location?
•Are the first contacts with consumers welcoming, respectful, and engaging?
•Do consumers receive clear explanations and information about each task and procedure? Are the rationales made explicit? Is the program mission explained? Are specific goals and objectives made clear? Does each contact conclude with information about what comes next?
•Are staff attentive to signs of consumer discomfort or unease? Do they understand these signs in a trauma-informed way?
•What events have occurred that indicate a lack of safety—physically or emotionally (e.g., arguments, conflicts, assaults)? What triggered these incidents? What alternatives could be put in place to minimize the likelihood of their recurrence?
•Is there adequate personal space for individual consumers?
•In making contact with consumers, is there sensitivity to potentially unsafe situations (e.g., domestic violence)?

Domain 1B. Trustworthiness—Maximizing Trustworthiness through Task Clarity, Consistency, and Interpersonal Boundaries

♦ ***Key Questions: "To what extent do the program's activities and settings maximize trustworthiness by making the tasks involved in service delivery clear, by ensuring consistency in practice, and by maintaining boundaries that are appropriate to the program? How can services be modified to ensure that tasks and boundaries are established and maintained clearly and appropriately? How can the program maximize honesty and transparency?"***

Sample Specific Questions:

•Does the program provide clear information about what will be done, by whom, when, why, under what circumstances, at what cost, with what goals?
•When, if at all, do boundaries veer from those of the respectful professional? Are there pulls toward more friendly (personal information sharing, touching, exchanging home phone numbers, contacts outside professional appointments, loaning money, etc.) and less professional contacts in this setting?
•How does the program handle dilemmas between role clarity and accomplishing multiple tasks (e.g., especially in residential work and counseling or case management, there are significant possibilities for more personal and less professional relationships)?
•How does the program communicate reasonable expectations regarding the completion of particular tasks or the receipt of services? Is the information realistic about the program's lack of control in certain circumstances (e.g., in housing renovation or time to receive entitlements)? Is unnecessary consumer disappointment avoided?
•What is involved in the informed consent process? Is both the information provided and the consent obtained taken seriously? That is, are the goals, risks, and benefits clearly outlined and does the consumer have a genuine choice to withhold consent or give partial consent?

Domain 1C. Choice—Maximizing Consumer Choice and Control.

♦ ***Key Questions: "To what extent do the program's activities and settings maximize consumer experiences of choice and control? How can services be modified to ensure that consumer experiences of choice and control are maximized?"***

Sample Specific Questions:

•How much choice does each consumer have over what services he or she receives? Over when, where, and by whom the service is provided (e.g., time of day or week, office vs. home vs. other locale, gender of provider)?
•Does the consumer choose how contact is made (e.g., by phone, mail, to home or other address)?
•Does the program build in small choices that make a difference to consumer-survivors (e.g., When would you like me to call? Is this the best number for you? Is there some other way you would like me to reach you or would you prefer to get in touch with me?)
•How much control does the consumer have over starting and stopping services (both overall service involvement and specific service times and dates)?
•Is each consumer informed about the choices and options available?
•To what extent are the individual consumer's priorities given weight in terms of services received and goals established?
•How many services are contingent on participating in other services? Do consumers get the message that they have to "prove" themselves in order to "earn" other services?
•Do consumers get a clear and appropriate message about their rights and responsibilities? Does the program communicate that its services are a privilege over which the consumer has little control?
•Are there negative consequences for exercising particular choices? Are these necessary or arbitrary consequences?
•Does the consumer have choices about who attends various meetings? Are support persons permitted to join planning and other appropriate meetings?

Domain 1D. Collaboration—Maximizing Collaboration and Sharing Power

♦ ***Key Questions: "To what extent do the program's activities and settings maximize collaboration and sharing of power between staff and consumers? How can services be modified to ensure that collaboration and power-sharing are maximized?"***

Sample Specific Questions:

•Do consumers have a significant role in planning and evaluating the agency's services? How is this "built in" to the agency's activities? Is there a Consumer Advisory Board? Are there members who identify themselves as trauma survivors? Do these individuals understand part of their role to serve as consumer advocates? As trauma educators?

•Do providers communicate respect for the consumer's life experiences and history, allowing the consumer to place them in context (recognizing consumer strengths and skills)?
•In service planning, goal setting, and the development of priorities, are consumer preferences given substantial weight?
•Are consumers involved as frequently as feasible in service planning meetings? Are their priorities elicited and then validated in formulating the plan?
•Does the program cultivate a model of doing "with" rather than "to" or "for" consumers?
•Does the program and its providers communicate a conviction that the consumer is the ultimate expert on her or his own experience?
•Do providers identify tasks on which both they and consumers can work simultaneously (e.g., information-gathering)?

Domain 1E. Empowerment—Prioritizing Empowerment and Skill-Building

♦ ***Key Questions: "To what extent do the program's activities and settings prioritize consumer empowerment and skill-building? How can services be modified to ensure that experiences of empowerment and the development or enhancement of consumer skills are maximized?"***

Sample Specific Questions:

•Do consumer-survivor advocates have significant advisory voice in the planning and evaluation of services?
•In routine service provision, how are each consumer's strengths and skills recognized?
•Does the program communicate a sense of realistic optimism about the capacity of consumers to reach their goals?
•Does the program emphasize consumer growth more than maintenance or stability?
•Does the program foster the involvement of consumers in key roles wherever possible (e.g., in planning, implementation, or evaluation of services)?
•For each contact, how can the consumer feel validated and affirmed?
•How can each contact or service be focused on skill-development or enhancement?
•Does each contact aim at two endpoints whenever possible: (1) accomplishing the given task and (2) skill-building on the part of the consumer?

Domain 1F. Safety for Staff—Ensuring Physical and Emotional Safety

♦ ***Key Questions: "To what extent do the program's activities and settings ensure the physical and emotional safety of staff members? How can services be modified to ensure this safety more effectively and consistently?"***

Sample Specific Questions:

- Do staff members feel physically safe? Do staff members provide services in areas other than the office? If so, what safety considerations are important?

- Do staff members feel emotionally safe? In relationships with administrators and supervisors, do staff members feel supported?
- Is the physical environment safe–with accessible exits, readily contacted assistance if it is needed, enough space for people to be comfortable, and adequate privacy?
- Do staff members feel comfortable bringing their clinical concerns, vulnerabilities, and emotional responses to client care to team meetings, supervision sessions or a supervisor?
- Does the program attend to the emotional safety needs of support staff as well as those of clinicians?

Domain 1G. Trustworthiness for Staff—Maximizing Trustworthiness through Task Clarity, Consistency, and Interpersonal Boundaries

♦ ***Key Questions: "To what extent do the program's activities and settings maximize trustworthiness by making the tasks involved in service delivery clear, by ensuring consistency in practice, and by maintaining boundaries that are appropriate to the program? How can services and work tasks be modified to ensure that tasks and boundaries are established and maintained clearly and appropriately? How can the program maximize honesty and transparency?"***

Sample Specific Questions:

- Do program directors and clinical supervisors have an understanding of the work of direct care staff? Is there an understanding of the emotional impact (burnout, vicarious trauma, compassion fatigue) of direct care? How is this understanding communicated?
- Is self-care encouraged and supported with policy and practice?
- Do all staff members receive clinical supervision that attends to both consumer and clinician concerns in the context of the clinical relationship? Is this supervision clearly separated from administrative supervision that focuses on such issues as paperwork and billing?
- Do program directors and supervisors make their expectations of staff clear? Are these consistent and fair for all staff positions, including support staff?
- Do program directors and supervisors make the program's mission, goals, and objectives clear?
- Do program directors and supervisors make specific plans for program implementation and changes clear? Is there consistent follow through on announced plans? Or, in the event of changed plans, are these announced and reasons for changes explained?
- Can supervisors and administrators be trusted to listen respectfully to supervisees' concerns—even if they don't agree with some of the possible implications?

Domain 1H. Choice for Staff—Maximizing Staff Choice and Control.

♦ ***Key Questions: "To what extent do the program's activities and settings maximize staff experiences of choice and control? How can services and work tasks be modified***

to ensure that staff experiences of choice and control are maximized, especially in the way that staff members' work goals are met?"

Sample Specific Questions:

- Is there a balance of autonomy and clear guidelines in performing job duties? Is there attention paid to ways in which staff members can make choices in how they meet job requirements?
- When possible, are staff members given the opportunity to have meaningful input into factors affecting their work: size and diversity of caseload, hours and flex-time, when to take vacation or other leave, kinds of training that are offered, approaches to clinical care, location and décor of office space?

Domain 1I. Collaboration for Staff—Maximizing Collaboration and Sharing Power

♦ ***Key Questions: "To what extent do the program's activities and settings maximize collaboration and sharing of power among staff, supervisors, and administrators (as well as consumers)? How can services be modified to ensure that collaboration and power-sharing are maximized?"***

Sample Specific Questions:

- Does the agency have a thoughtful and planned response to implementing change that encourages collaboration among staff at all levels, including support staff?
- Are staff members encouraged to provide suggestions, feedback, and ideas to their team and the larger agency? Is there a formal and structured way that program administrators solicit staff members' input?
- Do program directors and supervisors communicate that staff members' opinions are valued even if they are not always implemented?

Domain 1J. Empowerment for Staff—Prioritizing Empowerment and Skill-Building

♦ ***Key Questions: "To what extent do the program's activities and settings prioritize staff empowerment and skill-building? How can services be modified to ensure that experiences of empowerment and the development or enhancement of staff skills are maximized? How can the program ensure that staff members have the resources necessary to do their jobs well?"***

Sample Specific Questions:

- Are each staff member's strengths and skills utilized to provide the best quality care to consumers/clients and a high degree of job satisfaction to that staff member?
- Are staff members offered development, training, or other support opportunities to assist with work-related challenges and difficulties? To build on staff skills and abilities? To further their career goals?
- Do all staff members receive annual training in areas related to trauma, including the impact of workplace stressors?
- Do program directors and supervisors adopt a positive, affirming attitude in

encouraging staff, both clinicians and support staff, to fulfill work tasks?

- Is there appropriate attention to staff accountability and shared responsibility or is there a "blame the person with the least power" approach? Is supervisory feedback constructive, even when critical?

Domain 2. Formal Services Policies

Key Questions: "To what extent do the formal policies of the program reflect an understanding of trauma survivors' needs, strengths, and challenges? Of staff needs? Are these policies monitored and implemented consistently?"

Some Possible Indicators:

♦Policies regarding confidentiality and access to information are clear; provide adequate protection for the privacy of both consumers and staff members; and are communicated to the consumer and staff in an appropriate way.

♦The program avoids involuntary or potentially coercive aspects of treatment—involuntary hospitalization or medication, representative payeeship, outpatient commitment—whenever possible.

♦The program has developed a de-escalation or "code blue" policy that minimizes the possibility of retraumatization.

♦The program has developed ways to respect consumer preferences in responding to crises—via "advance directives" or formal statements of consumer choice.

♦The program has a clearly written, easily accessible statement of consumers' and staff members' rights and responsibilities as well as a grievance policy.

♦The program's policies address issues related to staff safety. For example:

- Policies address if and when a staff member may be alone in the building or on duty.
- Policies govern specific ways for staff to offer home or community based services.
- Incident reviews follow verbal or physical confrontations and lead to effective plans to reduce staff vulnerability.

Domain 3. Trauma Screening, Assessment, Service Planning and Trauma-Specific Services

Key Question: "To what extent does the program have a consistent way to identify individuals who have been exposed to trauma, to conduct appropriate follow-up assessments, to include trauma-related information in planning services with the consumer, and to provide access to effective and affordable trauma-specific services?"

Some Possible Indicators:

♦ Staff members have reviewed existing instruments to see the range of possible screening tools.

♦ At least minimal questions addressing physical and sexual abuse are included in trauma screening.

♦ Screening avoids overcomplication and unnecessary detail so as to minimize stress for consumers.

♦ The program recognizes that the process of trauma screening is usually much more important than the content of the questions. The following have been considered:

- What will it mean to ask these questions?
- How can they be addressed most appropriately—for the likely consumers, for the service context, time available, prior relationship, possible future relationship, at various points in the intake/assessment process?

♦ The need for standardization of screening across sites is balanced with the unique needs of each program or setting.

♦ The screening process avoids unnecessary repetition. While there is no need to ask the same questions at multiple points in the intake or assessment process, there is often a good rationale for returning to the questions after some appropriate time interval.

♦ Screening is followed as appropriate (given the nature and goals of the program, the length of time consumers are involved, and the specific relationships established with staff members) by a more extensive assessment of trauma history (type, duration, and timing of trauma) and of trauma-related sequelae (addressing resilience-related strengths and coping skills as well as vulnerabilities and problems).

♦ In service planning, clinicians and consumers discuss ways in which trauma may be taken into account in clinicians' work with the consumer to achieve the consumer's goals (e.g., the place of trauma and trauma-related strengths and problems in giving shape to the recovery plan, its priorities, and the services and other supports that may be useful).

♦ The program either offers or makes referrals to accessible, affordable, and effective trauma-specific services. Group and individual approaches to trauma recovery and healing are both available.

Part B: Systems-level/Administrative Changes

Domain 4. Administrative Support for Program-Wide Trauma-Informed Services

Key Question: " To what extent do program or agency administrators support the integration of knowledge about violence and abuse into all program practices?"

Some Possible Indicators:

♦ The existence of a policy statement or the adoption of general policy statement from other organizations that refers to the importance of trauma and the need to account for consumer experiences of trauma in service delivery.

♦ The existence of a "trauma initiative" (e.g., workgroup, trauma specialist).

- Designation of a competent person with administrative skills and organizational credibility for this task.
- Chief administrator meets periodically with trauma workgroup or specialist.
- Administrator supports the recommendations of the trauma workgroup or specialist and follows through on these plans.

♦ Administrators work closely with a Consumer Advisory group that includes significant trauma survivor membership. Consumer-survivor members of this group identify themselves as trauma survivors and understand a part of their role as consumer advocacy. They.play an active role in all aspects of service planning, implementation, and evaluation.

♦Administrators are creative in finding ways to elicit consumer suggestions and feedback on the process of becoming trauma-informed. These mechanisms may include focus groups; suggestion boxes; walk-throughs by senior administrators to "check in" with consumers (and staff); brief feedback sessions or surveys following groups or other interventions; special events to highlight the initiative; among others.

♦Administrators actively support the trauma-informed culture change initiative by "marketing" it throughout the agency, raising its profile and making it a central part of the program's agenda and mission. Administrators recognize the value of everyone's enthusiastic participation in the initiative and facilitate broad-based buy-in from all groups.

♦ Administrators make collaboration and shared decision-making a key part of their leadership style. When working with staff members and consumer advisors, they listen respectfully and solicit ideas for project development. Whenever possible and practical, they involve both staff and consumers in planning, implementing, and evaluating program changes.

♦ Administrators make basic resources available in support of trauma-informed service modifications (e.g., time, space, training money).

♦ Administrators support the availability and accessibility of trauma-specific services where appropriate; they are willing to be creative about finding alternative reimbursement strategies for trauma services.

♦ Administrators find necessary sources of funding for trauma training and education (this sometimes requires going outside the usual funding mechanisms in a creative way).

♦ Administrators are willing to release both direct service and support staff from their usual duties so that they may attend trainings, plan trauma-informed changes, and deliver trauma-specific services. Funding is sought in support of these activities.

♦ Administrators are willing to attend trauma training themselves (vs. sending designees in their places); they allocate some of their own time to trauma-focused work (e.g., meeting with trauma initiative representatives, keeping abreast of trauma initiatives in similar program areas).

♦ Administrators participate actively in identifying objectives for systems change.

♦ Administrators monitor the program's progress by identifying and tracking core objectives of the trauma-informed change process

♦ Administrators may arrange pilot projects for trauma-informed parts of the system.

Domain 5. Staff Trauma Training and Education

Key Question: "To what extent have all staff members received appropriate training in trauma and its implications for their work?"

Some Possible Indicators:

♦ General education (including basic information about trauma and its impact) has been offered for all employees in the program with a primary goal of sensitization to trauma-related dynamics and the avoidance of retraumatization.

♦ Staff members have received education in a trauma-informed understanding of unusual or difficult behaviors. (One of the emphases in such training is on respect for people's coping attempts and avoiding a rush to negative judgments.)

♦ Staff members have received basic education in the maintenance of personal and professional boundaries (e.g., confidentiality, dual relationships, sexual harassment).

♦ Clinical staff members have received trauma education involving specific modifications of services in their content area: clinical, residential, case management, substance use, for example.

♦ Staff members have received training in basic coping skills for trauma survivors, including psychoeducational framing of trauma-related experiences and coping responses, grounding and emotional modulation techniques, and safety planning,

♦ Trauma clinicians have received training in additional skills-based and other trauma-specific approaches.

♦ Staff members offering trauma-specific services are provided adequate support via supervision and/or consultation (including the topics of vicarious traumatization and clinician self-care).

Domain 6. Human Resources Practices: "To what extent are trauma-related concerns part of the hiring and performance review process?"

Key Question: "To what extent are trauma-related concerns part of the hiring and performance review process?"

Some Possible Indicators:

♦ The program seeks to hire (or identify among current staff) trauma "champions," individuals who are knowledgeable about trauma and its effects; who prioritize trauma sensitivity in service provision; who communicate the importance of trauma to others in their work groups; and who support trauma-informed changes in service delivery.

♦ Prospective staff interviews include trauma content (What do applicants know about trauma? about domestic violence? about the impact of childhood sexual abuse? Do they understand the long-term consequences of abuse? What are applicants' initial responses to questions about abuse and violence?)

♦ Incentives, bonuses, and promotions for line staff and supervisors take into account the staff member's role in trauma-related activities (specialized training, program development, etc.).

Addendum A: Possible Items for Consumer Satisfaction Surveys

(Items are worded to be consistent with a Likert response scale from "strongly disagree" to "strongly agree;" specific items and wording should be tailored to the program's goals and services)

Safety
- When I come to [program], I feel physically safe.
- When I come to [program], I feel emotionally safe.

Trustworthiness
- I trust the people who work here at [program].
- [Program] provides me good information about what to expect from its staff and services.
- I trust that people here at [program] will do what they say they are going to do, when they say they are going to do it.
- The people who work here at [program] act in a respectful and professional way toward me.

Choice

- [Program] offers me a lot of choices about the services I receive.
- I have a great deal of control over the kinds of services I receive, including when, where, and by whom the services are offered.
- People here at [program] really listen to what I have to say about things.

Collaboration
- At [program], the staff is willing to work with me (rather than doing things for me or to me).
- When decisions about my services or recovery plan are made, I feel like I am a partner with the staff, that they really listen to what I want to accomplish.
- Consumers play a big role in deciding how things are done here at [program].

Empowerment
- [Program] recognizes that I have strengths and skills as well as challenges and difficulties.
- The staff here at [program] are very good at letting me know that they value me as a person.
- The staff here at [program] help me learn new skills that are helpful in reaching my goals.
- I feel stronger as a person because I have been coming to [program].

Trauma Screening Process
- The staff explained to me why they asked about difficult experiences in my life (like violence or abuse).
- The staff are as sensitive as possible when they ask me about difficult or frightening experiences I may have had.
- I feel safe talking with staff here about my experiences with violence or abuse.

This document was prepared by: Roger D. Fallot, Ph.D. and Maxine Harris, Ph.D.
Community Connections
October, 2002; May, 2003; March, 2004; February, 2005; March, 2006; April, 2009; July, 2009

For further information, please contact:

Roger D. Fallot, Ph.D.
Director of Research and Evaluation
202.608.4796 (voice)
202.608.4286 (fax)
rfallot@ccdc1.org

Rebecca Wolfson Berley, MSW
Director of Trauma Education
202.608.4735 (voice)
202.608.4286 (fax)
rwolfson@ccdc1.org

Community Connections
801 Pennsylvania Avenue, S.E.
Suite 201
Washington, DC 20003

Citation:

Harris, M. and Fallot, R. (Eds.) (2001). *Using Trauma Theory to Design Service Systems*. New Directions for Mental Health Services. San Francisco: Jossey-Bass.

The developers of this approach would like to acknowledge the assistance in expanding and enriching this protocol of the many individuals and programs that have participated in *Creating Cultures of Trauma-Informed Care* trainings and consultations.

Appendix C: Staff Interview Guide

RCA Staff Questions

Client Satisfaction Survey

Can you please describe TIC as you understand it?

What TIC background do you have? (Education/previous experience) (What formal training have you received in TIC?)

How comfortable do you feel when giving TIC?

How competent do you feel at providing TIC?

What does RCA do to support you in providing trauma-informed care? What more could they do?

How do you help clients feel empowered during sessions?

What do you do to help clients feel respected?

What do you do to keep clients informed about their treatment?

What do you do to keep clients hopeful about their recovery?

What do you do to help clients feel emotionally safe during individual counseling? How about group counseling?

What do you do to help clients feel physically safe during individual counseling? How about group counseling?

TRAUMA-INFORMED CARE

How do you help your clients make the connections between their trauma, trauma symptoms, and substance abuse?

How do you assess trauma during individual counseling? (When do you assess trauma during individual counseling?)

How do you record the trauma? (How do you make notes of trauma and triggers?)

What trauma-related referrals have you made? How do you follow up on these referrals? What support do you need to improve your referrals, if there is anything to improve?

How do you create treatment plans that address trauma?

How do you include the client in these plans? (Are the clients goals a priority? Does the client have a clear voice in plan?)

How do you think the clients feel about receiving TIC? Do they notice a difference?

What effect in your group/individual sessions does TIC have? (How does TIC improve your interactions with clients? What could be better?)

What self-care do you do? How do you stay safe?

Any other comments you want to make? (Is there anything you want the evaluation to include that I haven't asked?)

Appendix D: Client Interview Guide

RCA Client Questions

Age:	Date of Entry into Treatment Program:
Gender:	Other services from RCA:
Race/Ethnicity:	Identifier:

Safety

When I come to RCA, I feel physically safe.

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

What does RCA do to help you feel physically safe? What could RCA do to help you feel physically safer?

When I come to RCA, I feel emotionally safe.

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

What does RCA do to help you feel emotionally safe? What could RCA do to help you feel safer?

My first contact (by phone or in person) with the program was welcoming and respectful.

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

The staff (including the reception staff) notice signs of distress among fellow clients and respond in a gentle, compassionate way.

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

I was given clear guidelines **in advance** about what to expect of the program

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

Trustworthiness

I trust the people who work here at RCA.

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

RCA provides me good information about what to expect from its staff and services.

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

I trust that people here at RCA will do what they say they are going to do, when they say they are going to do it.

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

I trust that people here at RCA will protect my private information and records as much as possible.

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

The people who work here at RCA act in a respectful and professional way toward me.

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

Choice

I knew about all the service options at RCA, like the types of services offered, housing possibilities, and clinicians, before I started my treatment planning.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

RCA offers me a lot of choices about the services I receive.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

What improvements about choices would you like to see?

I have a great deal of control over the kinds of services I receive, including when, where, and by whom the services are offered.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

People here at RCA really listen to what I have to say about things.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

My goals are treated as the most important factor in my recovery plan by the people at RCA.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

RCA is easy to get to for me (by MARTA/car).

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

The services I receive are given at times that work for me.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

Collaboration

At RCA, the staff is willing to work with me (rather than doing things for me or to me).

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

When decisions about my services or recovery plan are made, I feel like I am a partner with the staff, that they really listen to what I want to accomplish.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

Consumers play a big role in deciding how things are done here at RCA.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

My group sessions are responsive to what I and other consumers want.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

Empowerment

RCA recognizes that I have strengths and skills as well as challenges and difficulties.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

The staff here at RCA are very good at letting me know that they value me as a person.

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

What have the staff said or done that made you feel valued or not valued?

The staff here at RCA help me learn new skills that are helpful in reaching my goals.

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

Can you think of a particular skill that RCA has helped you learn? What was the experience like?

I feel stronger as a person because I have been coming to RCA.

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

Can you tell me about a time that the program helped you feel stronger? Or what could the program do to help you feel stronger?

Now I am going to ask about questions related to "trauma." If you need to skip any questions or check in with a counselor, please let me know.

Trauma-Specific

I understand what trauma is.

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

I know what symptoms related to trauma are.

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

The staff explained to me why they asked about difficult experiences in my life (like violence or abuse).

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

Was never asked about difficult experiences

The staff are as sensitive as possible when they ask me about difficult or frightening experiences I may have had.

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

Was never asked about difficult or frightening experiences

I feel safe talking with staff here about my experiences with violence or abuse.

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

TRAUMA-INFORMED CARE

I'd like to ask some questions about the way that RCA handles trauma in the treatment setting. People can have different ideas about what trauma is, and there are no right or wrong definitions. For this interview, I am defining trauma as any experienced violence or trauma in any setting, including community or school violence; physical, psychological, or sexual mistreatment/assault within or outside of the family; natural disaster; terrorism; neglect, or traumatic grief (GPRA). Please consider this definition as you answer the next questions, even if you don't think that those experiences were traumatic. Also, some people have trauma that is related to their substance abuse or substance abuse related to their trauma. If you feel like some questions do not apply to you or you do not want to answer these questions, please let me know.

RCA staff have helped me understand the connections between my trauma and symptoms related to trauma.

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

Not Applicable

RCA staff have helped me understand the connections between my trauma and substance abuse.

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

Not Applicable

RCA staff have helped me understand the connections between my trauma symptoms and substance abuse.

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

Not Applicable

What could they do better in helping you make connections between your trauma, trauma symptoms, and substance abuse?

Can you tell me about a time where peer leaders at RCA have helped you in your recovery?

Can you tell me about any trauma-specific referrals RCA has made and how they worked out for you?

I feel hopeful about my recovery

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

What have the staff said or done that made you feel hopeful or not hopeful?

Are there any comments or stories that you would like to add as a part of the evaluation?

Appendix E: Client and Staff Combined Codebook

Evaluation Question	Codes and Subcodes	Explanations of Code	
		Clients	Staff
Institution	Institutional Support		How RCA supports staff in providing care to clients, particularly TIC
Institution	TIC Training and Education		TIC training or education
	Comfortable and Competent		How comfortable and competent staff feel in providing TIC
Institution	Self-Care		How staff take care of themselves and how RCA supports them in self-care
Institution	TIC Definition		How staff define TIC
Institution	Effects of TIC		What effects of TIC staff observe on clients
Institution	Peer Leaders	Peers who help them; People who are former clients who have leadership positions (alumni); counselors who are/were in recovery	
Institution	Trauma-related Referrals	Experiences with referrals for trauma treatment outside of RCA	When, how, and why trauma referrals are made and work out for clients
Trauma Addressed			
Trauma Addressed	Trauma Addressed	How the staff members make connections between substance abuse, trauma, and symptoms related to trauma. Client experience of trauma treatment at RCA, including referrals.	How the staff make connections between substance abuse, trauma, and symptoms related to trauma. Activities related to the treatment of trauma
Trauma Assessment	Trauma Assessment		How staff assess trauma

5 Principles of TIC	Empowerment		Feel stronger or weaker or empowered or unempowered. Or valued or not valued	How staff helps clients feel respected and empowered at RCA
		Skills	Skills they feel RCA helped build	Specific skills taught by staff to clients or learned by clients
		Hopeful	How they feel RCA helps them be hopeful. Or reasons why they feel hopeful	How staff helps clients feel hopeful.
5 Principles of TIC	Safety		General safety or protection from harm	General safety or protection from harm
		Physical Safety	Physical safety	Providing or experiencing physical safety
		Emotional Safety	Emotional safety and support, including triggers	Providing or experiencing emotional safety and support, including triggers
5 Principles of TIC	Trustworthiness		They feel like they can trust or not trust RCA	They feel like they can trust or not trust RCA
5 Principles of TIC	Collaboration		Organization does stuff with them not to them. Clients have active say in their treatment plans.	How staff work with clients in creating treatment plans.
5 Principles of TIC	Choice		The clients feel like they have choices or don't have choices. They are informed or uninformed about choices	How staff keep clients informed about their treatment options and plans.
Overall	Positive Experiences		Specific instance or a specific attribute that the client feels is good	
Overall	Negative Experiences		Specific instance or a specific attribute that the client feels is bad	
Overall	Reasons for Not Agreeing		Any responses to non-agreeing quantitative questions	
Overall	Suggestions for Improvement		Recommendations and solutions to problems	Recommendations and solutions to problems

Appendix F: IRB Exemption

RE: IRB approval for a program evaluation
Copplestone, Martha
Sent: Friday, April 05, 2013 11:35 AM
To: Acker, Carolyn Jayne

Hi Carolyn,

If the results will not be generalizable, then your project isn't considered "research" according to our definitions. So you won't need IRB review or oversight. If you have any further questions, please let us know.

Thanks!
Martha

Appendix G: Staff Consent Form

Emory University
Consent to be a Research Participant

Title: Process Evaluation of a Trauma Informed Care at Recovery Consultants of Atlanta, Inc.

Principal Investigator:
Carolyn Acker, BA
MPH Candidate 2014
Behavior Science and Health Education
Emory University

Funding Source:
SAMHSA

Introduction
You are being invited to be in an evaluation that will be used as a Master's thesis. An evaluation is a study that finds out if a program works the way that it wants to. This form is designed to tell you everything you need to think about before you decide to consent (agree) to be in the evaluation and Master's thesis research or not to be in them. **It is entir ely your choice. If you decide to take part, you can change your mind later on and withdraw from the research. You can skip any questions that you do not wish to answer.**

Before making your decision:

- Please listen carefully as I read this form to you
- Please ask questions about anything that is not clear

You can take a copy of this consent form, to keep. Feel free to take your time thinking about whether you would like to participate. By signing this form you will not give up any legal rights.

Evaluation Overview
The purpose of this evaluation is to find out how well RCA is implementing Trauma-Informed Care. The findings will be used to keep doing or grow what works well and to improve what could be done better. They will also be used as Carolyn Acker's Master's thesis.

Procedures
This is a one-time interview. The interviewer will ask questions, and, based on your understanding of the question, you are free to answer as few or as many questions as you want with details and stories that you have experienced. If you need the interviewer to repeat or explain the question, feel free to ask her to do so. It should take about 30 minutes.

Risks and Discomforts
By signing this consent form you agree to allow the evaluation team to produce confidential files. To keep your records confidential, your written records, including this informed consent form, notes from this interview, and a transcript of the interview, will be kept offsite in a locked filing cabinet. The recorded interview will be kept in two locations: on a password-protected computer and a secure personal drive on a university computer. The interview will be erased from the recording device as soon as possible. However, it is possible that a breach of confidentiality can still occur.

I will not ask for details about your trauma and am not trained to help. I will only ask questions related to your activities at RCA. However, this interview still may cause discomfort. You are free to stop the interview at any time, and the researcher will connect you with a counselor here at RCA.

Benefits

This evaluation is designed to benefit you directly through improved services at RCA. It could also improve care for others at RCA, too.

Compensation

You will not be offered payment for being in this evaluation, but you will be provided snacks and drinks for your participation.

Working at RCA

You do not have to be in this evaluation to work at RCA. It will **not** affect your current position at RCA to be or **not** to be a part of it.

Confidentiality

Certain offices and people other than the researchers may look at evaluation records. Evaluation records include the recorded and written version of your interview and consent form. These records include demographic information, like gender and age. A pseudonym rather than your name will be used on evaluation records wherever possible. These documents will be kept on password-protected computers and in locked file storage. Records will be destroyed in May 2015, a year after the evaluation and thesis are completed in May 2014. Government agencies and Emory employees overseeing proper evaluation conduct may look at your records. These offices include those of RCA, Khurram Hassan, Carolyn Acker's internship supervisor and a consultant working with RCA, and Dr. Iris Smith, faculty thesis advisor at Emory University. Emory will keep any research records we create private to the extent we are required to do so by law. Your name and other facts that might point to you will not appear when we present this evaluation.

Evaluation records can be opened by court order. They may also be produced in response to a subpoena or a request for production of documents.

Your evaluation records will not be filed in your personal records at RCA.

Voluntary Participation and Withdrawal from the Evaluation

You have the right to leave the evaluation at any time without penalty. You may refuse to answer any questions you do not wish to answer. Your interview and evaluation records will be destroyed and the information not used.

Contact Information

Contact Carolyn Acker at 817-874-4927:

- if you have any questions about this evaluation or your part in it, or
- if you have questions, concerns or complaints about the evaluation

Contact Khurram Hassan at Advantage Consulting LLC at 404-213-9825:

- if you have questions about your rights as an evaluation participant, or
- if you have questions, concerns or complaints about the evaluation.

Contact Dr. Iris Smith at Emory University at 404-727-2925:

- if you have questions about your rights as an evaluation participant, or
- if you have questions, concerns or complaints about the evaluation.

Consent

Please, print your name and sign below if you agree to be in this evaluation. By signing this consent form, you will not give up any of your legal rights. I will give you a copy of the signed consent to keep.

_____

Name of Subject

_____ _____

Signature of Subject Date Time

_____ _____

Signature of Person Conducting Informed Consent Discussion Date Time

Appendix H: Client Consent Form

EVALUATION AND MASTER'S THESIS CONSENT FORM

Emory University
Consent to be a Research Participant

Title: Process Evaluation of Trauma Informed Care at Recovery Consultants of Atlanta, Inc.

Principal Investigator:
Carolyn Acker, BA
MPH Candidate 2014
Behavior Science and Health Education
Emory University

Funding Source:
SAMHSA

Introduction
You are being invited to be in an evaluation that will be used as a Master's thesis. An evaluation is a study that finds out if a program works the way that it wants to. This form is designed to tell you everything you need to think about before you decide to consent (agree) to be in the evaluation and Master's thesis research or not to be in them. **It is entirely your choice. If you decide to take part, you can change your mind later on and withdraw from the research. You can skip any questions that you do not wish to answer.**

Before making your decision:

- Please listen carefully as I read this form to you
- Please ask questions about anything that is not clear

You can take a copy of this consent form, to keep. Feel free to take your time thinking about whether you would like to participate. By signing this form you will not give up any legal rights.

Evaluation Overview
The purpose of this evaluation is to find out how well RCA is implementing Trauma-Informed Care. The findings will be used to keep doing or grow what works well and to improve what could be done better. They will also be used as Carolyn Acker's Master's thesis.

Procedures
This is a one-time interview. The interviewer will ask questions, and, based on your understanding of the question, you are free to answer as few or as many questions as you want. The format of the interview is a mix of open-ended and close-ended questions. For the close-ended questions, statements will be made and you can indicate how strongly you agree or disagree with that statement. The open-ended questions request personal opinions and stories that you have related to the program. If you need the interviewer to repeat or explain the questions, feel free to ask her to do so. The interview should take about 20-30 minutes.

Risks and Discomforts
By signing this consent form you agree to allow the evaluation team to produce confidential files. To keep your records confidential, your written records, including this informed consent form, notes from this interview, and a transcript of the interview, will be kept offsite in a locked filing cabinet. The recorded interview will be kept in two locations: on a password-protected computer and a secure personal drive on a university computer. The interview will be erased from the recording device as soon as possible. However, it is possible that a breach of confidentiality can still occur.

EVALUATION AND MASTER'S THESIS CONSENT FORM

I will not ask for details about your trauma and am not trained to help. I will only ask questions related to your care at RCA. However, this interview still may cause discomfort. You are free to stop the interview at any time, and the researcher will connect you with a counselor here at RCA.

Benefits

This evaluation is designed to benefit you directly through improved services at RCA. It could also improve care for others at RCA, too.

Compensation

You will not be offered payment for being in this evaluation, but you will be provided snacks and drinks for your participation.

Care at RCA

You do not have to be in this evaluation to receive care at RCA. It will **not** affect your current services at RCA to be or **not** to be a part of it.

Confidentiality

Certain offices and people other than the researchers may look at evaluation records. Evaluation records include the recorded and written version of your interview and consent form. These records include demographic information, like gender and age. A pseudonym rather than your name will be used on evaluation records wherever possible. These documents will be kept on password-protected computers and in locked file storage. Records will be destroyed in May 2015, a year after the evaluation and thesis are completed in May 2014. Government agencies and Emory employees overseeing proper evaluation conduct may look at your records. These offices include those of RCA, Khurram Hassan, Carolyn Acker's internship supervisor and a consultant working with RCA, and Dr. Iris Smith, faculty thesis advisor at Emory University. Emory will keep any research records we create private to the extent we are required to do so by law. Your name and other facts that might point to you will not appear when we present this evaluation.

Evaluation records can be opened by court order. They may also be produced in response to a subpoena or a request for production of documents.

Your evaluation records will not be filed in your personal records at RCA.

Voluntary Participation and Withdrawal from the Evaluation

You have the right to leave the evaluation at any time without penalty. You may refuse to answer any questions you do not wish to answer. Your interview and evaluation records will be destroyed and the information not used.

Contact Information

Contact Carolyn Acker at 817-874-4927:

- if you have any questions about this evaluation or your part in it, or
- if you have questions, concerns or complaints about the evaluation

Contact Khurram Hassan at Advantage Consulting LLC at 404-213-9825:

- if you have questions about your rights as an evaluation participant, or

- if you have questions, concerns or complaints about the evaluation.

Contact Dr. Iris Smith at Emory University at 404-727-2925:

- if you have questions about your rights as an evaluation participant, or
- if you have questions, concerns or complaints about the evaluation.

Consent

Please, print your name and sign below if you agree to be in this evaluation. By signing this consent form, you will not give up any of your legal rights. I will give you a copy of the signed consent to keep.

_____

Name of Subject

_____ _____

Signature of Subject Date Time

_____ _____

Signature of Person Conducting Informed Consent Discussion Date Time

Appendix I: Client Survey Reasons for Less than Agreement

Client Survey Reasons for Not Agreeing			
Empowerment (n=23)	**Average Score**	**Less than Agree**	**Explanation**
I feel hopeful about my recovery	4.8	0	
The staff here at RCA are very good at letting me know that they value me as a person.	4.6	0	
I feel stronger as a person because I have been coming to RCA.	4.5	0	
The staff here at RCA help me learn new skills that are helpful in reaching my goals.	4.5	1	Client neither agreed nor disagreed. Reported learning skills.
Total	**4.6**	**1**	

Safety (n=23)	**Average Score**	**Less than Agree**	**Explanation**
The staff (including the reception staff) notice signs of distress among fellow clients and respond in a gentle, compassionate way.	4.7	1	"In the housing, they kinna nosy and treat you like little kids."
My first contact (by phone or in person) with the program was welcoming and respectful.	4.6	1	
I was given clear guidelines in advance about what to expect of the program	4.6	1	Better job explaining program to clients unfamiliar with the program before they commit to it.
When I come to RCA, I feel emotionally safe.	4.5	1	Program does things to help them feel emotionally safe, and the participant doesn't know what they could do better.
When I come to RCA, I feel physically safe.	4.4	0	
Total	**4.5**	**4**	

Trustworthiness (n=23)	**Average Score**	**Less than**	**Explanation**

		Agree	
RCA provides me good information about what to expect from its staff and services.	4.7	0	
I trust the people who work here at RCA.	4.6	0	
The people who work here at RCA act in a respectful and professional way toward me.	4.5	0	
I trust that people here at RCA will protect my private information and records as much as possible.	4.5	1	Had Breach of Confidentiality
I trust that people here at RCA will do what they say they are going to do, when they say they are going to do it.	4.3	2	Could have better follow-up on referrals.
Total	**4.5**	**3**	

Collaboration (n=23)	Average Score	Less than Agree	Explanation
At RCA, the staff is willing to work with me (rather than doing things for me or to me).	4.6	0	
My group sessions are responsive to what I and other consumers want.	4.4	1	Reported being assigned classes without their input.
When decisions about my services or recovery plan are made, I feel like I am a partner with the staff, that they really listen to what I want to accomplish.	4.3	2	Reported being assigned classes without their input. Another thought the service providers could listen more.
Consumers play a big role in deciding how things are done here at RCA.	4.2	3	Listen more. Another didn't know what RCA could do better.
Total	**4.4**	**6**	

Choice (n=23)	Average Score	Less than Agree	Explanation
My goals are treated as the most important factor in my recovery plan by the people at RCA.	4.6	0	
RCA is easy to get to for me (by MARTA/car).	4.5	1	Issues with MARTA
People here at RCA really listen to what I have to say about things.	4.5	1	Listen more.
The services I receive are given at times that work for me.	4.5	0	
RCA offers me a lot of choices about the services I receive.	4.2	3	More help with jobs and job placement, including possibly a connection with an outside employer; more leads on hospitalization and housing. One indicated that while there aren't many choices, they are happy with the service they are receiving
I knew about all the service options at RCA, like the types of services offered, housing possibilities, and clinicians, before I started my treatment planning.	4.0	3	Didn't know what to expect when they came to the program. One felt they were getting half of the information. One indicated that they got the information but it didn't stick because they weren't thinking clearly.
I have a great deal of control over the kinds of services I receive, including when, where, and by whom the services are offered.	3.8	7	Only question with average below Agree. Many said that there was a set format that they had to follow. One doesn't want to be in control – that's the program's job. Another thinks that the program's format is good. One wanted more leeway with being in phase 2. Another client was frustrated with lack of follow-up and not earning income.
Total	**4.3**	**15**	

Address Trauma	Average Score	Less than	Explanation

		Agree		
		<4	n/a	
RCA staff have helped me understand the connections between my trauma symptoms and substance abuse. (n=18)	4.5	1	5	Didn't want to say what could be better. Three do not have trauma histories. Two were not asked different question but reported ways that RCA helped with trauma and SA connections.
RCA staff have helped me understand the connections between my trauma and substance abuse. (n=18)	4.4	0	5	Three do not have trauma histories. Two were not asked different question but reported ways that RCA helped with trauma and SA connections.
I understand what trauma is. (n=23)	4.4	2	0	One was not sure and the other reported not having trauma.
RCA staff have helped me understand the connections between my trauma and symptoms related to trauma. (n=18)	4.3	1	5	Didn't want to say what could be better. Three do not have trauma histories. Two were not asked different question but reported ways that RCA helped with trauma and SA connections.
I know what symptoms related to trauma are. (n=23)	4.0	5	0	All were men. One reported not having trauma. Another didn't know all of them.
Total	**4.3**	**9**	**-**	

Assess Trauma	**Average Score**	**Less than Agree**		**Explanation**
		>4	n/a	
The staff are as sensitive as possible when they ask me about difficult or frightening experiences I may have had. (n=21)	4.5	0	2	1 client reported not being asked about trauma, and other was not sure.
I feel safe talking with staff here about my experiences with violence or abuse. (n=23)	4.4	2	0	One previously mentioned confidentiality breach. One mentioned that staff could listen better, and the other said staff could ask more questions.
The staff explained to me why they asked about difficult experiences in my life (like violence or abuse). (n=21)	4.4	1	2	1 client reported not being asked about trauma, and 2 others were not sure.
Total	**4.4**	**3**	**-**	